

Operation Recovery: Fort Hood Soldiers & Veterans Testify on the Right to Heal

Iraq Veterans Against the War
Civilian Soldier Alliance
Under the Hood Cafe & Outreach Center

2014

Authorship & Credits

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Cover Image: Chas Jacquier's paperwork binder, folded flag, and munition scrap, photographed in 2014 by Civilian-Soldier Alliance.

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Date of First Publication: May 26, 2014.

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Acknowledgements

This report would not be possible without the many years of GI resistance and campaign organizing engaged in by Iraq Veterans Against the War, Civilian Soldier Alliance, and Under the Hood Cafe and Outreach Center, along with many other individuals and organizations who have committed to this effort.

Many soldier, veteran, and civilian organizers in the Operation Recovery campaign provided critical insights which the authors of this report have attempted to reflect here. We sincerely and humbly hope this writing bolsters the organizing efforts of all who work to transform US militarism.

We would like to give special thanks to participants in the Operation Recovery research team who shaped the testimony project at many points along the way.

Our deep gratitude to Deborah Popowski and Cara Solomon of the International Human Rights Clinic at Harvard Law School, and their student team, which included Aaron Blacksberg, Alexandra Gliga, Stella Kim, and Ankita Ritwik, for their vital research and extremely principled commitment and approach to working with veterans, civilian-allies, and grassroots organizations. Thank you also to Harvard Law Student Advocates for Human Rights members Kathleen Borschow, Kathryn Boulton, and Mary (Katie) McCarthy for their generous help in transcription and editing.

We would also like to extend our appreciation to the following:

The Board staff of Under the Hood, especially Malachi Muncy and Lori Hurlebaus; The Military Law Task Force of the National Lawyers Guild for legal advisement and technical assistance at many points along the way; Heidi Rhodes for providing critical editorial support and feedback; scholars Angana P. Chatterji and Richard Shapiro; Jose Vasquez and the Winter Soldier testimony team for setting up rigorous practices enabling veteran testimony which we drew from; Right to Heal Initiative partners: The Center for Constitutional Rights, Organization of Women's Freedom in Iraq, and The Federation of Workers Councils and Unions in Iraq; Professor Mutombo Mpanya; The Operation Recovery outreach team and resident organizers: Aaron Hughes, Maggie Martin, Matt Howard, Sergio Kochergin, Scott Kimball, Graham Clumpner, Jason Matherne, Malachi Muncy, Lori Hurlebaus, LT Taylor, Rushelle Frazier, Sergio Espana; and the Operation Recovery campaign organizing team.

We dedicate this work to the many who have died after the wars have ended, including IVAW member Jacob David George, and to those who are still suffering.

Finally, we would like to thank the testifiers themselves who took time and care in sharing their experiences and insights with the hope of building communities based on dignity, compassion, and respect.

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Preface: A Letter from a Veteran

Aaron Hughes, September 2014

Where the sun beats down, in Killeen, Texas, on Fort Hood Street, there is an empty neglected parking lot. Every day, thousands of Killeen citizens and Fort Hood soldiers pass by without notice. But in the midst of this vast blacktop field, there are blades of grass breaking through into the light, revealing cracks in the structure designed to transform the grasslands into a sturdy functional lifeless space. And just as these blades of grass break through the neglected lot reclaiming landscapes, the voices in this report break through the military culture and reclaim their humanity.

In this report, you will read 31 testimonies from Fort Hood active-duty soldiers, veterans, and family members who bravely and with great vulnerability shared their stories in order to expose the disconnect between the realities of their military experiences and the military's policies and procedures for supporting them. Their voices, and the years of research, organizing, and relationship building that went into this report, expose the neglect and abuse inherent in the current military structure, and lay bare the isolation that many service-members, military family members, and veterans feel.

I believe this report will serve as a bridge between American civilians and the lived experiences of our current military members during this perpetual Global War. The testimonies ask a question about empathy: can the gulf between someone in pain and someone hearing about pain be bridged? Elaine Scarry sums up the inherent disconnect between those in pain and those hearing about pain in her book *The Body in Pain*. Scarry writes:

To have pain is to have certainty; to hear about pain is to have doubt...for the person in pain, so incontestably and un-negotiably present is that "having pain" may come to be thought of as the most vibrant example of what it is to "have certainty," while for the other person it is so elusive that "hearing about pain" may exist as the primary model of what it is "to have doubt."

Can this doubt be overcome? The individuals that made this report possible—the organizers, community members, allies, and testifiers—would like to think it can be overcome with only a bit of compassion. Unfortunately, from what I have seen, studied, and experienced, the military does not value or promote compassion. Compassion is not one of the seven Army values, nor is it mentioned as a "core value" by any of the other branches of service. Instead, compassion is often viewed in the military as a sign of weakness and vulnerability.

Alternatively, pain itself is lifted up as an unofficial value and an understood constant on the path to strength, power, and leadership in the military. "No pain, no gain" and "Pain is weakness leaving the body" are common Army sayings. This pain uplifted by the military culture may look like blood pooling from massive physical trauma, or it may look like fractured bones, missing limbs, and burnt flesh; more than likely, though, it does not have a look. Instead it is hidden deep inside inflamed lungs from cancer-causing burn pits, or in the sound of popping, rotting arthritic joints from years of toting heavy gear, or in the irritation of an itchy chronic rash from an undiagnosed, unknown disease, or in the fog of benzodiazepines, or in the isolation of harassment, abuse and assault, or in the forgetting of Traumatic Brain Injury, or in the confusing anxiety of Post Traumatic Stress, or in the anger and depression of knowing that none of it—not the catch 22s, the military bureaucracy, the killing, the destruction, the death, the failed foreign policy, nor the daily mind-numbing grind—stops.

The truth is that this state of pain, dehumanization, and violence has become institutionalized and normalized in the military so much so that many service-members stop seeking out relief or have any hope for compassion for their pain. This report, however, is an opportunity for individuals in the military structure and the wider American society to be inspired to compassion and begin to understand the certainty of service-members' pain and the military structure that perpetuates it. This compassion is the first step towards ensuring the dignity, respect, and humanity of service-members, military family members, veterans, and those affected by war.

While I was in the military, and specifically during my deployment, I would obsessively look for signs of hope and beauty in the midst of the desolation and exhaustion of long missions, mind-numbing tasks, and hours upon hours of waiting. I remember finding delicate desert flowers growing in dry drab earth, obsessively watching small, scraggly sparrows sing in engine-roaring motor pools, and pink sunrises on cold, gray mornings.

It was these sunrises, desert flowers, and sparrows that came to mind in 2008 when I first learned of Iraq War veteran Ron Cantu and other anti-war active duty soldiers organizing themselves at Fort Hood, and again in 2009 when I learned about the opening of Under the Hood Cafe and Outreach Center, just down the road from the East Gate of Fort Hood. Like desert flowers, these individuals and the space they built were beacons of hope and compassion in the midst of the exhaustion of accelerated deployment cycles and a community grappling with the isolation and pain from nearly a decade of war.

For the next two years, under the guidance of military spouse Cindy Thomas and a growing community of anti-war active duty soldiers, Under the Hood helped soldiers and their families as they sought acknowledgement, understanding, and relief from their pain, as well as support in resisting the military structure that perpetuated it. Furthermore, the safe space created at Under the Hood facilitated discussions that revealed shared experiences and transformed what the Army considered individual soldiers' issues into military-wide issues that could be confronted as a community. With that framework, a group of people deeply rooted in compassion emerged with the power to provide mental health services for soldiers and family members struggling with trauma, legal support for war resisters, and a community to break through the desolation, exhaustion, and isolation.

It was this work that in January of 2011 inspired the Campaign Team of Iraq Veterans Against the War and Civilian-Soldier Alliance to consider Fort Hood as the focus for its national campaign to stop the deployment of traumatized troops and win service-members' and veterans' right to heal. Later that spring, organizers from around the country put their lives on hold and moved to Fort Hood to join the Operation Recovery campaign. It was an idealistic vision born of an overwhelming situation, but all great social transformations have started off this way. And it is through their campaign work that structural reforms at Fort Hood began to take hold. By summer of 2012, Fort Hood had re-issued a more specific version of its policy protecting soldiers on health-related work restrictions, and command had held a town hall meeting to address the community directly.

This report holds the stories of the individuals that made these changes possible and have paved the way for future voices to speak out. I believe their words will continue to inspire readers to compassion and help them begin to understand the certainty of service-members' pain and change the military structure the perpetuates it. Compassion is the first step towards ensuring the humanity and the right to heal of those in the military and those affected by war.

I leave you with hope, compassion, and two poems from Fort Hood.

Therapy

by Kyle Wesolowski

In this town therapy is secondary
To the needs of our cities' health and humanity
The powers that decide our livelihood make another primary priority
Deciding to fill up our bathroom cabinets instead of giving us therapy
It's all good
They like to prescribe medication to GIs
It's easier to control them when they've made them dependent on a drug forming habit
Forget about fixing combat stress
Just hop us up on benzodiazepines
So we forget the past
dulling our painful reality
Of what war does to our mentality
For some of us we may not have scars or limbs lost
It's taboo in this town
We all know war affects every soldier not just physically
For the pill popping soldier
Fort Hood makes it easier for us who suffer from overmedication
A normality in our health care society
Don't worry about it
If you get the shakes there's a new expressway lane for your quick fix
It just opened up for business
Roll up in your ride to Thomas Moore clinic
10 minutes later you got your fill of dependency
All that's left to do is grab a bottle of water to swallow down handicapped half-assed therapy
So quick so easy, you'll make it back in time to your motor pool duties
The military clearly would rather find their own quick fix to the mental health epidemic
Where did the battle buddy system go?
Anyone can be your battle buddy even General Campbell.
It doesn't exist anymore
A soldier is no better than an Afghan or Iraqi
Put their problems to the side and worry about it years later after they forgot about us
Pills have their place but without therapy the veterans can't live this way forever
For many the help won't come
Suicides happen in regularity
If they're lucky they will at least see the pearly gates
The gates that big book we all know talks about.

Broken Bottles

by Malachi Muncy

Reflected fluorescence
Refracted candescent
Nuance of neons
Outshining ions
Broken bottles
Glisten in the gutter

There are more broken vessels here
More glass
Than stars in the sky
More light from liquor stores
Than shining in eyes

The bottom of bowls burn
Brightly in front of our face
Light bulb of a bad idea
Flickering on
Outshining space

Reflected fluorescence
Refracted condecents
Nuance of neons
Outshining ions
Broken bottles
Glisten in the gutter

Even after emptying every vexing vessel to maintain
Memories mixing menacing most minds may contain
Because this is a military town
There is no such thing as sane

Reflected fluorescence
Refracted candescents
Nuance of neons
Outshining ions
We are broken bottles
and the might of the military is reflected in our remains

Introduction

The 'invisible wounds' of war are everywhere visible at Fort Hood, Texas. As the largest US Army installation, Fort Hood has been home to the highest deployment rates in the country since 2001.¹ Nationally, a total of over 2.6 million service-members have deployed to the wars in Iraq and Afghanistan,² with another 9,000 soldiers deployed to Afghanistan during the winter of 2013-14.³ Fort Hood's III Corps Headquarters recently returned from their April 2013 deployment to Afghanistan as part of the drawdown to 34,000 US troops in Afghanistan as of February 2014.⁴ Now entering its thirteenth year, the war in Afghanistan is the longest-running war in US history, and as of this writing is faced with uncertain future US troop levels and looming post-war insecurity. As this report will address, the tens of thousands of soldiers returning from Afghanistan

also face uncertain futures here at home, as they return to fight for their own medical and mental health care in the military and Veterans Affairs (VA) health systems.

As the first large-scale engagements of the US military since the Vietnam War, the wars in Iraq and Afghanistan were also the first major engagements of the all-volunteer military. Since 2001, the rules and regulations concerning soldier deployment have been revised, and many times neglected, in order to provide the military labor force necessary to engage in simultaneous wars in two different theaters. Never before have US service-members been expected to repeatedly deploy to combat operations on such a massive scale. Over one million veterans of these conflicts



Fallen soldier memorial on Fort Hood

have deployed twice or more—43% of veterans who have served since 2001.⁵ Of these, 20% of active duty soldiers have completed three or more tours, and many special forces units have completed up to eight deployments.⁶ What has been required of a soldier—and their support system—has been drastically different than in previous generations.

Fort Hood and the Right to Heal

This report will present testimony from active duty service-members and veterans who have served at Fort Hood, most of whom have deployed to Iraq and Afghanistan more than once.⁷ Their stories testify to the impacts of the current era of US warfare on soldiers, their families, and communities. Their testimonies highlight the effects of multiple deployments on the experience of trauma, injury, and what it would take to recover. Their testimonies also reveal the unique context of military policies and practices that have made this era of warfare possible, often to the detriment of soldiers and their families.

The Department of Defense (DoD) dictates that all US military departments must “promote and sustain a healthy and fit force, prevent injury and illness, protect the force from health hazards, and deliver the best possible medical and rehabilitative care to the sick and injured anywhere in the world.”⁸ Medical and mental health professionals in the military are tasked with the physical and psychological evaluation and treatment of soldiers, which must be coordinated with the soldier’s chain of command. However, often, the only point of contact between the military health professional’s evaluation and the soldier’s command is a slip of paper. This is the soldier’s ‘Physical Profile,’ which details medically necessary work



US Army III Corps Headquarters building on Fort Hood

restrictions. It remains legal under DoD directives for commanding officers without medical training to override a Physical Profile.⁹ Despite the DoD's stated aspiration to provide unparalleled medical care to its forces, DoD policy also ensures that commanders are able to override work

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restrictions deemed to be medically necessary by military health professionals—up to, and including, the redeployment of medically non-deployable soldiers. Commanders maintain complete discretion over soldiers' medical treatment.

For a soldier with medical or mental health concerns that should limit his or her work duties, the profile governs everything from the routines of daily life and physical training (PT) to whether he or she can carry a weapon or deploy to war. A

physical injury, for example, could necessitate the soldier's profile to order that she not lift over 30 pounds, or that he should "run at his own pace and distance" instead of being required to run in the unit's formation at all times. For soldiers suffering mental health concerns, a profile can direct them to work limited hours, to not handle weaponry or hazardous materials, or to depart regularly from unit activities to attend appointments.

In contrast to DoD policy, at Fort Hood, US Army III Corps Command policy mandates that commanders "must ensure [that] leaders at all levels in their command" adhere to the assessment of soldiers' health restrictions or limitations stipulated by military medical and mental health professionals, as documented on the soldier's profile.¹⁰ Despite its own command policy, profile violation practices remain widespread at Fort Hood—up to, and including, soldiers with 'non-deployable' profiles having been forced to re-deploy to Iraq and Afghanistan, against medical orders.

Rampant profile violation at Fort Hood during the decade-plus of war in Iraq and Afghanistan has meant that traumatized and injured troops have been re-deployed; that soldiers enduring



Carl R. Darnall Army Medical Center, Fort Hood

psychological trauma have been repeatedly made to work in conditions unsafe for their mental health needs; and that the physical health of countless soldiers has been deteriorated because they were forced to complete work tasks harmful to their medical needs. The practice of profile violation at Fort Hood has also meant that commanders and first-line supervisors have been going against command policy, a well-known fact which is met with total impunity.

In response to the military's abuse of soldiers' access to medical and mental health care, Iraq Veterans Against the War (IVAW) began its Operation Recovery campaign in 2010, to demand that the military stop deploying traumatized troops, and that Fort Hood enforce its own policy mandating commanders to respect medical orders.

IVAW based its work during Operation Recovery at Under the Hood Cafe and Outreach Center, a GI coffeehouse modeled after the Vietnam era GI coffeehouse movement, located in Killeen, Texas, just outside the gates of Fort Hood. During the summers of 2011 and 2012, members of

IVAW and Civilian-Soldier Alliance (CivSol) organized outreach drives at Fort Hood, speaking to hundreds of active duty soldiers on base about their rights and their experiences accessing treatment for injuries and trauma, including post-traumatic stress,¹¹ Traumatic Brain Injury (TBI), and military sexual violence.¹² Operation Recovery was an explicitly anti-war campaign; IVAW knew that the US military lacked the power to hold down wars in multiple theaters with an all-volunteer force without enforcing multiple deployments, which in effect meant deploying troops



Under the Hood Cafe and Outreach Center

who had been found medically unfit for re-deployment. The Operation Recovery outreach effort was also undertaken in order to build community and help service-members and veterans transform their own conditions. For many soldiers and veterans, the campaign became a site of their own leadership development, as well as personal transformation—from surviving war and military service to actively participating in work that could transform militarism.

Our conversations quickly revealed that many soldiers and veterans who have served after 2001 now live with extensive histories of abuse and neglect within the military health care system, with little available recourse. The testimony gathering that led to this report began from a need to tell



Campaign banner at Fort Hood gates on Memorial Day in 2012

those histories in a more in-depth form. We imagined these conversations at Fort Hood would give soldiers the opportunity to break the isolation and pathologization surrounding their own struggles. As organizers, we also felt that soldier and veteran testimony could bolster advocacy efforts to change the working conditions of the military and stop the deployment of traumatized troops to war.

The testimony in this report evidences a host of barriers to adequate medical and mental health care in the military, beyond profile violation. One of the most devastating barriers is a military culture that stigmatizes admissions of vulnerability and injury. This stigma not only functions as an informal social norm, but is also institutionalized within the military chain of command and treatment facilities. Many soldiers at Fort Hood testified that they waited until the last possible moment to seek help for their health concerns because of the pervasive culture of stigma. This often exacerbated their injuries and mental health conditions far beyond what might have occurred with immediate treatment. Soldier testimony on this issue shows the military to be often an extremely alienating and punishing context for soldiers who are wounded, which is a hidden factor underlying the surge of active duty and veteran suicides in the last several years.

Military suicides reached an all-time high in Summer 2011, when one active duty service-member died by suicide every 36 hours, a rate which far outpaced combat deaths and was nearly double the civilian suicide rate.¹³ Suicides among veterans continue to be very high as well, with the VA

estimating that an average of 22 veterans die by suicide each day.¹⁴ Active duty suicides at Fort Hood were especially high between 2008 and 2012, peaking in 2010 with 22 soldiers dying by suicide that year. Fort Hood's 19 soldier suicides in 2012 translates to a rate of 42 per 100,000, which is more than double the civilian suicide rate. Suicides at Fort Hood dropped significantly in 2013, but the community continues to grieve the many who have taken their own lives in the last decade.¹⁵ Suicide is most prevalent among young, low-ranking service-members. Moreover, nearly a third of active duty suicides happen among service-members who have never been deployed, suggesting that a military culture stigmatizing health concerns in an era of multiple deployments and rampant trauma takes a toll on all of its members.

As the military reduces its size following troop surges and the end of the Iraq War, the stakes are even higher for soldiers in need of care. As testimony from Fort Hood reveals, behavioral infractions that were routinely overlooked in previous years are now being punished severely. This is an especially alarming practice given that many returning veterans are being disciplined for infractions attendant to their traumatic injuries incurred during service. Disciplinary discharges, classified as Other than Honorable, disqualify service-members from benefits promised upon

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enlistment, and represent a method by which the US military skirts accountability for the continued care of its injured troops. Alternately, soldiers who seek treatment despite the pressures of stigma now face the increasing possibility of being medically discharged, without adequate care for their traumatic injuries, and often unprepared for work in the civilian sector.

For active duty soldiers who experience these issues during service, not only is their overall health adversely affected, but the lack of necessary medical or psychological attention and documentation of conditions by the military communicates their needs poorly to the Veterans

Affairs (VA) system they will enter following discharge. Veterans of Fort Hood who were discharged without adequate recognition by the army of their service-related disabilities, testified that they spent months advocating for their illness to be recognized by the VA. In other cases, veterans who were ultimately recognized as disabled by the VA had been unable to receive an appropriate disability rating by the military, and thus were unsupported in their transition. Taken together, these issues testify to a military and VA system whose response to the widespread experience of traumatic injuries since 2001 remains underprepared at best, and dismissive at worst.

Soldiers and veterans coping with post-traumatic stress, traumatic brain injury, and military sexual trauma—along with diverse experiences of physical injuries—have been severely affected by these systemic issues. A primary result of the technological advancement in US war-fighting and combat equipment has been that service-members more often survive attacks and injuries that have historically proven fatal. However, while such technology has allowed more soldiers to live



Combat boots which serve as planters in the summer months at Under the Hood

through the events of their injuries, resources for the institutions that would help them rehabilitate afterward have lagged far behind. Veterans' struggles with TBI are unique to the current era of warfare for this very reason, as improvements in armor and immediate medical response have allowed troops to survive blasts and head injuries as never before possible. Up to 30 percent of service-members have been affected by some kind of brain injury,¹⁶ and the symptoms of TBI correlate with those of depression and post-traumatic stress, making it difficult to diagnose and treat. As a result, by 2009, 20-40% of soldiers leaving on repeated deployments were reporting symptoms of past concussive injuries.¹⁷ The effects of TBI are wide-ranging and can result in long-term cognitive deficits, memory loss and impairment, physical disabilities, seizures, personality changes, emotional dysregulation, difficulties communicating, and future development of neurodegenerative disorders such as dementia of the Alzheimer's type and Parkinson's Syndrome.¹⁸

Post-traumatic stress is also extremely prevalent amongst service-members and veterans who have served since 2001. VA records reveal that 30% of veterans serving after 2001 have been diagnosed with PTSD.¹⁹ This figure underestimates the prevalence of PTSD, as only a fraction of veterans leave the military with claims that have already been processed by the VA, and some veterans never enroll in VA care. There is also strong evidence indicating that military and VA health practitioners routinely under-diagnose PTSD in favor of conditions that lessen veteran benefit percentages, or disqualify them for benefits altogether.²⁰ Soldiers and veterans of Fort Hood testify in this report to their own such experiences of military and VA diagnostic practices.

The high prevalence of post-traumatic stress amongst service-members since 2001 has also stemmed from the nature of counterinsurgency operations in Iraq and Afghanistan, which have been characterized by patrols of civilian populations, extension of the combat zone into civilian sectors, and the absence of a clearly defined 'front line.' These factors may serve to compound service-members' stress effects, such as hyper-vigilance and difficulty distinguishing between conditions of safety and danger.²¹ Further, with each re-deployment the likelihood of developing post-traumatic stress and its severity both increase. Bearing witness to, and indeed feeling responsible for, the effects of the US occupations on Iraqi and Afghan civilians can further

contribute to a sense of moral injury, which is central to the experience of post-traumatic stress for many service-members and veterans.²²

Military sexual trauma remains epidemic within the US military, with extremely high prevalence for all service-members. ‘Military sexual violence’ (or military sexual trauma, MST) refers to the particular features of sexual violence in the military, wherein survivors are violated by those responsible for ensuring their safety within high-stress, dangerous contexts. Servicewomen make up 14.5% of the armed forces and 11.4% of post-2001 veterans,²³ and one in three servicewomen experiences sexual harassment and/or assault within her command.²⁴ Women’s

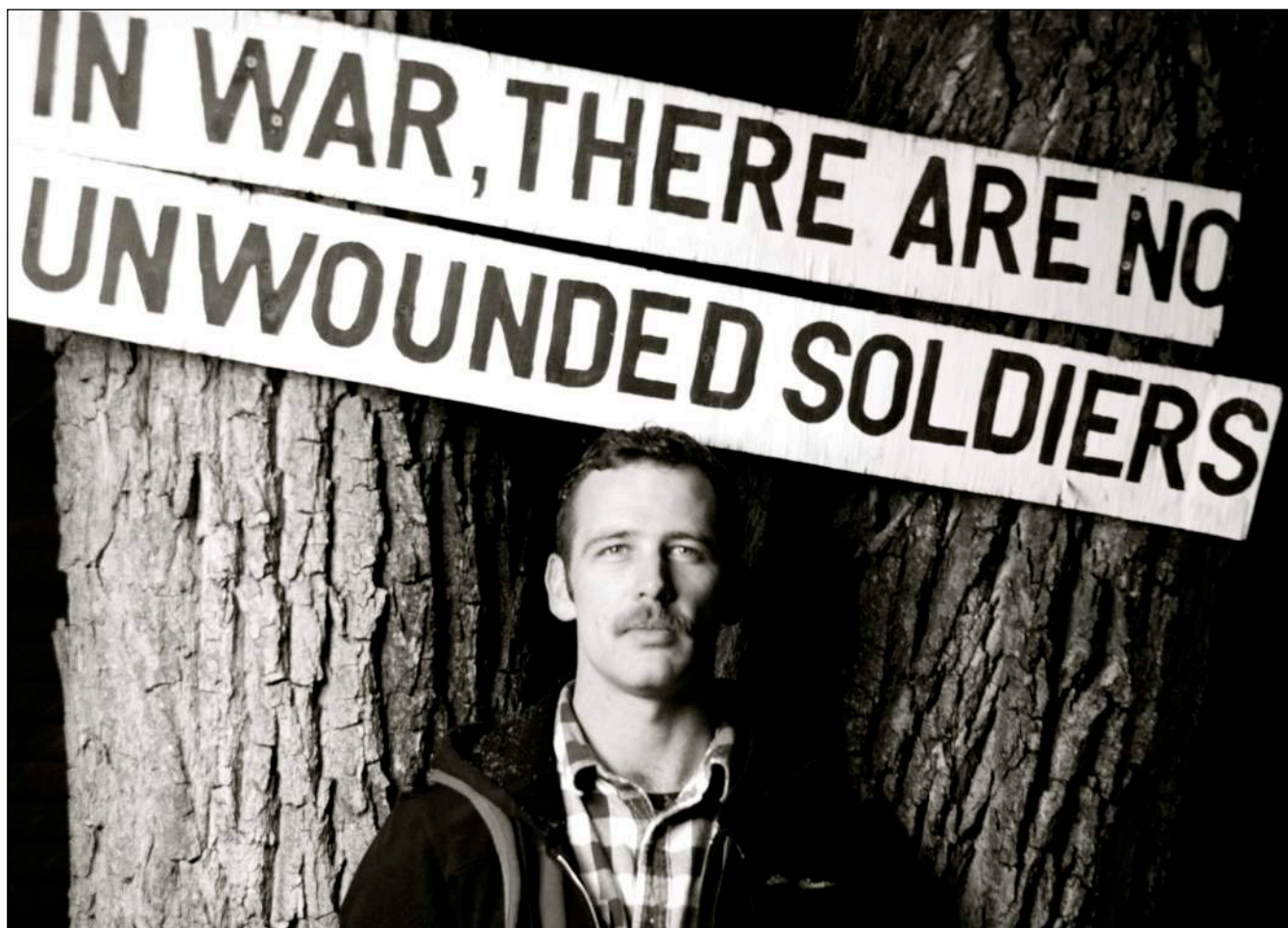


The Sexual Harassment/Assault Response & Prevention (SHARP) office on Fort Hood

experiences of sexual assault in the military are often not isolated incidents by a single perpetrator.²⁵ Among servicewomen, military sexual violence is the leading indicator of post-traumatic stress, yet PTSD claims based on sexual trauma are approved far less often than those based on combat experience.²⁶

Servicewomen experience a much higher prevalence of MST proportional to their population in the military than do men, and around 16%—or one-in-six—transgender service-members have experienced military sexual trauma.²⁷ According to the DoD’s own record-keeping, the proportion of male active duty service-members experiencing military sexual assault is far lower, at 1.2%, or about one in a hundred male service-members. However, due to the much larger male population in the armed services, that percentage equals approximately 38 men per day experiencing MST, in comparison to 33 women per day.²⁸ Additionally, due to the culture of hyper-masculinity and homophobia within the military, male-on-male rape is likely underreported. Sexual assault is usually perpetrated down the chain of command, presenting major barriers to reporting assaults

and holding perpetrators accountable. Even after the DoD created the Sexual Assault Prevention and Response Office (SAPRO) in 2005, only 13.5% of assaults were reported, even by the DoD's own estimates. Only a fraction of reported assaults are later prosecuted (21%), as SAPRO has failed to work in conjunction with the disciplinary arm of the DoD.²⁹ Despite recent Congressional advocacy to end commander discretion in MST cases, military officers within the chain of command remain in charge of deciding whether or not to prosecute MST cases.³⁰



Fort Hood veteran Ryan Holleran outside Under the Hood, see testimony on page 274.

Service-members enduring all of these conditions are subject to ridicule and stigma, excessive waiting lists, violations of confidentiality, and heavy medication in the place of counseling. Those who are able to access care or report sexual assaults have been redeployed, made to work in proximity to their abuser, and in general faced with a context of degrading abuse and stigma while continuing to serve in the military. We believe that these issues amount to a widespread pattern of disregard for the well-being of service-members and their right to heal from the violence of war

and military life. The effects of this dismissal are shouldered by civilian populations who continue to live under US occupation in Afghanistan, and those who lived under the former occupation of Iraq, who are forced to contend with traumatized and non-combat-ready troops performing operations in their communities.³¹ The military's abdication of responsibility for the treatment of traumatized service-members is also shouldered by the families and communities to which they return.

We engaged in the interviews at Fort Hood as a practice of alliance building, between civilians and veterans, or veterans and active duty soldiers, and as part of a transformative organizing effort that recognizes the dialogue as having its own potential, for transformation—or simply, the disalienation that can come from telling one's story. The following section will review the methods we employed throughout the project. Chapter four will then present findings and analysis drawn from the testimony, followed by a human rights analysis of the issues at stake for injured soldiers in Chapter five, and a section of recommendations organized by policy area. Finally, Chapter seven will present the testimony of Fort Hood service-members and veterans, in a narrative format which has been edited to protect the anonymity of testifiers who chose not to speak publicly. We believe that active duty service-members, veterans, and their families are uniquely positioned to hold the US military accountable. We hope the testimony and analysis provided herein will further their efforts to win the right to heal.

How to Use this Report

This report was constructed to be amenable to a range of uses, and includes several elements designed to assist readers in engaging with the material. For readers who would like to encounter the first-hand experiences of Fort Hood soldiers and veterans in-depth, reading the testimony archive first may help contextualize the project and accompanying analysis presented in the full report.

Throughout the report sections, sources and brief comments are indicated by endnotes, which are presented in full at the end of the report. Following the report's Findings and Recommendations sections is the most extensive portion of the report—the edited first-person

testimonies of Fort Hood service-members and veterans. Throughout the testimony, endnotes mark technical terms, acronyms, and some military slang. These are also collected for reference in the Glossary of military terms and acronyms on page 466.

To assist readers who would like to focus on specific issues included in the testimony, these are compiled in a Testimony Index on page 463. This serves as an index of the central topics in the report, along with some topics that came up repeatedly as soldiers and veterans testified to their experiences. It is in no way exhaustive of the issues represented in their stories, but has been included in order to facilitate further engagement with the material and advocacy on behalf of those affected. Where a topic appears in a particular testimony, the number of the testimony presented in the report is indicated in the index. Finally, the last pages of the text are devoted to a small set of Appendices, which include some of the most critical policies in need of reform at Fort Hood and beyond.

Methodology

The 31 formal testimonies contained in this report were gathered by researchers working with active duty leaders and veteran and civilian organizers in the Killeen/Fort Hood area between March 2012 and January 2013. Research team members conducted follow up interviews with several testifiers in January 2014.

The findings in this report are further substantiated by the Operation Recovery campaign team's semi-structured conversations with over one thousand active duty soldiers at Fort Hood during on-post outreach and dozens of follow-up home visits and surveys conducted between Summer 2011 and Fall 2012, as well as weekly themed discussions with service-members and their families held at Under the Hood Cafe and Outreach Center in Killeen, Texas between 2011 and 2014.

Iraq Veterans Against the War & Active Duty Organizing

After spending the first half-decade of the Iraq War building a veteran-led protest movement, supporting conscientious objector claims, and organizing an appeal for redress requesting withdrawal from Iraq, members of Iraq Veterans Against the War were convinced that another strategy for building anti-war resistance was needed. Unlike early in the Iraq war's history wherein most active duty soldiers had joined during peacetime, by 2010, many soldiers had willingly enlisted after the war was already in full swing. Most had already deployed multiple times.³² Assessing that these multiple deployments relied on unprecedented command abuse of soldiers' access to medical and mental health care, IVAW decided to target the policies allowing multiple deployments using worksite organizing strategies addressing access to care and commander discretion over soldiers' medical rights.

Drawing on the history of highly effective GI organizing efforts during the Vietnam War era, which placed considerable emphasis on military worksite concerns ranging from racial discrimination in



Killeen, Texas signage in 2014

the military to housing conditions for GIs, IVAW began to turn attention towards active duty organizing. They assessed that an effective anti-war strategy would address the fact that the US military lacked the labor power to hold down wars in multiple theaters with an all-volunteer force without enforcing multiple deployments—indeed, without deploying troops who had been found medically unfit for redeployment. Further, IVAW had assessed that building consensus against the post-9/11 wars in military communities would require deeper engagement with the daily struggles faced by service-members, necessitating a broad range economic and social justice values and long-term organizing approaches currently being carried forward by their allies in poor people's organizations like United Workers and the Coalition of Immokalee Workers.

Fort Hood and Operation Recovery

Fort Hood, Texas, home to the largest military installation in the US, is also home to approximately 41,000 soldiers,³³ 108,000 military dependents, 9,000 contractors and other military employees.

An even larger number of veterans live throughout the surrounding counties.³⁴ Throughout the Iraq War, Fort Hood soldiers were subject to especially high deployment and redeployment rates. As the largest military base in the US, mental health care resources were strained. In 2010, Fort Hood experienced a record suicide rate, with 22 active duty suicide deaths.³⁵

In short, a crisis had arisen between the demands of the military and the needs of its soldiers. But service-members and families were standing up. In 2010, spouses shouted down their husbands' commanders and successfully kept them from redeploying their injured husbands. In 2009 a military spouse, Cindy Thomas (see interview on page 207) opened Under the Hood Cafe and Outreach Center off the East Gate of Fort Hood, where she and other community members provided direct support to soldiers seeking health care or refusing additional deployments. One of three contemporary cafes carrying forward the Vietnam War era legacy of GI coffeehouses and counseling networks, Under the Hood provided and still provides social programming, support groups, rights workshops, and legal aid for active duty soldiers in the Fort Hood-Killeen area.

In 2010, IAW and Civilian-Soldier Alliance launched a national campaign, Operation Recovery, which was centered at Fort Hood, Texas. Operation Recovery targeted the policies allowing multiple deployments and focused on demanding soldiers' rights to heal from PTSD, TBI, and Military Sexual Trauma. Iraq Veterans Against the War and Civilian-Soldier Alliance committed to a minimum two-year outreach effort at Fort Hood. When the outreach campaign began, approximately 28,000 of Fort Hood's 50,000 active duty troops were deployed to Iraq or Afghanistan.³⁶ During Summer 2011, the campaign's first season of outreach to active duty soldiers, the Iraq war was still in full swing. It was not uncommon for campaign team members to begin conversations during their on-post outreach with, "So, are you coming or are you going?"

Veterans and civilian allies would do on-post outreach during lunchtime each day, discussing people's experiences accessing medical and mental health care. Each evening, they would do follow-up house visits to allow for further discussion and ask soldiers to fill out informal surveys covering topics such as PTSD, TBI, and MST. Additionally, campaign team members would hold weekly programming at Under the Hood, such as women's discussion groups, arts events, and

the ever-popular weekly 'Ribs and Rights' BBQs and GI rights workshops.

During Summer 2011, campaign team members spoke with hundreds of active duty GI's and family members and heard stories of violated medical profiles, the dire effects of multiple deployments, and the high number of suicides wreaking havoc on units both during and after deployments. Injured soldiers in the process of being medically retired showed particular interest in the campaign. Remaining at Fort Hood as part of their deployed units' rear detachments, many of them experienced routine humiliation and stigma for their medical conditions, as well as regular violation of their medical orders by commanding officers.

As troop withdrawal from Iraq progressed in 2010-2011, the population surrounding Fort Hood swelled. Suddenly, rather than being sent back on deployments with a medical concern, soldiers were being drummed out of the army—debt, injuries, and all—for everything from being overweight; to newly enforced disciplinary infractions; to advocating for their own mental health



A sign warns drivers exiting Fort Hood of the high frequency of traffic fatalities in the area

care. The climate surrounding the Operation Recovery outreach effort changed drastically. While the drawdown revealed a new dimension of the administrative violence faced by service-members, individual soldiers became incredibly afraid to speak out, for fear of being chaptered out of the military.

Developing a Formal Interview Process and Locating Testifiers

The changes brought by the military drawdown following withdrawal from Iraq alerted Operation Recovery leaders to the need to both tell the story of the rapidly changing conditions at Fort Hood, and to offer increasingly secure ways for soldiers to share their stories. During IAW and CivSol's February 2012 national campaign meeting in Killeen, active duty leaders decided to focus on the urgent issue of medical profile violation at Fort Hood. They recommended a more formalized approach to the follow-up conversations and surveys that they had conducted throughout the first year of the outreach campaign. The interview project would support emerging community demands by documenting soldier testimony about profiles and access to medical and mental health care.

Two Civilian-Soldier Alliance members, graduate students in social anthropology, had been partnering with other graduate students and independent scholars to conduct thematic and policy research relevant to the Operation Recovery campaign. A total of four graduate students in the human sciences teamed up with veteran and active duty members of IAW to form an Operation Recovery research team. As a research team, we reached out to Harvard Law School's International Human Rights Clinic and the Military Law Task Force who provided critical technical assistance.

Testifiers volunteered for participation through the following means: 1) By expressing interest during a follow-up visit with members of the Operation Recovery campaign team, after meeting them first during on-post outreach; 2) By expressing interest through contact with the Operation Recovery campaign team while attending Under the Hood community programming; 3) Through direct referral by other testifiers.

Consenting Practices, Verification, and Legal & Mental Health Support

Naturally, there were security concerns stemming from the limitations on service-members' free speech rights. Where the campaign had heretofore maintained a strong focus on identifying and building up active duty leaders, the interviews needed to be inclusive of active duty service-members who would not otherwise get involved with the Operation Recovery campaign. At the same time, the research team was committed to the interviews serving as a space of alliance-building and mutual reflection between soldier-testifiers and veteran-interviewers—as well as service-members and civilian-interviewers. We committed to undertaking methods that would be secure, ethical, and rigorous, as well as methods that could be carried forward by IVAW's member-leaders. Indeed, both our earliest and final interviews were conducted by active duty soldiers with other service-members.

With the insight of lawyers trained in the Uniform Code of Military Justice (UCMJ), we developed consenting practices. Our consent forms stated:

- The purpose and nature of the interviews
- A request for permission to record the interview
- Information about how interview results would be stored
- Affirmation that testers could decline to answer any question and could end the interview at any time or later redact the results of their interview from our records
- Possible risks and benefits of participating in the interview
- The estimated number of testers participating in the project
- That the interviews may be published, and that identifying characteristics would be redacted (we consulted with the Military Law Task Force to come up with recommendations for content to redact from anonymous interviews)
- That the names of individual leaders below the rank of O-3³⁷ disclosed in the course of the interview would not be included in published results
- Follow-up contact information to request transcripts, ask questions, or redact testimony

- Contact information for legal referrals
- An indication that the testifier would be provided with a blank copy of the consent form.

We knew the themes in the interviews had the possibility to bring up difficult emotions for testifiers. We also knew we might encounter soldier-testifiers who had an ongoing need for legal and/or mental health support. We secured legal referrals to GI-rights lawyers for any testifiers who had outstanding legal needs, or who might wish to discuss any concerns related to their decision to offer testimony directly with a lawyer. Interviewers also made sure to explicitly ask about whether testifiers desired mental health support at the close of the interview.

Questionnaires

Interviews began by verifying testifiers' military history first, by obtaining copies of testifiers' military IDs or DD214s. Interviewers took a thorough military history, including deployments and units testifiers had served with. They viewed pictures and obtained corroborating contacts of individuals testifiers had served with.

Questionnaire themes were developed with the insights of soldiers active in the Operation Recovery campaign, and by drawing on results from the informal surveys used in house visits during the Summer 2011 outreach. Our questionnaires came to focus on the following:

- Demographic information and reasons for joining the military
- Military experience: rank, stations, jobs, and number of deployments
- Access to, and quality of, physical and mental health care
- Medical profiles
- Concerns specific to Non-Commissioned Officers (NCOs)
- Experiences of stigma related to seeking health care
- Deployment-related health screenings
- Post-Traumatic Stress
- Traumatic Brain Injuries
- Military Sexual Trauma

- Medical Evaluation Boards
- Discharges
- Experiences as mediated by race, gender, sexuality, and citizenship status
- The experiences of spouses, partners, and families
- Veteran benefits
- Efforts to seek accountability through the Inspector General, commanding officers, and other means

These topics elicited additional reflection on topics such as: access to appointments and referrals; prescriptions and medications; the process of receiving a diagnosis; medical profile violation; awareness and compliance with base policies prohibiting profile violation; pressure faced by NCOs to violate soldiers' profiles; programs and policies that have supported or would support soldier well-being; attitudes towards those seeking care; pre- and post-deployment screening practices; suicide prevention and response; substance abuse treatment; disciplinary measures, effects of the drawdown; effects on families and communities; continuity of care within the VA system; and how soldiers imagined the military could be held accountable for providing proper access to medical and mental health care.

Security and Interviewer Training

While the interview project benefitted from working directly with a community space dedicated to addressing the concerns of our testifiers, there were several challenges related to operating out of a mixed-use community space with a high surveillance risk. The Operation Recovery campaign and the interview project integrated organizing, participatory-action research, and leadership development strategies that sometimes melded the categories of community member, organizer, and researcher.

As the campaign moved into a period where confidential formal interviews were conducted, and protected communication was to be provided for soldiers participating in a congressional appeal for redress, it became imperative that the campaign develop consistent procedures for how organizers handled and shared information. Therefore, the campaign developed new privacy

agreements and encryption standards for all of its outreach efforts.

Graduate student members of the Operation Recovery research team set up secure data storage with the use of downloadable encryption software, encrypted cloud storage, an encrypted external hard drive, and a safety deposit box for storage of audio recorders and consent forms. Campaign team members who underwent interviewer trainings were provided instruction on how to securely upload their own interview results, but a pair of core research team members maintained access to the overall interview results.

All interviewers received training in privacy and consenting practices and signed privacy agreements. We paid special attention to emphasizing both the availability of legal and mental health support and the testifier's right to end the voluntary interview at any time. This was important to us, as we wanted the interview to be a space in which soldiers could experience a level of agency often denied them in the course of their daily lives. The research team created a guide covering all sections of the questionnaire. This was used to train interviewers on how to ask questions in a semi-structured interview format, highlight the importance of the particular questions contained in the questionnaire, and to support interviewers in approaching difficult topics with testifiers.

The research team prioritized not having a clientist relationship with testifiers if and when testifiers later became involved in the community at Under the Hood. On the other hand, we acknowledged that we were dealing in sensitive information and that differences in rank, race, gender, sexuality, and military experience affected power dynamics among members of the military and the community around the cafe and outreach center. Therefore, it was made imperative that sensitive information be held in confidence, even as many interview participants later became part of the community around the outreach center and eventually chose to talk openly about their own story.

The Roles of Active Duty Leaders and Civilian Allies

Active duty leaders began conducting interviews during early Spring 2012. Active duty soldiers involved in the effort had an easier time securing interviews than civilian members of the Operation Recovery research team. However as the active duty members of the research team were in the midst of medically retiring from the military, the demands of their daily lives, and ultimately, their departure from Fort Hood after retirement, meant that civilian researchers maintained a large role in gathering testimony.

The interviews were very time consuming and were especially hard to schedule amidst daily programming at the outreach center, campaign planning, daily lunch hour outreach on base, and soldiers' work schedules. Additionally, the amount of back-end administrative work associated with securely uploading the interview paperwork and audio content was simply more than most active duty leaders could take on. On-site visits of 1-8 weeks from research team members provided support for the secure storage protocols and allowed us to debrief with interviewers and interview participants.

Alliance and Politics

We focused on preparing interviewers to use semi-structured interviewing methods that left space for compassionate reflection. We were interviewing people about their experiences with bureaucratic systems. A common account that surfaced in the interviews was that of service-members being made to give their medical and personal histories again and again while they were shuttled between medical providers and benefits administrators. In contrast to these experiences, we wanted the interviews themselves—not just our published results—to be a space for alliance and reflection. In part, this entailed refusing to reproduce the dynamics of bureaucratic indifference that soldiers described experiencing in the military, and which often only worsened the effects of the initial experience of trauma.

We treated these discussions as an act of alliance between veteran- civilian- and active duty-interviewer—and soldier-testifiers—who were otherwise systematically discouraged from considering *how* they were actually doing amidst their military service. We wanted the interviews



Under the Hood's front yard, Killeen, Texas

themselves to be a space where soldiers could intervene on the de-individuation that occurs in the military and hampers the ability to notice, reflect, and speak about one's own physical, mental, and emotional quality of life. We hoped to disrupt the silence and stigma surrounding soldiers' suffering in order to make room for another story. We also understood the interviews as being among the many conversations that would need to happen in order to build the leadership of a generation of veterans advocating for healthcare access.

By focusing interviews on the life-altering impacts of physical and traumatic injuries, we meant to do more than contribute to, or further politicize, an already-existing discourse around post-traumatic stress, combat trauma, and veterans' health care. Rather, what these interviews highlight is how the systematized production, dismissal, stigmatization, and criminalization of trauma in military communities is itself part of modern warfare's conditions of possibility.

Far from the exceptional or tragic, these stories represent highly-normalized ways of living amidst trauma and loss in military communities. Therefore, the organizing community that these testimonies arose from represents more than a demand for justice on behalf of individual soldiers. Rather, it is part of a collective will to transform the routinized suffering—and ways of life meant to accommodate that suffering—that the US military has relied on throughout the Iraq and Afghanistan wars.

While there is much attention dedicated to veterans' thwarted attempts to access care through the VA, far less attention has been dedicated to how and where these practices originate within the military itself. And while portrayals of disabled veterans as the tragic victims of a byzantine bureaucracy abound, the questions we have grappled with throughout this testimony project are otherwise seldom raised: How are mundane bureaucratic practices that produce, deploy—and indeed, re-deploy broken bodies—a part of the material conditions of contemporary warfare?



The 1st Cavalry Museum on Fort Hood, with barracks in the background

We are similarly familiar with journalistic attempts to render an understanding of what it was like “over there.” “Over there”—or Iraq and Afghanistan—become the supposed sites and sources of incomprehensible violences and trauma. As interviewers, we chose not to center our discussions on combat experiences. These experiences were nonetheless present in our discussions—not as singular events that soldiers’ trauma could be traced to—but rather, as one among multiple traumas compounded through ongoing encounters with the Army’s bureaucratic indifference and administrative neglect. If we consider that soldiers’ trauma may be less easily traceable to an ‘elsewhere,’ we reopen the question of how routine aspects of military life and policy—such as commander discretion over soldiers’ access to medical care—are materially tied to the US presence in Iraq and Afghanistan.

The changing conditions associated with the drawdown beginning in 2012, whereby the Army sought to shrink its ranks following withdrawal from Iraq, further highlighted the issue of stigma related to medical and mental health needs. At the same time, it compounded difficulties in having these conversations by putting further limitations on soldiers’ speech as a matter of job security. In this way, these testimonies also mark a point in the history of the wars and of the administrative practices that characterized them.

The insights gained from undertaking this research amidst the withdrawal from Iraq and the Afghanistan drawdown refute the popularly held belief that the shift in US military strategy toward highly-technologized tactics (i.e. drone warfare) will diminish the incidence of traumatic injuries among soldiers, and perhaps the use of soldiering altogether. Among the insights to be drawn about the technologization of warfare over the last decade is that soldiers are surviving their injuries—and they are surviving them not only to come home and live with them, but rather, to go back and fight again.

Presently, urban counterinsurgency continues to involve ‘boots on the ground’, and at great expense. But perhaps the more salient conclusion of this report, which examines the effects of a decade-long attempt to hold ground wars in two theaters with an all-volunteer force, is that US military capacity and strategies now rely on the labor and suffering of service-members and the

millions of people who care for them in different—not lesser—measure.

Reading the Testimonies

Many of the issues discussed in the testimonies, such as profile violation, are a matter of everyday course in military communities, even as they remain largely unknown to the US public. It is precisely their status as non-events that allows these practices to go unexamined. If little time is wasted speaking about these issues, then our approach involved asking people to do the opposite by spending time reflecting in detail on issues like health care access, stigma, and profile violation. And they did spend time—a great deal of it. Single interviews lasted 2-3 hours on average, with several testifiers offering follow-up interviews. Our 31 testimonies amounted to over 800 typed pages, once transcribed.

When faced with the question of how to best represent the stories shared by testifiers, we had to take into account issues of instrumentalization. Soldiers' stories are often appropriated and deployed toward political ends. While this is perhaps most evident amongst lawmakers, the anti-war movement has not been immune to this practice. As well, the many feelings soldiers have about their military service—belonging and abandonment, loyalty and mistrust—do not always lend themselves to clean and tidy narratives about injustices related to stigma and health care access—nor their potential remedies. Therefore, it felt important to allow these many qualities to remain present and unresolved within the testimonies, respecting the multiple and sometimes contradictory feelings and attachments that inform how soldiers encounter the issues discussed here.

For these reasons, we decided to publish the testimonies contained in this archive as discrete, stand-alone stories. These stories do not, however, stand alone. They are substantiated by over one thousand conversations conducted throughout the Operation Recovery outreach campaign, as well as by the weekly programming and discussion groups held at Under the Hood between May 2011 and February 2013.

And while the themes discussed in these testimonies are neither extraordinary nor exclusive to

one individual, they express themselves through the lives of individuals where they are lived—intimately and painfully, and in ways that defy easy comprehension. We have done our best to handle them carefully. We humbly ask that our readers approach them in the same way: carefully—and with appreciation for the possibilities these individuals have labored to hold open through their remembering, risk-taking, and reflection.

Findings and Analysis

Fort Hood and Beyond: Evaluating the Testimony

The testimonies herein concern Fort Hood—as the country’s largest Army installation; as a place that experienced high deployment and redeployment rates throughout the Iraq and Afghanistan wars; as a post with a notoriously under-resourced and over-taxed mental health care and service infrastructure; and as a community grappling with the effects of those shortfalls. But the Fort Hood testimonies also concern something much broader—the Army’s attempt to hold down combat and counterinsurgency operations in two theaters with volunteer forces over the course of a decade; the long legacy of multiple deployments; and the ongoing health care needs of a generation of veterans on whose labor and bodies these wars have depended.

Fort Hood is at once many things. It is a garrison, a temporary duty station, and a training ground. It is a base-town where families live and children go to school. It is a command structure and a set of policies that interlock with larger bureaucratic structures and institutions which regulate not only Fort Hood, Texas—but the path between Fort Hood and Iraq, Afghanistan, and other sites of US military action. If the wounds of war seem invisible to much of the country beyond its gates, Fort Hood is a place where the effects of thirteen years of war are self-evident. Life and work at Fort Hood are integral to the production of US warfare abroad.

Each soldier and veteran who tells their story here has served and lived at Fort Hood—some for months and others for many years. Many have deployed from it and returned home to it. Some have spent time in its inpatient psychiatric ward; raised children; gone AWOL; or become conscientious objectors. All have borne witness to the way life and military service change when soldiers deviate from the norm of ‘fit for duty.’

Each testifier also tells a story spanning beyond Fort Hood. The soldiers who testify here have served at many other bases—from Fort Riley in Kansas and Elmendorf-Richardson in Alaska, to Camp Zama, Japan. They have not only served in Iraq and Afghanistan, but in Bosnia, Kosovo, and Kuwait, as well as in Iraq during the first Gulf War. Some have served as many as four tours across these operations, while others have never deployed, yet have faced severe injuries at home. Twenty of the 31 testifiers served multiple deployments. Many who testified chose to do so anonymously. In order to protect their identities, details, dates, locations, and other identifiers have been changed or omitted, and where applicable, testifier aliases are denoted by an asterisk (*) next to their names.

The findings and analysis presented here describe Fort Hood as a site of multiple functions and histories—all essential to contemporary US war-making. They also evidence patterns and themes emerging from a military system much broader than Fort Hood alone. Testifiers discussed enduring concerns which were consistent over the course of their military service—over years and across duty stations—even as they marked acute and particular problems at Fort Hood. And although each story tells of unique struggles faced by each soldier—arising from their own unique experience in the military—we find a striking consistency in the ways these lives have been stressed, strained, and injured by the last decade of military service. Many of these abiding patterns are enshrined in policies determining how the military has responded to—and alternately ignored—the needs of its service-members and their families. In these ways, the testimonies and the analysis that follows from them can be read as being both about Fort Hood, as well as about a piece of US national history that we will be reckoning with for decades to come.

The following section outlines the key findings and analyses made possible by the 31 formal testimonies taken at Fort Hood between 2011-2013, and by outreach throughout the Operation Recovery campaign during the same period. These findings concern: the high rates of traumatic injuries—including PTSD and TBI—that are the legacy of the era of multiple deployments; the policies and practices allowing—and even promoting—the redeployment of injured and traumatized soldiers; the disciplining and discharging of injured soldiers during the course of the

drawdown; the abuse of the Medical Evaluation Board process; the routine violation of soldiers' medically-verified work restrictions, i.e. 'profiles'; the culture of stigma that discourages many soldiers from seeking care at all; a systemic lack of adequate health care and routine violations of medical ethics; the overuse of prescription medications and under-diagnosis of soldiers' illnesses; the lack of remediation following exposure to toxics during military service; and the absence of accountability and survivor-support in sexual assault cases.

Multiple Deployments

High rates of traumatic injuries, suicide, and other violence at Fort Hood evidence the legacy of multiple deployments during the wars in Iraq and Afghanistan, which continue to reverberate through family and community life on and around the post at Fort Hood.³⁸ In addition to increasing length and frequency of deployments, along with the shortening of dwell times between deployments that occurred throughout the Iraq War, Fort Hood soldiers testified that officials regularly flouted deployment health regulations by redeploying injured and traumatized soldiers.

Soldiers testified that they, along with other soldiers they knew, had often been re-deployed by command discretion over their medical and mental health work restrictions. Most soldiers who testified had either been re-deployed from Fort Hood with conditions they felt should have rendered them medically non-deployable, or knew others who had been. Those who testified that they did not see this happen instead reported that they saw soldiers sent home from deployments early on, who “snapped” under the stress of being there, turning suicidal or homicidal.

"I think multiple deployments is [sic] really harsh. 'Cause you're not the same person when you come back the first time. So you're gonna be even less of yourself when you come back the second time. It's like you sell yourself a little bit, every time you get on that plane."

-Shauna Dione*
Spouse of a Fort Hood soldier

Soldiers generally testified that they felt the safety and morale of their units had been adversely affected by the presence of soldiers who should not have been deployed, or sent on missions, while suffering injury and trauma.

As the simultaneous labor needs of two combat theaters escalated, rapid re-deployment cycles and stop-losses amplified the strain on soldiers' lives and psyches imparted by repeated deployments. With a year or less of dwell time between tours, soldiers testified that it was easier to completely postpone their re-integration into home and community life in the US—with the awareness of a near-future deployment. Indeed, soldiers testified they felt the need to simply get through the months until the next tour. And although this coping mechanism perhaps bolstered their immediate capacity to survive and complete further tours, in the long run it left a backlog of life-changing experiences and post-traumatic stress that soldiers struggled to find space to understand and address years later.³⁹

The inadequacies of Fort Hood's mandatory pre- and post-deployment health screening processes were reportedly a site where injured and traumatized soldiers were pushed through and re-deployed against medical advice, and where their conditions often went unaccounted for upon return. Soldiers testified overwhelmingly that the pre-deployment Soldier Readiness Process (SRP) and post-deployment Reverse-SRP (R-SRP) screening processes were cursory, biased, and corrupt. Soldiers described SRP and R-SRP as sites where soldier health was de-prioritized under their commander's mandates to meet deployment quotas. To soldiers, this was the scene of yet another "numbers game," in which they were treated as the number, and their health conditions regarded as just another 'box to check' to bureaucratically facilitate their entry into war. As testifiers report, commanders who wanted to deploy medically non-deployable soldiers had to do little more than make a few calls to ensure the soldier avoided scrutiny during SRP. Testifiers spoke of instances where they and others were pushed through and deployed, or nearly deployed, despite needing a cane to walk or being unable to wear a flak vest.⁴⁰

Soldiers and veterans testified that over the years of their deployments, they usually did not receive a mental health screening or even see a mental health provider in SRP, nor in the run-up

to deployments. Further, when soldiers were offered access to providers or screenings for mental health conditions prior to deployment, the lack of confidentiality imparted by the setting of SRP caused some soldiers to not report concerns. Without proper assurances of confidentiality in the gymnasium and open-air settings of SRP processing, the process was impacted by the same culture of stigma that pervades soldier life and work at the unit-level.

Testifiers emphasized the impact of stigma on R-SRP post-deployment health screenings, where they were keenly aware that fellow soldiers and leadership alike would either see them join a separate line for those reporting health issues, or receive notification that they needed further processing. Beyond its lack of confidentiality, testifiers repeatedly described R-SRP as an exceptionally poorly timed inquiry. For one, soldiers often cited that upon the moment of return, they had no idea if their mental health had ‘changed’ since they were deployed, nor whether symptoms would later surface. Many post-deployment screenings simply asked if various measures had changed in the soldier’s own experience, such as sleeping and mood. Not only were such questions inadequate screening tools in themselves, but they were not administered at a time conducive to accurate reporting of developing post-traumatic stress or other symptoms. Secondly, soldiers reported feeling multiple sources of pressure to simply rush through R-SRP and say ‘No’ to every question asked, both because they would be released to see family immediately after finishing the process, and because peers or leadership would encourage units to finish quickly.

Since at least August 2011, DoD and Army policies have mandated three repeated follow-up screenings after soldiers return from deployments.⁴¹ Soldiers who returned to Fort Hood from deployments as late as 2012 reported not having received further post-deployment screenings after their initial R-SRP. Others who disclosed physical and mental health symptoms during R-SRP received no subsequent follow-up from providers, leaving soldiers themselves to self-advocate through bogged-down primary care services if they chose to pursue further care.

By Any Means Necessary: The Drawdown ‘Numbers Game’

In January 2012, following the official end of the Iraq War, DOD officials signaled a change in strategy away from large-scale stability operations, instead envisioning “a smaller, leaner Army that is agile, flexible, rapidly deployable, and technologically advanced.”⁴² This proposal required a reduction in Army forces from 570,000 in 2010 to 490,000 in 2017, and was expanded and accelerated to 2015 due to federal sequestration.

“If they feel that they need you out, they're gonna kick you out. If they feel they can get a little bit more work into you, it doesn't matter what your case may be, it doesn't matter how injured you may be, they're going to work you until you're fully broken.”

-Cody DeSousa*
Fort Hood veteran

Amidst the drawdown, soldiers are being disciplined, punished, and discharged for infractions that were previously ignored, including behavior resulting from traumatic injuries. As the drawdown has progressed, this sense of betrayal has been sharpened for many soldiers by de facto changes in discipline and discharge practices at Fort Hood and beyond. Soldiers and veterans testified that commands

are determined “to get rid of soldiers by any means necessary.”⁴³ As swiftly as soldiers were required to re-deploy to combat operations irrespective of their medical needs when forces required, the Army has drawn down its forces by strategically discharging soldiers irrespective of ongoing treatment needs and justified service benefits. The Army's use of discharges to skirt its responsibility for providing health care and compensation to suffering soldiers is even more egregious considering many of these same soldiers who served multiple deployments experienced command-overrides of their needs for treatment at the time of re-deployment.

Fort Hood soldiers and veterans testified to commands handling the Army's force-reduction requirements as a ‘numbers game’ in similar fashion to their previous handling of troop redeployments. The bureaucratic mandates of the Army and DoD's force reductions are being

prioritized beyond the needs of soldiers discharged without appropriate benefits. These soldiers—when their discharges still leave them eligible for VA care—are dismissed into an overwhelmed VA system, where they encounter long waits for care without adequate transitional support from the military.

The manipulation and mishandling of the Medical Evaluation Board (MEB) process is a primary means by which Fort Hood is discharging soldiers without appropriate benefits. Testifiers describe how access to MEB—and the possibility of medical retirement with associated benefits—is

arbitrarily granted and revoked by commanders. Soldiers like Randal Terrell* were placed into MEB without their consent and at great cost to their ongoing treatment needs, while others like Cody DeSousa* were removed from MEB instantly by command discretion, in order to be re-deployed.

“So since I’m no longer in MEB now, I’m set to deploy soon...

But I can’t move with this gear on.”

**-Cody DeSousa*
Fort Hood soldier**

Soldiers who did gain access to MEB testified that the process seemed stacked against them. According to Army regulation, soldiers qualify to enter MEB if their mental or physical health imparts a significant, long-term disability from fitness for duty, or a need for greater ongoing treatment than military treatment facilities can provide. Yet, many soldiers in MEB at Fort Hood are mired in the same

overwhelmed treatment facilities as the general service-member population, resulting in long wait times, inadequate access to care, and lengthy delays to the evaluations which move them through the retirement process.

Testimony from Fort Hood further evidences that some soldiers in MEB paradoxically faced less access to care than soldiers outside of MEB. Fort Hood service-member Randal Terrell* was repeatedly denied medical care due to his MEB status. He testified that he “was getting more help before” he was placed in MEB.

Randal was by no means alone in the experience of such denials. Several soldiers testified that they were disallowed access to vital treatments and surgeries that would have impacted their condition while in the long course of being medically evaluated. In general, soldiers and veterans testified that MEB was an overly long, drawn-out process in which military healthcare providers favored diagnoses and treatment recommendations which would place them as eligible for diminished disability ratings. This left soldiers struggling to self-advocate for proper diagnoses and better access to care—often with little if any patient advocacy assistance from within the system. Many of these conditions mirror the larger context of inadequate physical and mental health care at Fort Hood, while others are injustices specific to inadequacies in the MEB process.

Regardless of MEB status, soldiers face long wait-lists for medical and mental health care at Fort Hood, leading to lags in accessing initial treatment, as well

“A couple of times in the middle of the night the pain hit me so bad that I had to be escorted to the emergency room. I’m laying there crying. And they’re like, ‘Well, you’re in the Med Board process, we can’t give you anything.’”

-Randal Terrell*
Fort Hood soldier

as between appointments. Care provision is frequently pushed down to the lowest level of medical qualification—often onto Physicians Assistants and Medics—resulting in poor quality and continuity of care. The months, and sometimes years, soldiers spend in MEB processing at Fort Hood result in the worsening of their injuries and mental health, as well as frequent profile violation and stigmatizing and degrading encounters with peers and superiors. The long delay itself is yet another cause of inappropriate discharges. Facing interminable wait-times, soldiers are being offered alternative chapter discharges which release them sooner, and with lesser benefits than medical retirement would afford. With the medical and administrative system stacked against them in these ways, soldiers suffering injury or trauma are placed in no-win situations.

"I know soldiers who want to get out, but they want to Med Board out so they can at least get a percentage before they get out. But the Med Board is drawing out so long, they just say forget it, go ahead, I'll just take the chapter. And they'll just chapter out with nothing."

-Randal Terrell*
Fort Hood soldier

Soldiers in MEB are often on profile for medically necessary work restrictions, and as such face a context of stigma and punishment, along with other systemic factors blocking access to care. Testifiers frequently reported being denied time off to attend medical appointments. These instances included appointments for evaluations

which were integral to the soldier's progress through MEB. Frequently, supervisors claimed the soldier could not be spared from the kinds of banal work details injured soldiers were often placed on, such as picking up trash, pulling weeds, or mopping hallways on post for many hours at time. These details often pushed the limits or ambiguities of soldiers' profiles, or violated them altogether, and in general were experienced as punitive and degrading by soldiers who were waiting to be acknowledged for having been injured in the course of their service, and medically retired from the Army. Soldiers often described these experiences as the Army adding insult to injury, as they were already struggling with a sense of loss because their profile restrictions kept them from doing the work they had been trained for, and which gave them a sense of worth, purpose, or pride.

The barriers to evaluation and treatment in MEB amount to a denial of service-members' right to medically retire with proper benefits once they are no longer fit for long-term duty.

Soldiers and veterans testified that they had seen

"You have to really fight in the MEB process. Just like anything medical in the military, you really need to fight to your death."

-Devon Sawyer*
Fort Hood veteran

and suffered Article 15's⁴⁴ and other disciplinary actions, such as extra duties, poor evaluations, blocks to promotion, and generally degrading and abusive treatment from supervisors and peers, because of the symptoms of their injuries. Throughout the drawdown, commanders at Fort Hood have heavily relied on the use of disciplinary measures rather than proper treatment to address behavior commonly understood to result from traumatic injuries—such as substance abuse. At other times, soldiers have been disciplined for issues directly resulting from their treatment—such as oversleeping while on heavy medications used to treat TBIs. In other instances, soldiers were discharged for being overweight—even when they had previously deployed at the same weight. These demonstrations of soldiers' disposability, as well as a dire lack of effective pathways for redress, have contributed to a climate in which soldiers are afraid to even request care. This has resulted in immense pressure on soldiers—especially those supporting families—to not admit vulnerability or injury out of fear of retaliation or losing their job security. Many active duty soldiers who testified for this report indicated they chose to testify anonymously for fear of repercussions on their military status or benefit evaluations for pending discharges.

Fort Hood soldiers, veterans, and their family members testified that existing methods of redress for these and other grievances were often dead-ends. While some testifiers reported positive experiences of assistance from resources such as the Inspector General, and the Ombudsman's office,⁴⁵ as a whole, the testimonies evidence that soldiers and their families had to self-advocate—usually over extended periods of time and at risk to their military careers—before they were granted any redress. Many others reported that they either did not try to access methods of redress for fear of retaliation, or that they were discharged before having any opportunity to access redress. As a whole, the testimony evidences that health care protocols at Fort Hood are being conducted under a grave lack of appropriate oversight, accountability, and available recourse for those suffering such violations.

Testifiers acknowledged Fort Hood's efforts to cope with and adapt to the widespread struggles of its soldiers and their families, yet they described these efforts as systematically lacking, and leaving soldiers open to scrutiny. One soldier described command's efforts as “[putting] a band-aid over a gaping wound.”⁴⁶ Another veteran testified that the military's efforts were just an

Involuntary Discharges

At Fort Hood, Chapter 10 discharges (for Patterns of Misconduct) have remained high since 2009, and Chapter 14 discharges (for alcohol and substance use) are generally rising:

- 2009: Chapter 10: 23 discharges
Chapter 14: 742 discharges
- 2010: Chapter 10: 89
Chapter 14: 1072
- 2011: Chapter 10: 60
Chapter 14: 1164
- 2012: Chapter 10: 59
Chapter 14: 982

(Source: DoD documentation released in 2013 in response to FOIA, documents on file)

Substance abuse-related discharges have been steadily increasing Army-wide. These statistics include Chapter 9 and Chapter 14 discharges for alcohol and substance use.

- FY2009: ~3,100
- FY2010: ~3,350
- FY2011: ~3,500

(Source: "Army 2020: Generating Health & Discipline in the Force," US Army (2012))

attempt to manage bad publicity and “get through each year” with the bare minimum of reform.⁴⁷ Particular efforts—especially several of the military’s efforts to attend to health care—were described as provisions that allow Fort Hood to simply ‘check the box’ on paper. Soldiers described positions such as Equal Opportunity (EO) leadership as secondary or tertiary duties assigned to soldiers that do not have adequate time or training for them.

When Doctors’ Orders are Not Orders:

Command Discretion Over Medical Care

Commanders and supervisors with no medical or mental health training maintain total discretion over soldiers’ medical and mental health care at Fort Hood. Commanders routinely disregard and override doctors’ orders for soldiers’ medically necessary work restrictions, as expressed in the soldier’s ‘profile.’ This practice is rampant at Fort Hood, despite its own command policy against profile violation, SURG-05 (see Appendix A), which states that doctor’s orders should be respected by commanders and supervisors, and not regarded as ‘recommendations.’ Despite its own policy, profile violations at Fort Hood are an everyday occurrence. The policy’s lack of specificity and the total absence of enforcement mechanisms render it ineffectual. Soldiers and veterans of Fort Hood testified that violations of their profiles were so common as to be ‘non-events,’ part of the expected, everyday fabric of life on post. Extensive profile violation at Fort Hood has caused medically non-deployable

Fort Hood has an “Open door policy...On the other hand, that Sergeant Major's gonna go back, and rip the First Sergeant a new asshole, and it's gonna come back on that soldier. One way or the other, it's gonna come back on that soldier.”

**-Jim Frank*
Fort Hood veteran**

soldiers to be redeployed, and has exacerbated the medical and mental health conditions of countless soldiers and veterans, worsening their long-term prognosis.

While Fort Hood has had command policy against profile violation in effect since at least 2011, in reality, the chain of command remains systematically set up to allow for, and in certain ways promote, profile violation as an everyday norm. Throughout our interviews and outreach at Fort Hood during 2012 and 2013, most soldiers testified that they were unaware of these command policies against profile violation. This included many NCOs who were in charge of the daily activities of lower enlisted soldiers. Nearly all soldiers and veterans who testified reported that, regardless of policy, the sanctity of profiles depends entirely on the individual leadership of units, and varies widely between them.

“Purpose: To inform commanders of the requirement to ensure leaders at all levels in their command adhere to the restrictions documented on DA Form 3349 (Physical Profile) by medical and behavioral health (BH) personnel and not view them as ‘recommendations.’”

III Corps and Fort Hood
Command Policy SURG05,
June 18, 2012

The soldier profiling and communication system at Fort Hood seems engineered to fail the command’s promise to respect the medical needs documented in soldiers’ profiles. Army regulations in place since January 2011 mandate that all soldier profiles for conditions lasting for, or longer than, eight days are to be recorded by health care providers and communicated to the

chain of command electronically through the MEDPROS e-Profile system.⁴⁸ Army policy specifically dictates that with this electronic system in place, neither soldiers nor unit leadership should accept new paper profiles. In subsequent Compliance Report Clarifications on how units should implement e-Profile, the Army has directed leadership that “compliance is mandatory and overdue” for its instructions.⁴⁹

Fort Hood soldiers testified to a wide range of routine violations to these policies, which occur at the expense of soldiers' physical and mental health. In practice, the systemic treatment of soldiers on profile at Fort Hood is in utter contradiction to the instructions of both Fort Hood's own command policy and Army regulations.

"Bottom Line: The intent of physical profiling is to ensure qualified medical and BH [Behavioral Health] personnel determine functional activities and limitations/restrictions related to medical and BH conditions. If a commander disagrees with the profile...they are required to notify the profiling officer to discuss the Soldier's limitations and request reconsideration."

**III Corps and Fort Hood
Command Policy SURG05**

Soldiers testified that in many units, profiles are simply disregarded, or soldiers are pressured to break them, on a day-to-day basis. Others reported that supervisors were always pushing the stated limits and unstated ambiguities of their profile's restrictions—for example, a soldier whose profile stated they should not carry a rucksack over a certain weight was made to carry an alternate heavy object on a ruck march. Many testified that the common profiles for "Do not run" or "Run at own pace and distance" were treated as cause to push injured soldiers into more strenuous activity, often lengthening healing times for injuries, or causing re-injuries.

In practice, the systemic treatment of soldiers on profile at Fort Hood is in utter contradiction to the instructions of both Fort Hood's own command policy and Army regulations.

Soldiers also commonly reported that their supervisors and commanders only regarded profiled work restrictions as valid if the soldier could present the paper profile at the time a duty is requested of them. This held true at Fort Hood consistently, throughout our interviews, even while Army policy had long been on the books upholding the validity of electronic profiles, and indeed

discouraging reliance on paper profiles. For soldiers on profile at Fort Hood, “If you don’t have it on you, it doesn’t exist according to our command.”⁵⁰ In many units, the e-Profile system seems to be regarded as nonexistent. In other units, soldiers reported profile violations stemming from problems with the inconsistencies in the implementation of the e-Profile. In those instances, provider compliance with e-Profile meant that they electronically entered but did not print the soldier’s profile, which left the soldier without the paper profile which was treated by their unit as the only valid release from work. When soldiers needed to log-in to e-Profile and print their profile for their supervisor, but had problems with access or printing services, their profiles were disregarded. These practices are in stark contrast to the Army’s e-Profile instructions to commanders and NCOs, who are mandated to actively monitor their soldiers’ work restrictions, communicated electronically by providers. Instead, multiple points of leadership are pushing the responsibility onto soldiers to self-report their profiles. Injured soldiers at Fort Hood are shouldering the burdens of this ill-implemented system.

“[As an NCO] I was more or less told, especially when it came to smoking soldiers, and writing them up, to do everything I could to f--k them up without breaking their profile. Like, some people's profiles say, “Run at own pace and distance.” The Army takes that as, “You run until you fking die.” Until you can't run anymore, because you're so hurt.”

**-Jim Frank*
Fort Hood veteran**

In yet other ways, Fort Hood soldiers are pressured to disregard or violate their own profiles for a host of reasons. Even when not explicitly instructed to violate profiles, when consequences to their NCO Evaluation Reports (NCOERs), PT tests, promotions, or their ‘good grace’ with command were held over soldiers’ heads, they often felt pressured to engage in re-injuring work activities. Fort Hood veteran Ian Augusto* reported that the daily “extreme pressure” to violate his profile was paired with threats of punishment if he did not follow the dictates of his own profile ad

nauseum. For example, Ian was threatened with punishment when he was five minutes early to work, while his profile required that he should only work from 9am to 5pm. Max Diaz* reported that a supervisor would threaten to “Article 15 you for malingering” if caught violating one’s own profile, even while his unit leadership pressured soldiers to violate profiles daily.⁵¹

Widespread profile violation at Fort Hood exacerbates soldiers’ physical and mental health issues, stifles the potential benefits of any treatment and counseling they are receiving, and is itself a source of chronic stress on soldiers. For many who testified, what may have been temporary injuries if proper treatment and work restrictions had been applied, instead became long-term, chronic health conditions. Profile violation by those in leadership positions also contributes to the stigmatization of medical and mental health concerns by perpetuating a culture of disregard for injury.



The R&R Center on Fort Hood, one of the first places many soldiers turn to for help

A Culture of Stigma with Concrete Consequences

Soldiers at Fort Hood fight a severe culture of stigma that discourages them from seeking treatment for physical as well as mental health issues. While Fort Hood has maintained command policy explicitly instructing leadership at every level to work against the stigmatization of mental health concerns since at least 2011,⁵² the culture of stigma continues unabated, and its pressures have become even more extreme amidst the drawdown. Military-wide, this stigma is partly evidenced by the fact that more than half of service-members with mental health issues forego treatment.⁵³

Fort Hood soldiers and veterans describe stigma against physical and mental health issues as a pervasive aspect of their lives in the military, circulating by implicit, cultural means, as well as through explicit events which label, ostracize, and degrade soldiers for their health concerns, or for simply being on profile. These explicitly stigmatizing events were often accompanied by ridicule, humiliation, punishment, or ‘corrective training’ in front of peers applied by leaders to degrade and stigmatize soldiers with profiles or injuries. With the de-stigmatizing command policy SURG-01 (See Appendix B) in place, yet largely ignored, Fort Hood’s pervasive stigma operates in similar fashion to its empty prohibition of profile violation. While SURG-01 instructs “leaders to do everything possible to eliminate any stigma or adverse consequences for soldiers associated with

“It’s sickening how leaders can turn a population against another—it happens all the time to those on profile.”

-Max Diaz*
Fort Hood veteran

behavioral health assistance,” its prohibition lacks any definition of stigma, as well as any enforcement mechanisms. SURG-01 is thus largely ineffectual at its mission; non-specific prohibitions of stigma by both DoD and Fort Hood have not eased the extremely negative context endured by soldiers who suffer physical and mental health issues.

Meanwhile, the effects of stigma at Fort Hood continue to exert concrete and injurious effects on soldiers. Many testifiers reported that the

extreme stigma often causes soldiers to wait to seek care until their injuries or mental health concerns are so severe that they have no other choice. For Oscar Leighton,* this meant waiting to seek care until his drinking had become chronic and debilitating, while others such as Chaplain's Assistant James Cleary* put off seeking care until he was hospitalized for suicidality. Under the pressure of stigma and the threat of punishment, soldiers' injuries generally worsened while they avoided seeking care, usually over the course of several years of service. Mental health concerns which may have affected soldiers on a temporary basis were exacerbated without access to treatment and through the stressful and punitive events associated with the culture of stigma at Fort Hood. Many soldiers testified that after suffering for many years, they finally sought care when they were about to ETS,⁵⁴ or that they waited until they were completely discharged to try to access care at the VA. However, soldiers like Curtis Sirmans, who waited to disclose his post-traumatic stress symptoms until entering the VA, face uphill battles in accessing care and proper disability ratings as veterans. Curtis, like many others, was denied acknowledgement by the VA for conditions which were not reflected in his Army medical records. Several veteran-testifiers described struggling with the culture of stigma and limited health care access at Fort Hood, followed by months and years of wait-lists at the VA.

Soldiers and veterans of Fort Hood testified that it did not seem to matter how "squared away" of a soldier you were before an injury or mental health concern emerged. Regardless, injured soldiers were "looked down upon," and labeled with an array of derogatory terms, circulated by lower enlisted as well as those in leadership. Soldiers enduring this stigma felt doubly betrayed, for being stigmatized despite their service and sacrifice, as well as for being denied the care they were promised. And while the abiding stereotype against soldiers on profile is that they are 'faking it' or 'riding their profiles' to avoid work or deployment, many soldiers testified that they were already suffering the loss of their sense of worth that came with their work restrictions, and some continued to wish that they could still do their jobs.

For many soldiers, this stigma was synonymous with a culture of pressure on soldiers to simply override their own profiles or health needs to continue doing their assigned work no matter the consequence to their health. The possibility of being labeled a 'shitbag' loomed large, and was

What is Stigma?

Fort Hood command policy against stigma continues unenforced, due to its lack of operational definition of stigma and the absence of any accountability mechanisms. While the testimony presented here identifies soldiers' perspectives on how stigma operates and what perpetuates it at Fort Hood, leadership could also benefit from recognizing applicable definitions of stigma presented by various perspectives in public health.

“Stigma relates closely to power and inequality, and those with power can deploy it at will. Stigma can be broadly understood as a process of dehumanizing, degrading, discrediting and devaluing people in certain population groups, often based on a feeling of disgust...Stigma attaches itself to an attribute, quality or identity that is regarded as ‘inferior’ or ‘abnormal.’ Stigma is based on a socially constructed ‘us’ and ‘them’ serving to confirm the ‘normalcy’ of the majority through the devaluation of the ‘other’... In many instances, stigma is compound, multiple or intersectional, meaning that a single person can possess different attributes to which stigma are attached... Individuals experiencing compound stigma are often the ones who are most marginalized and discriminated against.”

- UN Human Rights Council, Twenty-first session, 2 July 2012

Stigma should “be analyzed within frameworks drawing on concepts of power, dominance, hegemony, and oppression.” Interventions on stigma should have “deeper social, political, and economic roots, because stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality.”

- Arachu Castro, PhD, MPH and Paul Farmer, MD, PhD, Public Health Researchers (Castro & Farmer, 2005)

often reported as enough cause in itself for soldiers to avoid even being on profile or seeking treatment at all. Ridicule from supervisors and other soldiers for asking to go to sick call was frequently cited by soldiers as a deterrent for even pursuing that first step toward accessing care. There is no operational definition of stigma, nor means of enforcement.

"All these policies that the Army has are just a front... What happens on the ground, from what I've seen, is that if you have a profile, 9 times out of 10 you're going to be labeled a shitbag."

-Mitchell Tate*
Fort Hood soldier

Much like systemic profile violation at Fort Hood, soldiers report that the severity of stigma at the small unit level depends entirely on their leadership. Fort Hood soldiers testified that there were only a small minority of units in which leaders fostered respect for soldiers on profile or those in discharge processing—such as Warrior Transition Units (WTU). With access to WTUs extremely limited, this does not represent any significant headway at Fort Hood to destigmatize injury.

"I get punished all the time, for fighting uphill battles to try and take care of [my soldiers]. So much that I don't want to be in the Army anymore. I'm just fed up with it. And all these other soldiers are now stuck with the NCOs who don't care. They're here for a paycheck... There's no reward for taking care of soldiers."

-Paul Avett*
Fort Hood soldier

Fort Hood NCOs testified that their own efforts to de-stigmatize injury and advocate for soldiers' care needs had put them at odds with their command. Several testified to the impossibility of complying with conflicting orders to complete jobs they were not staffed for and abide by their soldiers' profiles and care needs. NCOs testified to their own dissonance as they sought to comply with

the competing obligations of the NCO creed—“accomplishment of my mission and the welfare of my Soldiers.”⁵⁵ Many NCOs faced direct pressure from the chain of command to cease their advocacy on behalf of lower-enlisted soldiers,⁵⁶ but more often, NCOs were simply left alone to shoulder conflicting demands. As we spoke with soldiers, there emerged a distinct division of labor around maintaining the order and well-being of soldiers, wherein top leadership defer to un-enforceable policies concerning stigma and profiles while non-commissioned officers must attempt manage irreconcilable demands. Indeed, it was extremely difficult for testifiers to imagine forms of accountability that might implicate commissioned officers. When asked what types of actions would reduce stigma related to accessing health care, most testifiers responded that more punitive action should be taken against unsupportive NCOs—even in cases where the testifier themselves was an NCO who had faced pressure to violate profiles.

“If you come up on the Flight Surgeon's book for depression, forget it. You are done. If you ever fly again—which you might not—you're definitely not gonna be in the running for any of those good jobs. Depression holds such a negative stigma in aviation that you're a whiner, you're a crybaby, there's something wrong with you, you can't be trusted, you can't hang, et cetera. Which is total nonsense. I'm no medical professional, but trust me, walking around and dealing with some of these people, there's plenty of depression going on in the aviation field. It's just no one says anything.”

**-Nicolas Addison*
Fort Hood soldier**

Soldiers repeatedly testified that stigma was even more extreme in certain MOSs, such as Combat Arms and Aviation. Those serving in Infantry units often reflected that they were particularly rife with stigma, remarking they were directly trained to “just rub some dirt on it and move on.”⁵⁷ Likewise, while commanders reportedly emphasized the value of seeking help, Apache Pilot Nicolas Addison* testified that anti-stigma edicts in Aviation brigades amount to empty rhetoric hiding the retaliatory context around disclosing mental health issues. Addison testified that, “You cannot have PTSD as a pilot. I mean, kiss your career goodbye. You’re done.” Yet he also reflected that he saw many peers continuing to endure symptoms of untreated post-traumatic stress. Addison himself resorted to seeking care through off-record appointments with

providers and taking a Wellbutrin prescription for his self-diagnosed post-traumatic stress under the pretense of using it for smoking cessation.

Women soldiers and veterans at Fort Hood further testified that this stigma is intensified under the pressures faced by female service-members, who feel they have to be “more hoo-ah” and “prove themselves” due to a sexist workplace culture which regards them as less capable overall than male soldiers. Female soldiers testified that this intersection of sexism with the blanket stigma at Fort Hood made it even harder to decide to seek care, as they already faced the differential perception of being weak or inferior before suffering injury. The culture of sexism also combines harshly with Fort Hood’s generally lacking treatment of health concerns to place unrealistic expectations on women in service, for example, on pregnant active duty soldiers. As Anja Perry* testified, “Nobody expects you to fully recover in six months in the civilian world.” Yet, after her pregnancy, her command afforded no profile restrictions past that date and expected full physical performance and weight maintenance. Male soldiers confirmed that in historically all-male units where women are beginning to serve, women face a generally negative attitude from their peers, who believe they “cause trouble,” and that these sites can be rife with sexual violence against female soldiers and civilians alike.⁵⁸ Nicolas Addison* testified that, for women entering Aviation units, “Nobody’s gonna be glad to see you, including myself.”

These testimonies reveal that the effects of this stigma are becoming more detrimental amidst the drawdown. Soldiers testified that commanders are more punitive and dismissive towards soldiers in need of care. Where soldiers once encountered rampant ridicule, they now fear the initiation of discharge proceedings likely to result in the fewest benefits that might be accorded. Supporting families, having accrued debt, or having one’s military experiences mediated by gender and race discrimination all compound the ways in which soldiers differently suffer under the drawdown’s implicit mandate to remain silent while suffering.

Betrayed Promises:

Fort Hood's Systemic Lack of Health Care

The aforementioned conditions are accompanied by many other structural barriers to health care access and quality which soldiers endure at Fort Hood. Their testimony provides evidence of a generally poor quality of care offered, and a poor-to-nonexistent continuity of care. The sense of betrayal as a result of these inadequacies runs strong amongst soldiers and veterans, as well as their family members who remain responsible for providing care and support where the military denies it.

“How in the hell are you going to say to me that you can't help me, when I gave you all of my fucking youth?”

-Josue Gomez*
Fort Hood soldier

Often when soldiers at Fort Hood can access treatment, they are forced to rely on Physician Assistants—or on Medics when they are in the field—who are, in turn, under structural pressure to practice beyond their scope of professional competence. With systemic lack of access to doctors and specialist providers, many soldiers only saw their assigned PAs over lengthy

periods.⁵⁹ In some cases, their treatment recommendations, diagnoses, and prescriptions would later be overridden by physicians once they finally saw them.⁶⁰ Between a lack of communication between providers, and changes to her primary care doctor approximately every three to four months, Fort Hood veteran Anja Perry* reported she had to “start over” in seeking treatment at

“It basically took me getting with the military liaison there and losing my mind, losing my military bearing, and being like, ‘What do I have to do? Do I have to come back with no legs? Do I have to come back in a casket for you guys to actually care?’”

-Chas Jacquier
Fort Hood veteran

nearly every appointment.

Soldiers frequently reported that medical and mental health providers at Fort Hood used diagnostic practices which relied heavily on self-reporting, paper questionnaires, and very little time spent actually interviewing their soldier patients. Their testimony presents evidence that medical professionals serving in the military are not following consistent diagnostic and treatment protocols agreed upon as standard in the civilian medical sector, and prescribed in medical ethics codes of practice nationally. The perpetuation of command discretion over medical treatment likewise contributes structural pressures on providers to declare soldiers ‘fit for duty’ and send them back to work prematurely, in accord with command’s desires to meet readiness and deployment quotas.

This context of poor quality care has exacerbated injuries over the course of soldiers’ service. For some who testified, their physical injuries began during Basic Training, and the generally stigmatizing conditions and lack of longer-term care accessed since first enlisting resulted in chronic injury far beyond what was the natural result of the original incidents.⁶¹

“The Army's gonna do what the Army has to do to protect itself. I personally don't believe that the Army gives a dang one way or the other if somebody smokes themselves, other than the financial and political ramifications.”

-Nicolas Addison*
Fort Hood soldier

Perhaps the most chilling effect of these conditions combined is the high number of active duty soldiers and veterans who end their lives by suicide. Record high suicide rates—which far outpaced combat deaths and peaked in 2010 at Fort Hood with 22 active duty suicides—come as little surprise in light of the difficulty accessing care on post—and the increasingly high stakes of possible discharges for doing so. Painfully aware of the culture of stigma and scarcity of care, soldiers testified that they see through the Army’s suicide prevention efforts, which seem to amount to lip-service while the system at large is left in poverty.

Over-Medicated and Under-Documented

Over-medication for both physical and mental health symptoms is a primary means by which Fort Hood treatment facilities provide substandard care to soldiers on a routine basis. Nearly all soldiers and veterans who testified reported they were given prescription drugs for nearly anything which ailed them, often as a substitute for more thorough screening and non-pharmaceutical treatment. This is reflected in the daily averages reported by Fort Hood's main medical facility, Darnall Army Medical Center: it reports a daily average of 4,258 patient encounters, and an average of 4,160 daily prescriptions.⁶²

"I was prescribed...Prozac and some other drug, during my first deployment. That was part of what they said made me suitable to be back on the road so quickly. Like, I had a prescription, so I was good. In between my two deployments, I got a new prescription for Lamictil. It seemed like prescriptions were just another box to check for somebody who had an issue. 'Well, okay, you have an issue. That adds a box to check, for well, you need to have this pill.' If you have this issue but you have this pill, you're deployable."

-Malachi Muncy
Fort Hood veteran

For many, this heavy reliance on medication was accompanied by an alarming lack of medication management, both at home and on tour. In general, many Fort Hood soldiers' impressions of medical and mental health treatment was that drugs were "thrown at them" indiscriminately to see if their problems would go away. Soldiers reported being prescribed medications instead of being given diagnoses, surgeries, and counseling.

Over-the-counter pain-killers and prescription opiates were some of those most commonly reported "indiscriminately" prescribed medications. Soldiers reported being on these prescriptions

“I was really, really high at work, with a loaded gun.

But we didn't have any bodies, so I had to do what I had to do.”

**-Curtis Sirmans
Fort Hood veteran**

during deployments, and being assigned to duties and missions which they felt incapacitated to perform. Infantry soldiers such as Oscar Leighton* felt they were thus unable to protect themselves and their fellow soldiers on missions, which was both a dangerous and stressful experience.⁶³

Along with frequently receiving psychotropic drugs as the only treatment offered for mental health concerns at Fort Hood, soldiers testified to being supplied with psychoactive drugs in large quantities in

order to get them through their deployments. These soldiers, such as Allen Dunajs,* then received little to no medication management during their tours overseas—the nearest qualified provider to Dunajs while deployed to central Iraq was in Kuwait. At other times, soldiers would run out of their psychotropic medications while on tour and need to have a convoy assigned to retrieve supplies from another base in country. NCO Ian Augusto* testified that he struggled as a team leader to accommodate his soldiers' prescription needs in Afghanistan, where miscommunication and base clinic's supplies running out meant soldiers faced gaps in medication, and sometimes had other psychotropics substituted on the fly.

The general practice of over-medication for both physical and mental health conditions at Fort Hood often also took place without providers assigning soldiers accompanying diagnoses. With their conditions undocumented over long periods of service, soldiers struggled to make their case for a just disability rating ahead of discharge if they were able to enter MEB, and regardless often left the military with medical records which grossly underreported their disabilities and treatment needs to the VA.



A drive-through pharmacy on Fort Hood helps service its high prescription rates

Struggling Families

While the effects of multiple deployments on families at Fort Hood have been harsh, imparting long absences, fears of loss, secondary trauma, domestic violence, and uncertain futures amidst the changing context of the military, family members testified that the stakes felt even higher since the advent of the drawdown. The threat of pay cuts and risks to promotions following from the disclosure of injuries has become more severe, leading soldiers and families further into isolation and away from seeking help and treatment. Over the last decade, and throughout the drawdown, the spouses, partners, children, and community members surrounding soldiers at Fort Hood have shouldered soldiers' needs for care where the

"What was going on back at home affected me a lot more than what was going while I was [in Iraq and Afghanistan]."

-Anja Perry*
Fort Hood soldier

military has discouraged and denied those needs. Families have remained soldiers' de facto caregivers while often receiving little support from the military themselves.

What testifiers described as a dire lack of access to care for soldiers, is only more acute for their families. Family members testified that Fort Hood's rhetoric of support for families lives on as yet another broken promise. Its standard family support programs, such as Family Readiness Groups (FRGs), frequently did not feel supportive to family members in need.⁶⁴ Meanwhile, financial

"I think that war affects the soldier very much, I have no doubt about that. But I think it equally affects the family. Equally, because I could not even describe to you the pain in the wife's point of view or the child's point of view, when the soldier acts out. Like when he gets triggered, or just the irritability, the mood swings, all that kinda stuff. Yes, the soldier is angry but they're, in turn, taking their hurt and moving it to their family."

-Shauna Dione*
Spouse of a Fort Hood soldier

support and health care was in even shorter supply than that available to soldiers. Amidst these conditions, soldiers expressed deep concerns for their family's well-being, and family members described the isolation of life on and around Fort Hood as compounded by a lack of access to adequate health care and counseling resources.

Fort Hood Soldiers and veterans also cited the lack of support for their families as a source of stress they carried while on deployment—which intensified the host of other stresses they faced. The rigors of back-to-back deployments with inadequate dwell times meant that neither the soldier nor their family members could re-integrate and learn to cope with soldiers who reported feeling like "different people" after each deployment. For the children of soldiers, the fact of their long absences alone was difficult, and more so in combination with their parents' emotional struggles or physical disabilities upon return.

Unfortunately, the struggles lived by soldiers' families throughout a decade of deployments are now followed by drawdown practices that throw families into uncertain futures. The strains of the past decade have broken apart many marriages and parent-child bonds. And while families may have supported soldiers through years of service, even when their relationships paid the price, ex-spouses only maintain access to health care and military programs in extremely limited circumstances following a divorce.⁶⁵ Cynthia Thomas supported her husband, soldier Chris Thomas,* and their two children through three deployments over the course of almost two decades. They met upon his return from Desert Storm in 1991. Despite being severely injured in 2005 with multiple fractures and a Traumatic Brain Injury, after which he was declared medically non-deployable, Chris's command re-deployed him to Iraq once more in 2007. Despite supporting Chris and their family for nearly two decades during his service, after their divorce Cynthia and her two daughters were left without benefits from the VA. As of January 2014, they testified that as a family, they continued to live without health insurance.

Fact Box:

- The Army itself acknowledges that domestic violence and child abuse “may be one of the leading indicators of stress on the Force.” From FY2001 to FY2011, soldier domestic violence offenses increased by 85%, and child abuse offenses increased 44% (Army Gold Book, 2012, 145).
- In Killeen, Families in Crisis, a temporary shelter for families affected by domestic violence, records how many shelter nights are provided to local families. In 2002, at the beginning of major troop deployments from Fort Hood, they recorded 8,365 emergency shelter nights provided. In 2013, they provided 20,120 shelter nights (Bragg, 2014).
- The percentage of family members who have considered suicide (10%) is almost equal to the percentage of service members who have considered suicide (9%) (The Blue Star Families Survey of Military Life, 2012).

While family members' access to military and VA benefits may be compromised, the emotional struggles continue. Parents testified that both they and their children suffered the effects of secondary trauma—though children seemed even more vulnerable. Testifiers who were separated from their children for years at a time continued to reckon with whether their tours abroad were worth the separation from their children's lives and early development.⁶⁶ Seeing the effects of the wars in Iraq and Afghanistan on Iraqi and Afghan children threw into relief questions of conscience for soldier-parents.

As a community, the greater Killeen and Fort Hood area continues to endure high rates of family violence and child abuse, as well as high divorce rates,⁶⁷ evidencing a community whose resilience has been repeatedly tested by multiple deployments and inadequate resources. The Fort Hood area continues to cope with a high rate of traffic fatalities, as well as the long-term effects of the two mass shootings perpetrated on post in the last five years.⁶⁸ While each incident of violence is caused by unique factors in the lives of soldiers and their families, it is clear that the Fort Hood and Killeen community at large bears burdens of trauma, stress, and economic hardship that have uniquely accumulated over the last decade of U.S. wars.

"We were admitting my friend's son" to a psychiatric inpatient facility near Killeen. "I asked, 'How young do they come?' 'Four'... Then I said, 'Do you have military kids in here?' And he said, 'The majority of our patients are military brats.' And that was when I started becoming aware of what's happening.

-Cynthia Thomas
Former spouse of Fort Hood veteran,
Soldier advocate



A view of Rancier Avenue in Killeen

The Decade's Signature Traumatic Injuries

The counterinsurgency operations in Iraq and Afghanistan have been characterized by patrols of civilian populations, extension of the combat zone into civilian sectors, and the absence of a clearly defined 'front line.' These factors have served to compound service-members' traumatic stress effects. Service-members' risk of developing post-traumatic stress increase with each repeated deployment.⁶⁹ PTSD diagnoses in the military increased by 650% between 2000 and 2011,⁷⁰ which likely represents a gross underestimate of the prevalence of post-traumatic stress due to factors discussed below.

While many labels are applied to soldiers' distress, many Fort Hood testifiers spoke less concretely or categorically about how they experienced their own struggles, as well as the collective mental health struggles of their fellow soldiers and veterans. Some of the words they used to reflect on the causes of soldier trauma are presented in the text boxes on the following pages.

What are the major causes of soldier trauma?

We asked this question to every soldier, veteran, and family member who testified.

Below is a selection of their answers, in their own words.

"I think the major cause of the soldier's trauma is there's nothing to be proud of. That's my personal belief. I don't even think that everybody understands that that's what it is. But I think, deep down, everyone knows that there is no reason for the Iraq War. I think, deep down there, everybody knows that... I think it's like a light switch. If one day you realize, 'Shit. Everything I went to, everything I did, was bullshit. It didn't matter,' then that changes all your experiences..."

- Brandon Harris*

"Stigmatizing by local soldiers, misinformation, not enough information, and this machismo philosophy that the military uses."

- Max Diaz*

"I was scared because I'd heard about everybody else talking about their deployments... But then, what affected me even more was I was a single parent at the time. My son had just turned a year old. And so I have to worry about that right there and then along with am I going to see him again. So I think it's just a combination of what you've got going on back at home, what you think you're going to go to and then what's actually there. It's just, all of it into one."

- Anja Perry*

"You feel like there's no way out. Like you're trapped, like you don't have any more options. The military's so structured. It's like, you follow this path, or no path. It's the only way you can live. And anybody who tries to live outside of that is very quickly pushed back into it... And the causes of that would be like, failed marriages, extremely early, premature marriages, that suffer from the stress of regular deployments; the combat. Primarily, being deployed in a fucking place where you're forced to kill people, you don't know why, and you're forced to fucking watch your buddies die, and you don't know why. Even to the mentality of the day-to-day, you're living in a world who's foundation is violence and domination. And...I don't think those are very natural ways to live."

- Ryan Holleran

"The major cause of trauma is the loss of your friends, your partner, your brothers...You go through the motions, the 'What-ifs,' and the, 'What should I have done?' 'What could I have done?' ...The fact that I lost guys over there that were depending on me to bring them back, or that we were depending on each other to be there... And he gets to go on leave in a fucking box. He didn't even get to see his kids be born. And now he doesn't get to see them grow up. It's shit like that that's really what caused a lot of my issues. The taking of lives, you're never going to forget it, and it's always going to change you. But the actual losing lives is one of the big things for me... You get close to these guys. You live with them, you eat with them, you go out and work with them. Everything that you do in a day-to-day basis revolves around somebody else... That's would be what my post-traumatic stress would be, would be the losing of people that I consider family... Being able to open up about what's eating you is really the best medication for it. I think that hindering the ability of people to actually voice what's eating them, is really what's killing them."

- Ian Augusto*

"I personally have horrible anxiety. I never had problems with it before, I was very confident. I'm a nervous creature at this point. Especially in this nonlinear battlefield, where I'm forced to operate with these Afghans, who every month they kill four or five dudes, so I'm having to sit there and shake hands with them, hang out with these guys with loaded guns, who half of them want to see me dead. And then there's all the indirect fire, and the suicide bombings, and just everything. You get wound up so tight, and you're constantly on guard, to where when you get home, it just doesn't go away. You're still just on guard..."

- Nicolas Addison*

"The rigors of deploying, combat, that's a huge cause of trauma there. That, with a little bit of military culture, and all of the downsides of the culture. I think those two things are the biggest, right there. Toxic leadership is the third one. Those three things are the biggest causes of trauma. Because if something happens to you and you have good leadership, that incident can't go from being traumatic to nothing, but it could be a learning experience. Something bad could happen to you, you could learn from it. But if you have a horrible leadership who's not supportive to you, then it could turn into the most traumatic thing in your whole life. I mean, that's how important leadership is."

- Curtis Sirmans

Many testifiers spoke of how they felt “changed” in who they were as a person, with each deployment; that they were experienced as “a different person” afterward by loved ones. For many, this included being more “on edge,” irritable, or “ready to snap” than they had been before deploying. For others, alcohol or other drugs became a way to self-medicate. Many spoke of struggling with nightmares, night terrors, headaches, paranoia, memory loss, insomnia, hallucinations, flashbacks, despair, apathy, anger, guilt, feeling generally beaten down or betrayed by the military, and a profound questioning of the morality of their military service or conduct in theater.

While some soldiers testified to feeling lucky they did not develop what they saw around them as post-traumatic stress, PTSD, or TBI, they also reflected the great prevalence of “slight PTSD,” or soldiers generally not feeling like themselves, even if they did not feel they had ‘diagnosable’ mental health conditions. NCO Reese Stewart* testified to widespread mental health struggles amongst soldiers in his unit and others, and said that he himself simply felt that, after two tours in Iraq, “My give-a-fuck is busted.” Ian Augusto* reflected a similar sentiment, saying that amongst soldiers who had been on multiple deployments, “There’s a huge level of don’t-give-a-shitness, I guess you could call it.” Other soldiers instead felt a heightened sense of conscience, and questioned the morality of their own actions, as well as the wars they fought in. While many soldiers struggled for words to accurately describe the trauma or distress they continued to live with—especially when they did not feel the labels of ‘PTSD’ or other diagnoses fit those experiences—most testified that they were either diagnosed with PTSD or TBI, or that they would qualify for these diagnoses if properly evaluated.

Although the Department of Defense, the Army, and Fort Hood command alike maintain policies unequivocally upholding their priorities to respect and treat soldiers’ mental health concerns and traumatic injuries, testimony from Fort Hood shows a wide variation in how these are treated at the unit level, which has great bearing on soldiers’ mental health outcomes. The testimony also evidences an alarming tendency in military mental health treatment to avoid granting PTSD diagnoses in favor of other disorders less commonly linked to traumatic experiences—such as Adjustment Disorders, Personality Disorders, Bipolar Disorders, ADHD, Depression, and Anxiety

Soldiers' struggles with morality, conscience, and war

"Just because you have PTSD doesn't automatically mean that you need to start taking four or five different drugs to deal with PTSD...You're making me feel there's something mentally wrong with me to the point that I have take medication in order to deal with this. Well, I'm sorry that I have a problem with taking somebody else's life. I'm sorry that seeing a child dead bothers me. But, wait, No. I'm not sorry. Because if I didn't have those problems, I would be sick. I would be the one with the disorder at that point."

- Chas Jacquier

"I had to clean his body. Just one after another, people rolling in from different vehicle attacks. At that point I was a Chaplain's Assistant. If I needed to talk to anyone for my own care, I would talk to the Chaplain, or Major Jacks*... But I just kind of shut down on it. I just closed my heart off."

- James Cleary*

"I believe we are forcing medication down our soldiers' throats, and patting them on the back, telling them they did good and to strive on. That is not treating the condition, that is pacifying it. There's no shame in having a conscience, yet we treat it like an ailment."

- Max Diaz*

"In no way am I proud of any of my deployments anymore. I absolutely think that every single deployment I went on did more harm than good—without question."

- Brandon Harris*

Disorders.⁷¹ Soldiers who felt they had been wrongly diagnosed with these alternate disorders testified that it seemed like PTSD was the “last diagnosis” military providers wanted to give.⁷² Given this testimony, it is likely that the reported 5,000 soldiers diagnosed with PTSD at Darnall in Fiscal Year 2013 alone under-represents its true prevalence.⁷³

The application of alternative diagnoses to soldiers suffering post-traumatic stress also places diminished emphasis on their history of stressful or traumatic experiences during service, while implying their conditions are more characterologically rooted. This is greatly consequential to the service-connected benefits soldiers are offered at discharge, with alternative diagnoses often carrying less benefits. These diagnostic practices likewise may be miscommunicating veteran treatment needs to the VA in large numbers, and can result in soldiers unnecessarily struggling with their own mental health status or misattributing the causes of their symptoms to their own personal flaws instead of traumatic experiences.

Traumatic Brain Injuries have also become common during this decade of war. A primary effect of the technological advancement of warfighting since 2001 has been experienced by soldiers and veterans who have survived explosions and other injuries at rates never before possible. Higher survival rates have produced a generation of soldiers apt to be redeployed again after initial injuries. Unfortunately, the higher population of surviving soldiers has not been met by the military with sufficient resources to ensure their quality of life or psychological recovery. While enhanced physical survival has been enabled through advances in armoring and medical technologies, surviving soldiers have endured the absence of complementary breakthroughs in mental health treatment. Indeed, mental health treatment facilities at Fort Hood have been incredibly overwhelmed by the demand of soldier-patients seeking care.⁷⁴

The testimony reveals a general trend at Fort Hood from previously non-existent provider-training, screening, and treatment for TBI toward generally better provider-training and treatment options, along with better post-incident screening applications on tour. However, soldiers and veterans overwhelmingly testified that they still suffered untreated TBIs, and received inconsistent pre- and post-deployment evaluations after having been exposed to blasts. While the military did not begin

to widely acknowledge the prevalence of TBI amongst soldiers until the Iraq War was well underway, the reasons for this neglect are poorly founded, as a body of scientific studies on concussive brain injuries was already well developed in the arenas of sports medicine and other international conflicts.⁷⁵

Once the DoD began to evaluate soldiers for TBI, it selected an evaluation tool, the Autonomic Neuropsychological Assessment Metrics (ANAM) test, which is not scientifically validated as a brain injury detection tool.⁷⁶ The ANAM is a cognitive performance, or ‘aptitude,’ test. It was adopted by DoD and mandated as a pre- and post-screening for all deploying soldiers as a TBI screening tool in 2008.⁷⁷ A majority of Fort Hood soldiers and veterans who deployed after the ANAM was mandated testified that they had only received the pre-test, if they had been screened at all. This included veterans like Mark Simons,* who was exposed to multiple blasts on deployment, and reported chronic memory impairment and other TBI symptoms at the time of his interview, yet had never been screened for TBI by either the military or VA. The DoD’s lack of adequate TBI evaluation practices, including at Fort Hood, have caused uncounted soldiers to be redeployed and placed at risk of further aggravation to existing brain injuries, as well as allowed others to be discharged without benefits despite their symptoms.

When brain injury or other psychological distress results in memory loss or impairment, soldiers in need of care under the current health care system at Fort Hood are left at a systematic disadvantage due to the military’s over-reliance on self-reporting screening tools and lack of adequate record-keeping. Indeed, soldiers with memory impairments may be unable to recall or report their medical histories. For some who testified, this was compounded by the effects of stigma, which meant they had generally not spoken about their struggles, or the precipitating events of their injuries, to even their friends or loved ones.⁷⁸

The decade’s signature wounds also include a devastating range of toxic health effects wrought by soldiers’ exposures to experimental vaccines, toxic munitions, and burn pits. Fort Hood soldier Dan Michael’s* wife, also a veteran, was repeatedly exposed to incinerated chemicals from burn pits in Iraq, leaving her with severe degenerative joint issues. Upon being initiated for medical

treatment while on active duty, her supervising officers “treated her like she was the scum of the earth, especially when she had the nerve to speak up for soldiers’ rights.”⁷⁹ Fort Hood veteran Devon Sawyer* continued to struggle with complex health issues on top of his TBI and post-

“[My commander] said, in front of my ASAP counselor, with me in the room, ‘If you had not been drinking that night, you would never have been raped. It is your fault, because you were drinking. You could’ve stopped it, if you had not had alcohol.’

...Nothing was done according to regulation... Honestly, it makes me realize why so many victims do not report.”

**-Rebekah Lampman
Fort Hood veteran**

traumatic stress, and at the time of his interview in 2012 was in the process of being diagnosed with either Crohn’s disease or ulcerative colitis. Devon continued to wonder whether his health condition was caused by his exposure to experimental botulinum toxin injections for his migraines, which were not permitted among civilians at the time, as well as vaccine exposures and environmental toxins in Iraq.⁸⁰ While Congress has banned the future use of open air incineration by the armed forces, there remains a dire need to address the wide range of conditions veterans now suffer from following their exposure to burn pits. The DoD’s refusal to acknowledge the

extent and locations of its use of toxic munitions in Iraq and Afghanistan likewise leaves in the dark veterans who are suffering complex effects from potential exposures, and leaves entire Iraqi and Afghan communities to suffer severe, intergenerational epidemics without remedy or reparation.⁸¹

Since beginning to recognize the extremely high prevalence of sexual assault and harassment in the military during the last decade, the DoD and VA have only begun to implement the reforms and programs needed by the tens of thousands of soldier and veteran sexual violence survivors. Based on an anonymous survey, the Pentagon estimated that there were 26,000 incidents of “unwanted sexual contact” in FY2012, a large increase from the estimated 19,300 such incidents

in the same survey for FY2010.⁸² A stunning comment on the prevalence of sexual violence in the military, the difference in these numbers is a testament to the degree of underreporting likely taking place. The Pentagon released its FY2013 report on sexual assault earlier this month, which reports that the DoD received 5,061 sexual assault reports that year, a 50% increase over FY2012, in which 3,374 reports were received.⁸³ In an Institute of Medicine study, only 33% of women and 10% of men who reported experiencing unwanted sexual contact reported the incident to a DoD authority.⁸⁴

Testimony from Fort Hood evidences that even where policies supporting survivors are in place, they are very inconsistently applied, and soldiers—men and women alike—face vicious stigmatization, with care and accommodation left at the total discretion of their chain of command. In the aftermath of Fort Hood veteran Rebekah Lampman’s sexual assault by a fellow service-member, “nothing was done according to regulation.”⁸⁵ The report of her sexual assault was immediately spread amongst many service-members in her barracks; she was made to live in the same building with the same common facilities as her assailant for months on end; and her commanders repeatedly blamed her for the assault, telling her to “get up and move on.”⁸⁶ The intense culture of stigma and victim-blaming for sexual assault in the military meant that Rebekah, like many other soldiers, was considered at fault for her assault far before any court martial could consider the evidence. Unlike most cases of sexual assault, Rebekah’s assailant was eventually court-martialed and found guilty, subsequently serving around nine months jail time.

Male survivors of sexual assault in the military face added stigma, as hypermasculine norms not only focus blame on all victims of sexual assault, but further silence the presence of male survivors. Many Fort Hood soldiers testified that the trainings they receive on sexual violence focus solely on scenarios with women victims.⁸⁷ Fort Hood NCO Dan Michaels* was sexually assaulted early in his career, and when he asked for help, “was laughed at. When I called my first sergeant, he said he wished that happened to him.”⁸⁸ Dan further testified that his sexual assault was not documented in his medical records or treated legally or medically; instead “they treated it as some sort of a joke.”⁸⁹

The military's token attempts to address sexual violence and gender inequality continue to blame survivors and leave the behaviors of perpetrators unexamined and unaddressed. This affects service-members of all genders and the relationships, families, and communities to which they belong. The out of hand acceptance of gender-based targeting and harassment is a key means by which the military evades responsibility for acknowledging and addressing the violence and trauma its members experience during service.

Conclusion: Administrative Violence in Wartime and the Everyday

"The Military Departments shall employ flexible, modular, scalable, and interchangeable medical capabilities, logistics systems, and information management and/or information technology systems to ensure that the best possible medical and rehabilitative care is delivered to support military operations anywhere in the world."

DoD Directive 6200.04: Force Health Protection

While many testifiers questioned the justifications for having been sent to war, and described the feelings of futility associated with protracted counterinsurgency operations, all operated under the assumption that war is an inherently risky and unsafe business. But while initial experiences of trauma and injury ushered in both physical pain and the grief accompanying irreducible loss, soldiers' initial experiences of trauma were further compounded by encounters with bureaucratic indifference as they sought to access health care or counseling, restrict damaging work activities to avoid reinjury, or seek medical retirement. While there may be accepted means of thinking and speaking about what it means to survive a traumatic event, there are far fewer ways to account for the grief accompanying chronic pain; or the loss of activities that brought one joy or relief: exercise, playing with children, telling jokes, writing. There are still fewer ways to speak about the struggle of living amidst protracted uncertainty as one waits for medical evaluations or disciplinary decisions that will determine future access to one's family's future access to health care and income.⁹⁰

"Now, the installation commander at Fort Hood liked to push 'family first.' Their tenets of command always include family...How can we call ourselves the 'familyfirst corps' when we have soldiers that have to fight to bring their family member to an appointment?... We can't support the mission if we can't support ourselves. I've spent twenty years supporting the army, and I've had one person supporting me. And when I can't support her, I fail all around."

-Dan Michaels*
Fort Hood soldier

Testifiers described the dissonance associated with hearing repeated policy proclamations from the command—the Family First Corps, utilization of the physical profile, suicide prevention, Fort Hood's open door policy—which directly contradicted their own experiences. The Army—and the Fort Hood

command—is a complex, layered institution in which multiple, simultaneous functions work at cross-purposes to one another: Fort Hood is the 'Family First Corps,' while support for strained marriages may be limited to weekend retreats hosted by the chaplain; and more informally, withholding from civilian family members is promoted, and concerned spouses are regarded with suspicion; Fort Hood instituted electronic records for the purpose of efficiently verifying soldiers' physical limitations, but in practice, commanders demand written documentation from soldiers to substantiate work restrictions.

Caught in the midst of this tug-of-war is the soldier—who hears one thing, and experiences another. And if this array of conflicting protocols and practices serves to obscure accountability for abuses committed, it only makes more certain the isolation and suffering of the individual soldier.

Neglect towards soldiers' well-being pervades everyday life at Fort Hood. Through these conversations, a series of official and unofficial practices which function to explicitly override the health care needs of soldiers and veterans is thrown into relief. To view the protocols and practices that have served to stigmatize injury and restrict access to care as simply arising out of

the constraints of an over-taxed Army health care system would be to underestimate the utility of their effect. They are, in effect, the types of protocols required to create a class of fighters accustomed to protracted warfare and frequent deployments, and uninclined to remark upon or demand redress for their own suffering. The US military's capacity to conduct two simultaneous ground wars with a volunteer force over the last decade-plus has relied heavily on the routinized suffering of soldiers and the people who care for them. The military's historically-unprecedented use of the repeated deployments of a relatively small fighting force has been the primary instrument of this scale and duration of warfare.

A generation of soldiers and veterans have been witnesses to this—many initially unaware of what they had signed up for. The wars in Afghanistan and Iraq began in historically-standard year-long deployments, but the demands of two simultaneous wars soon pressurized the force's labor in ways never before seen. The need to re-deploy soldiers, both injured and well, escalated as the Iraq War continued. The stress of these deployments was intensified by stop-loss mandates that kept troops in theater longer, and reduced dwell times between deployments that compelled soldiers back to war sooner. By 2007-08, troop surges demanded more forces in theater. Many soldiers spent more time deployed than they spent at home over the course of the decade. Fort Hood soldier Brandon Harris* spent five out of ten years on four consecutive wartime deployments, and testified to their effects on him and his family on page 289.

Understanding the severity of many soldiers' physical and mental health care needs after this era of repeated deployments—along with the everyday violations to soldiers' health incurred in garrison service—underscores the gravity of the health care violations currently perpetrated by the military as it draws down troop levels using discharge practices which flout its responsibility to provide adequate health care to injured and traumatized service-members who have served in good faith.

These events—repeated troop deployments and the drawdown that followed—are enabled by a system of routine, everyday practices and regulations through which the military administers both its warfare and the conditions of everyday life for its soldiers. These administrative practices—

such as commander discretion over soldiers' medical care and their doctors' 'orders'—have produced a population of soldiers who are being worked until they are “fully broken.” Soldiers and veterans describe being moved through this system as disposable bodies, as a “pawn” or “just a number,” manipulated by supervisors to check off the necessary box on yet another form. This experience, for many, contrasts sharply with the promise of honor and loyalty they believed they were signing up for upon enlistment. Soldiers and veterans describe the experience of injury or trauma as intimately changing their experience of themselves and the military they were serving in, as they began to experience the dismissal and stigma accorded to those who deviate from the standards of unqualified ‘readiness.’

The systematic production, stigmatization, and criminalization of trauma in military communities is more than an unfortunate war-time deviation from the military's normal responsibility to care for its service-members. For Fort Hood veterans, soldiers of the post-9/11 Army, and their loved ones, it is an intimately-lived legacy with which they will continue to reckon for a lifetime. We hope that this process of listening, documenting—and indeed, reading—will initiate a basis for further solidarity, and will assist in some small way with the project of that reckoning.

Toward the Right to Heal: Human Rights at Stake for Injured Soldiers

“All human beings are born free and equal in dignity and rights... Everyone is entitled to all rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

Universal Declaration of Human Rights,
Articles 1 and 2

Toward the Right to Heal

Soldiers have human rights. They do not sign away their human rights upon enlistment in the US military, despite the military’s promotion of this belief amongst its service-members.⁹¹ They retain these human rights, despite Congress, courts, and the military’s drastic restriction of their rights under domestic US law and military law.⁹² As stated in the Universal Declaration of Human Rights, “[e]veryone is entitled to all rights and freedoms” protected by the Declaration, “without distinction of any kind.” This is the most powerful, fundamental assertion of human rights—that everyone, as a human being, should have full and equal access to all human rights.

We discuss a range of human rights in this section—some of them formally recognized by the United States, others not. However, all are fundamental rights recognized by the Universal Declaration of Human Rights and the American Declaration on the Rights and Duties of Man, foundational documents that the United States heavily influenced and promoted. Most importantly, they are rights that are essential to human dignity, and we articulate them here because we believe that service-members, veterans, and their families deserve to be treated with humanity.

We are not attempting here to give definitive legal meaning to the right to heal—the original demand of active duty and veteran organizers in the Operation Recovery campaign. To soldiers, veterans, and their families experiencing the complex struggles of this decade of war, this phrase represents something far more than a new human right, and more than the combined

achievement of the many human rights at stake for injured soldiers. Asserting their right to heal is a powerful call for justice and healing that exists independently of what any law, institution, or state might choose to recognize. It also holds different meanings for different people. This is reflected in the testimony of Fort Hood soldiers, veterans, and their family members. When asked what they thought it would take to get service-members the care they deserve and win the right to heal, testifiers reflected on a wide range of changes they would need to see, from the circumstantial, to the systemic and cultural. Some felt that the US military would need a policy overhaul, others a cultural transformation; others believe there needs to be a cultural-political shift in the way the broader US public relates to its military, its wars, and its service-members. Some who expressed moral struggles with their participation in US wars felt that achieving the right to heal would include justice and reparations for the populations affected by US military campaigns abroad. Some felt that it would take the US stopping its war-making altogether.

Our goal here is simply to show that the demands of Operation Recovery have a foundation in human rights—to show that these demands are rooted in what people around the world have demanded for years, that service-members and veterans calling for healing and justice have a whole history and world of social movements behind them, one so strong that an international body of law and standards has evolved around them.

Human Rights at Stake for Injured Soldiers

Under international law, the United States government is responsible for ensuring that all of its institutions and officials respect, protect, and fulfill human rights, including those of its armed forces personnel.⁹³

In this report, Fort Hood soldiers and veterans testify to complex experiences of injury and trauma that encompass violations of multiple, intersecting, and interdependent human rights, including the right to health, the right to life, the right to equality and non-discrimination, the right to humane treatment, the right to work under just and favorable conditions, and the right to justice. Although these rights can be examined individually, the full enjoyment of each also relies ultimately on the fulfillment of the others.

Some of the human rights we discuss here are absolute, meaning they can never be restricted. Others may be restricted by governments, but only for limited circumstances and reasons. Armed forces personnel should be treated as “citizens in uniform”—people whose rights should not be restricted by their military status except where it is absolutely necessary. Any such restriction to their rights must meet the following requirements: it must not illegally discriminate; it must be rationally related to military needs and not arbitrary; it must be firmly based upon law; and it must be proportionate, as in tailored specifically to address the military interest that would be compromised by the soldier’s full enjoyment of rights. Finally, the burden falls on the military to prove that the imposed restriction is in fact necessary.⁹⁴

Sexual and Gender-Based Violence

The extremely high prevalence of sexual and gender-based violence in the military is a prime example of the many simultaneous human rights at stake in soldiers’ experiences of trauma and injury.⁹⁵

Most saliently, sexual violence in the military violates the right to personal security⁹⁶ and the right to access to justice⁹⁷ of affected service-members (female and male) and of their families and communities. The US government bears responsibility both for its failure to prevent sexual violence within its military ranks, as well as for its systemic failure to adequately address the violence with proper investigation of the crimes, punishment of the assailants, and redress for those harmed. These failures lead to the fostering of a “rape culture” in the military, one that actively, even if often unofficially, promotes sexual violence and harassment, which in turn only reinforces the climate of impunity.

Rape by a service-member can constitute torture when it causes severe mental or physical suffering and when its objective includes intimidation, degradation, humiliation, punishment or control of the victim.⁹⁸ Commanding officers can also be held responsible for the torture when they are aware of the violence and fail to prevent or address it.⁹⁹ In particular, rape in the military that is perpetrated down the chain of command could well fit these conditions for torture,

especially when the rape is accompanied by other controlling, punishing, or humiliating actions against the lower-ranking service-member by a higher-ranking assailant.

Sexual violence also violates the right to equality of the women in the military who are disproportionately affected. Gender-based violence is widely recognized as “a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.”¹⁰⁰ Meanwhile, sexual violence against men, which is also prevalent and receives minimal attention from the military,¹⁰¹ may also be the product of gender discrimination when male service-members are targeted for deviance from the military’s hyper-masculine norms.

Soldiers’ Right to Health and Right to Work

Although military service can be an inherently dangerous job, human rights obligations still require the military to minimize the dangers and risks associated with employment in its ranks. Armed forces personnel are entitled to safety and health protection as part of their rights to work,¹⁰² health,¹⁰³ and personal integrity. Additionally, the state has a duty to “take reasonable measures ... to ensure proper access of members of the armed forces to health care where their lives are at risk.”¹⁰⁴ This obligation derives from the service-members’ right to life and is triggered whenever authorities have knowledge of immediate and certain risk to life and fail to take actions that are within their power to prevent or minimize those risks.¹⁰⁵

Command Discretion over Medical Care

Commander discretion over medical profiles allows for widespread violations of soldiers’ human rights. At their core, these medical orders are communications by health care providers to commanders that assigning service-members to certain work activities—including, in some cases, deployment—would expose them to conditions that would pose “imminent and serious danger to [their] life or health.”¹⁰⁶ This applies equally to soldiers serving at home as well as in theater.

Over-Medication

The military's over-medication of its soldiers with psychotropic prescription drugs infringes on soldiers' right to be free from "unjustified medication."¹⁰⁷ By contrast, medication should instead "meet the best health needs of the patient," should "never be administered...for the convenience of others," and "mental health practitioners shall only administer medication of known or demonstrated efficacy," with proper documentation "in the patient's records."¹⁰⁸ Additionally, the provision of psychotropic medication as the only mental health treatment offered to soldiers disregards their long-term health care needs. Soldiers have the right to treatment that respects and enhances their personal autonomy, is the "least restrictive or intrusive treatment appropriate," and is based on a treatment plan which the soldier can actively participate in forming.¹⁰⁹

Discipline and Discharge

Service-members' right to work under just and favorable conditions also includes the "right not to be deprived of work unfairly,"¹¹⁰ which requires the government to offer recourse for unjust termination.¹¹¹ This right—along with other rights like the rights to health, justice, and social security¹¹²—are violated through the military's discriminatory discipline, punishment, and involuntary discharge of service-members for behaviors or work restrictions associated with their disabilities. International law, like US law, affords special protections to persons with disabilities.¹¹³ These apply equally to people with mental or physical health impairments, whether "temporary or permanent," and include protection from discrimination even in "times of severe resource constraints."¹¹⁴ Accordingly, the DoD's force reduction goals are no excuse for its infringement on the rights of service-members with disabilities of any kind. The violation is particularly grave where such discharges leave veterans without access to long-term health care, and when the label of Other than Honorable will continue to affect their ability to access work in the civilian sector. Such violations intimately affect all families and communities to which injured soldiers and veterans are a part.

Transparency and Justice

The Department of Defense violates the rights of service-members and veterans, their families, and the US public by keeping them in the dark. With its lack of transparency in reporting statistics

on medical care and traumatic injuries, DoD fails to fulfill its duty to “ensure easy, prompt, effective and practical” access to information.¹¹⁵ Too many Fort Hood soldiers testified that they left the military without adequate medical records of their treatment, including of the medication prescribed for their traumatic injuries during the course of service.¹¹⁶ This alone amounts to a violation of service-members’ and veterans’ right to information¹¹⁷ as well as their right to health. Moreover, DoD’s refusal to provide adequate information on its use of toxic munitions and burn pits in Iraq and Afghanistan implicates not only the right to information, but also the rights to health, work, and in some cases, life of service-members, veterans, their families, and communities living in affected regions.¹¹⁸

At minimum, DoD should release data on the firing locations and amount of munitions deployed containing depleted uranium; detailed data on the location and type of materials incinerated in all burn pits; data concerning the administration of vaccines, the use of chemical and biological weapons, and other toxic materials service-members have been exposed to during the course of military service; and all relevant adverse health information in DoD’s possession related to these materials. “Access to information and communication of information about the effects and exact nature of toxic products released into the environment is essential [to the guarantee of associated rights such as the right to health and the right to life].”¹¹⁹ Failure to guarantee access to that information can aggravate health effects when it prevents affected persons from taking the “necessary measures that could mitigate those adverse effects.”¹²⁰ The fact that children are the most vulnerable population¹²¹ to the effects of environmental toxins—both the children of US veterans and those living in affected regions world-wide—only heightens the obligation on the part of the US government to provide this critical information as a first step toward environmental remediation.

Lack of Meaningful Access to Justice

Lastly, domestic legal bars and the military justice system severely restrict service-members’ right to justice, which includes the right to a fair trial and the right to judicial protection. Specifically, service-members whose rights have been violated have the right to access a competent, impartial, and independent tribunal that will conduct an inquiry “to establish whether or not a

violation has taken place and will set, when appropriate, adequate compensation.”¹²² Judicial remedies should do more than merely exist on paper. They must be available, adequate, and effective, and granted without “unwarranted delays.”¹²³ The current military justice system allows undue interference by the chain of command in what should be independent judicial processes that fulfill soldiers’ right of access to justice. This is especially relevant in cases of military sexual violence, as well as cases of disorderly, dangerous, or illegal behavior used as a basis for initiating the prosecution of service-members who may be suffering traumatic injuries.

Recommendations

On behalf of those who are suffering and will continue to suffer from the adverse consequences of the Department of Defense, Veterans Affairs, and command policies addressed herein, we recommend these changes be implemented immediately. The following recommendations are organized by policy area, and within each policy area, by the institutions relevant to the implementation of the recommended policy change.

Ensure Respect for Soldiers' Profiles

Violations of soldiers' medically necessary work restrictions violates their rights to health and well-being. Commander discretion over soldiers' profiles and access to treatment not only interferes with soldier well-being by impeding the treatment plan, but also perpetuates stigma against injured soldiers, and promotes a culture of fear whereby soldiers avoid seeking care.

To Fort Hood Command

Fort Hood should ensure that commanders and supervisors respect the work restrictions detailed in soldiers' medical profiles as orders rather than recommendations, in accordance with its own command policy.

- Establish immediate accountability mechanisms for all aspects of the standing III Corps and Fort Hood Command Policy SURG-05, including means for reporting command violations of soldiers' profiles and investigation and monitoring by an independent third-party.
- Stop the issuance of temporary profiles in serial fashion when a permanent or longer-term profile would ensure continuity of care and medically necessary work restrictions.
- Confirm the validity of all profiles which are recorded electronically by providers. Establish accountable means to ensure all supervisors and commanders consistently monitor e-Profile and abide by its profile restrictions, in accord with Army regulations on e-Profile.¹²⁴

Institute exemptions in soldier and NCO evaluations for sections that cannot be completed due to medically necessary work restrictions, e.g. PT tests. Ensure that no soldier is made to complete a PT test if their profile restricts them from any of its exercises.

To the Department of Defense and Department of the Army

End commander discretion over medically necessary work restrictions expressed by soldiers' medical and mental health care providers, to ensure doctor's orders are upheld within the chain of command. Ensure that no member of any of the DoD's forces is forced to work or deploy against medical advice.¹²⁵

- DoD, as well as all branches of the US military, must implement specific policy and enforcement mechanisms barring commander discretion over the professional advice of medical and mental health practitioners working in the military.
- Install enforcement mechanisms and reporting procedures to address commanders who fail to support the pursuit of health care.

Eliminate the Culture of Stigma

To Fort Hood Command

Fort Hood should employ extensive resources to actively reduce the perpetuation of stigma against soldiers with physical injuries and mental health issues. Fort Hood's command policies aimed at reducing stigma (SURG-01) must be accompanied by strong enforcement and accountability efforts.

- Expand existing policies (SURG-01) to include the elimination of stigma toward all soldiers on profile or experiencing medical issues, whether due to physical or mental health concerns.¹²⁶
- Implement pro-active medical and mental health care, to be offered periodically to all soldiers.
- Install reporting procedures and enforcement mechanisms against commanders and others who contribute to the stigmatization of soldiers experiencing medical and mental health concerns. These accountability mechanisms should be monitored by an independent authority, working in partnership with relevant military leadership.
- Institute quality commander and NCO training (levels E-7 and above) on issues and policies related to soldier care and profiles by hiring independent trainers from civilian organizations who are qualified to advise on medical and mental health care in institutional settings.

Ensure respect for the needs of disabled soldiers on-post and increase compliance with provisions of the Americans with Disabilities Act by planning for relevant facility accessibility upgrades, including disabled parking.

Stop Improper Discharge Procedures

The consequences of the drawdown should not be shouldered by injured soldiers and their families. The Department of Defense must ensure that no service-member is discharged improperly, outside of DoD separation regulations. DoD must enact immediate evaluation and monitoring of discharge practices in all departments. This must be followed by DoD instruction to address how the departments should drawdown their forces in an ethical manner which is aligned not only with DoD separation policies, but with service-members' rights to the health care they were promised upon enlistment. Fort Hood command must act simultaneously to implement these changes, using all available resources, to cease the violations of soldiers' right to health under its watch. These changes should be monitored by an independent body partnering with the military to ensure accountability.

To the Department of Defense and Fort Hood Command

Prioritize the provision of adequate medical and mental health care for all service-members as a military-wide commitment to implementing an ethical drawdown of the forces.

Cease improper screening and diagnostic procedures used to justify involuntary, disciplinary discharges and administrative separations, as well as inaccurate MEB disability evaluations.

- Provide proper diagnostic assessment. When a diagnosis of PTSD or TBI is warranted, it should never be replaced by diagnoses such as Personality Disorders, Adjustment Disorders, Depressive Disorders, Bipolar Disorders, Attention Deficit Hyperactivity Disorder, nor any other diagnosis which would misrepresent the service-member's condition by implying a pre-existing or characterological condition.
- Fort Hood must cease any pressure on or instruction to providers to avoid diagnosing soldiers with PTSD. Such practices allow the military to eschew its duty to provide due benefits to soldiers, and adversely affect soldiers' navigation of longer-term care.

Institute automatic mandatory comprehensive physical and mental health evaluations in all pending misconduct discharges and other involuntary discharges, especially as

many behavioral infractions at Fort Hood result from soldiers' psychological distress and/or treatment protocols, such as substance abuse, tardiness, and brief AWOLs.

To Fort Hood Command

Enact monitoring and enforcement mechanisms to ensure Fort Hood's compliance with DoD Instruction on Enlisted Administrative Separations.¹²⁷

Protect Service-Members' Right to Medically Retire

Given the evidence of improper diagnostic procedures and involuntary discharge proceedings at Fort Hood, command should implement special protections to ensure soldiers their right to medically retire.

The Department of Defense must work in partnership with the Department of Veterans Affairs in order to align disability ratings procedures and ensure consistent transfer of all medical and mental health records. The current disconnect between DoD medical retirement processing and access to VA health care results in extremely poor continuity of care.¹²⁸

To Fort Hood Command

Reform all MEB practices which impede access to care by unduly prioritizing the disability rating process over medical treatment. A service-member's access to timely diagnosis and treatment should never hinge on the proceedings of their MEB processing, for any reason.

Ensure the MEB process accommodates all qualifying soldiers and provides adequate diagnostic and treatment procedures for physical and mental health in a timely manner.

- Provide easy access to civilian doctors and mental health providers to all soldiers in MEB, including communicating lists of TriCare network providers and issuing referrals. Soldiers have a right to fair access to diagnostic services and screenings during active duty. These should not be unduly deferred during a soldier's transition out of the military for any reason, including during MEB processing.
- Establish means of voluntary communication and medical records exchange between civilian providers and those involved in the soldier's MEB process. Ensure confidentiality in such transactions.

- Honor the diagnoses of qualified civilian providers for consideration in MEB, especially in cases where service-members encounter undue wait times when accessing military providers.
- Maintain proper medical records for all service-members in MEB, and provide service-members unqualified and ready access to these records before and after discharge.
- Provide accessible means for investigation and correction of missing medical records.

To the Department of Defense

Ensure compliance with regulations protecting service-members who acquire disabilities in the workplace, in accordance with international labor codes.¹²⁹

Create and expedite the implementation of cross-department medical and mental health disability ratings procedures and records-keeping systems in partnership with the Department of Veterans Affairs. The current disconnect between these systems blocks proper continuity of care, and exacerbates the treatment delays of service-members in MEB and veterans at the VA alike.

Stop Deploying Soldiers Against Medical Orders

To the Department of Defense

Remove command discretion in the issuance of deployment waivers for medical and mental health conditions.¹³⁰

Develop transparent pre- and post-deployment screening processes that are aligned with civilian screening and treatment guidelines, for implementation in SRP and R-SRP, respectively. Ensure implementation of the pre- and post-deployment procedures across all military branches.

- Ensure that every soldier is screened for psychological trauma before and after deployment at key follow-up benchmarks.¹³¹
- Ensure comprehensive screening for post-traumatic stress, traumatic brain injury, and military sexual trauma, before and after deployments.

- Initiate review of confidentiality practices in SRP and R-SRP. Implement changes to the processes where confidentiality protections can be increased, especially where soldiers' mental health conditions may be subject to increased stigma if revealed during or after SRP/R-SRP.
- Ensure that protocols for in-theater post-incident screening for traumatic brain injury are consistently applied.

To Fort Hood Command

Ensure that neither physicians assistants, nor any other medical or mental health personnel should be placed under any pressure or quotas for characterizing a soldier's condition as 'deployable' when medically evaluating them.

Commanders and supervisors must be banned from any interference in medical and mental health evaluations during SRP and R-SRP.

Stop Over-Medicating Soldiers and Unethically Prescribing Psychotropic Medications

To the Department of Defense, Department of the Army, and Fort Hood Command

Increase non-pharmaceutical treatment options for traumatic injuries and mental health concerns, as well as for medical conditions which would benefit from non-pharmaceutical treatment—such as referrals to specialist care and further testing.

Per the instruction of the DoD Inspector General,¹³² DoD must issue comprehensive policy to track and reconcile medication management in all departments and establish drug take-back programs.

Enhance medication management and oversight for any soldier prescribed multiple psychotropic medications.¹³³ Provide easy access to civilian psychiatrist referrals where additional medication management is needed.

Discontinue the issuing of prescriptions without the assignment of diagnoses for complex medical conditions and mental health treatment.

Institute medication evaluations at an enforced standard of every three months, at minimum wherever psychotropic prescription drug treatment is necessary.

Install means for closely monitoring any soldier prescribed multiple or off-label psychoactive drugs for the treatment of PTSD and other mental health conditions. Severely restrict the prescription of benzodiazepines, atypical anti-psychotics,¹³⁴ and other off-label drugs for the treatment of mental health conditions.

Provide Soldiers Adequate Physical and Mental Health Care

To the Department of Defense, Department of the Army, and Fort Hood Command

Increase the ratio of mental health professionals to soldiers both on base and in theater to ensure timely access to care and continuity of care, and expand referrals to civilian providers when necessary to meet soldiers' needs for timely care and diagnosis.

- Reduce reliance on physicians assistants and medics instead of physicians for the diagnosis and treatment of conditions beyond their scope of practice.
- Ensure adequate civilian providers are covered under military insurance plans, emphasizing coverage for specialist providers.

Support service-members in following through on treatment plans by providing child care during medical appointments and allowing passes to attend appointments during work hours, regardless of training schedules.

- Commanders and NCOs should not be permitted to disallow soldiers from attending health care appointments. DoD, DoA, and Fort Hood command should issue new policy clarifying command adherence to soldier appointments, and devoting resources to facilitate soldiers' attendance.

Ensure that every soldier preparing to deploy is proactively contacted by a mental health provider who is assigned as their provider before and after deployment.

Improve tracking, record-keeping, and communications between health care providers.

Provide consistent medical records to the service-member at all times and to Veterans Affairs immediately upon discharge, to ensure continuity of care and diminish long transition times to access proper VA treatment.

Ensure Comprehensive Treatment for Traumatic Brain Injury

To the Department of Defense, Fort Hood Command, and Veterans Affairs

Establish consistent pre- and post-testing protocols to properly diagnose instances of TBI.

- The ANAM is not an adequate diagnostic tool—DoD should issue new policy specifying adequate diagnostic protocol for implementation in all departments.¹³⁵
- As the Army has itself recommended, unit leaders should “understand the requirements for concussive care” and be “trained to implement the policy” specified in the Military Acute Concussion Evaluation and Blast Exposure/Concussion Incident Report.¹³⁶
- Decrease reliance on service-member self-reporting in screenings for psychological trauma and traumatic brain injury. Increase reliance on proactive and periodic diagnostic inquiry.
- Discontinue screening procedures which rely solely on questionnaires and paper forms.
- Ensure that every screening and diagnostic tool used on US service-members meets established diagnostic guidelines and codes of practice published by the American Psychiatric Association and American Psychological Association.

End Command Discretion to Prosecute Sexual Violence Cases

The Department of Defense must remove decision-making power over whether or not to initiate prosecution for cases of sexual violence in the military from all personnel inside the chain of command.

Ensure Proper Command Response and Comprehensive Treatment for Military Sexual Violence

DoD and Fort Hood Command must work to ensure comprehensive physical and mental health treatment for survivors of sexual harassment and violence, and institute consistent command response with a focus on victim protection in cases of sexual violence. Training and leadership on sexual violence must turn away from victims and instead focus on perpetrators and leadership accountability for eradicating sexual violence, and must work to reduce the prevalence of sexual violence on both male and female service-members.

To the Department of Defense, Department of the Army, and Fort Hood Command

Ensure comprehensive physical and mental health treatment for survivors of sexual violence by instituting further protections and bolstering existing programs.

- Protect survivors of sexual violence from under-diagnosis of mental health conditions by instituting special treatment reviews for survivors within military treatment facilities, along with offering referrals to civilian mental health providers specializing in treating survivors of sexual violence.
- Honor records and diagnoses when they are voluntarily submitted by civilian providers treating victims of sexual violence.

Install means for consistent, comprehensive command response to instances of sexual violence, that focus on supporting and respecting the survivor.

- Implement protocols for victims to transfer units after reporting a sexual harassment or assault without approval from their direct chain of command.

- Institute mandatory evaluation criteria for NCOs on how well they address military sexual violence.
- Include commander and NCO evaluations on leadership climate for eradicating military sexual violence in regular performance and promotion reviews and make the results publicly available.

To Fort Hood Command

Ensure comprehensive medical and mental health treatment for survivors of sexual violence and dedicate resources that ensure proper access to treatment, including child care and time off to attend appointments. Commanders and NCOs should ensure soldiers' access to appointments, and not be permitted to disallow soldiers' attendance.

Eradicate stigma against survivors of sexual violence through specific measures at both garrison and unit levels. All training and leadership should emphasize enforcement and perpetrator accountability for both violence and associated stigma, and never reinforce victim-blaming.

- Enhance Fort Hood's sexual assault training curriculum by hiring proficient trainers from third-party civilian organizations, programming smaller class sizes, and ensuring more in-depth training for units with identified cases of repeated sexual assaults.
- Establish periodic, anonymous surveys to capture sexual harassment and assault incidence at the unit level. Record and release this information, along with comprehensive sexual assault reporting statistics, to enhance oversight.
- Implement specific training toward lessening stigma and ridicule toward male survivors of sexual assault and harassment.

Ensure Confidentiality and Adherence to Principles of Medical Ethics

To the Department of Defense and Department of the Army

Ensure neither physicians assistants, nor any other medical or mental health personnel, are placed under any pressure or quotas for sending soldiers back to work when medically evaluating them.

Ensure soldiers have a right to confidentiality with their medical and behavioral health providers by requiring commanders and others privy to private health information to adhere to standard health care privacy regulations.¹³⁷

- Establish means of redress and accountability for breaches of confidentiality and improper release of private health information. If such breaches result in adverse effects on soldiers, e.g. in discharge proceedings, due compensation should be awarded.

Medical and mental health care providers serving in the US military should be governed by the same medical and mental health codes of ethics as civilian providers.¹³⁸

- DoD should allocate resources for regular, periodic review of adherence to these standards in all military treatment facilities and screening procedures, to be implemented by independent oversight bodies working in partnership with military leaders.
- Ensure that providers working in military treatment facilities adhere to ethical standards of care and diagnosis. Providers should never be placed under institutional duress or instruction to short-cut psychological evaluations or prescribe medication in any fashion otherwise than is standard in civilian medical practice.

To Fort Hood Command

Strengthen patient advocate services on-base¹³⁹ by pro-actively assigning a patient advocate to each service-member enrolled in care.

Maintain the privacy of soldiers' medical records and private health information at all times, and disseminate into the chain of command on a strict need-to-know basis.

Strengthen Support for Spouses and Families

To Fort Hood Command

Ensure access to high-quality counseling services for families and pro-actively offer support to military dependents.

- Ensure greater access to counseling and other mental health support for military spouses and families by increasing the provider to family member ratio and allocating more counselors to support positions for families.

- Create mental health support programming specifically for the children of soldiers, with proactive outreach to military families.
- Ensure that every family is offered mental health support proactively when the service-member is preparing to deploy.

Reinforce Soldier Care and Develop Leadership Accountability Mechanisms

To Fort Hood Command

Hold quarterly town halls in which soldiers, spouses, family members, and local community can address Fort Hood command in person, in a public forum.

General Milley should make unannounced visits to platoon battalion level to speak with lower enlisted (E-4 and below), without other leadership present.

Department of Defense, Department of the Army, and Fort Hood Command

Institute standards for soldier care a regular, binding, and enforceable component of the review and evaluation of leadership.

- Subject commanders and NCOs to regular, periodic review regarding their promotion of health care and well-being for soldiers in their charge, including their ability to foster a unit culture which works to destigmatize these issues.
- Include sections for adherence to profiles, promotion of health care, and destigmatization in NCO and Officer Evaluation Reports and make them integral criteria for promotion.
- Institute anonymous evaluations of NCOs and commanders by junior enlisted which are also considered on NCOERs and other leadership evaluations.

Provide Adequate Veteran Health Care

The US government should ensure comprehensive medical and mental health treatment for all service-members and their families by allocating funding for these services as an integral component of any future war budget. Funding for long-term care within both DoD and the Department of Veterans Affairs must be in proportion to the US government's commitment of its troops to military operations which place their physical and mental health at risk.

The US government must also holistically reform its programs by systematically linking DoD with VA healthcare, as well as integrating VHA and VBA records systems, to foster a context of continuous healthcare for all service-members and veterans.

To Veterans Affairs

Discontinue over-reliance on prescription drug treatment for both medical and mental health issues.

Implement policy which ensures regular, periodic review of all VA healthcare facilities by independent, third-party civilian organizations who are qualified to evaluate adherence to the standards of medical and mental health care practice published by the American Medical Association, American Psychological Association, and American Psychiatric Association.

Pending the amelioration of VA wait times to access benefits and health care, provide all veterans with VA health care, as well as paid referrals to civilian healthcare providers in their local area, while their VA benefits claims are pending.

Begin Remediation for Toxic Health Effects

To the US Government and Department of Defense

Fully disclose and publish the extent, locale, and practices of the US military's use of burn pits and toxic munitions (to include depleted uranium, white phosphorus, and Mark-77) in Iraq and Afghanistan.

Fund comprehensive, unbiased, scientific study of the medical and mental health issues caused by the US military's use of toxic munitions and burn pits to be conducted by non-military affiliated institutions. This must include health effects suffered by Iraqi and Afghan populations as well as US service-members and veterans.

Provide funding, assistance, and resources to all who suffer as a result of these toxic exposures, including funding for specialized treatment of toxic health effects, cancer treatment clinics, and reparations for the affected families of US service-members, Iraqis, and Afghans.

Re-allocate funding from military budgets to fund and support the comprehensive environmental clean-up of sites in Iraq and Afghanistan which remain contaminated by the US military's use of toxic munitions and burn pits.

Ensure that all military operations in foreign territories dispose of wastes in manners which respect the health of civilians, US service-members, and the environment. DoD must enforce the ban on open pit incineration mandated in the National Defense Authorization Act for FY 2010.¹⁴⁰

Initiate Accountability and Reparations Processes

To the US Government and Department of Defense

The US government must take full responsibility for the lasting effects of the wars in Iraq and Afghanistan on both its veterans and Iraqi and Afghan civilians by responding with full transparency on the conduct of its operations in both wars, and by paying appropriate reparations to all who have suffered their unjust consequences.

DoD must take responsibility for its neglect of service-member health and the lack of oversight under its jurisdiction which have adversely affected US service-members and veterans. DoD should pay reparations to the families of service-members and veterans whose long-term medical and mental health prognosis have been exacerbated due to neglect and abuse the service-member suffered under DoD-regulated healthcare systems, as well as for service-members who have suffered from PTSD, TBI, military sexual trauma, and the health effects of exposure to toxic munitions and burn pits.

Additional Recommendations for Members of the US Congress

End commander discretion over service-members' access to medical care and service-members' medically-verified work restrictions, including their deployability status.

- DoD, as well as all branches of the US military, must implement specific policy and enforcement mechanisms barring commander discretion over the professional advice of medical and mental health practitioners working in the military, and take measures to ensure that soldiers are not compelled to redeploy against previous medical orders.

Ensure medical and mental health care providers serving in the US military observe the same medical and mental health codes of ethics free from institutional pressure stemming from their embeddedness within the military's chain of command.

- DoD should allocate resources for regular, periodic review of adherence to these standards in all military treatment facilities and screening procedures, to be implemented by independent oversight bodies working in partnership with military leaders.
- Implement periodic independent monitoring of all military and VA healthcare facilities to review their compliance with medical and mental health treatment ethics as published by the American Psychiatric Association and American Psychological Association. Ensure results of each review are published publicly and reported to Congress to identify gaps in health care funding and to promote transparency.
- Ensure providers in the military chain of command are never be placed under institutional duress or instruction to short-cut psychological evaluations or prescribe medication in any fashion otherwise than is standard in civilian medical practice.

Establish reporting and enforcement mechanisms that provide soldiers redress when their rights to medical care are violated.

- Install reporting procedures and enforcement mechanisms against commanders and others who contribute to the stigmatization of soldiers experiencing medical and mental health concerns, and the violation of soldiers' profiles. These accountability mechanisms should be monitored by an independent authority, working in partnership with relevant military leadership.

Ensure greater public transparency of issues related to the military's treatment of its service-members.

- We submitted a series of requests for information, including some which had been previously published, to the Fort Hood Public Affairs Office and Darnall Army Medical

Center at Fort Hood, all of which resulted in referrals, within minutes, and without explanation, to the FOIA office. Our questions covered post-specific statistics such as deployments, sexual assaults and case outcomes, mental health visits and diagnoses, psychotropic prescriptions, and waiting lists for mental health treatment programs. Further consultation with those who had pursued FOIA requests at Fort Hood confirmed that they were almost always denied, including some which had been previously published.

- As this lack of clear and accurate information about the experiences and treatment of service-members undermines efforts to ensure that they are being supported and receiving quality care, as well as basic measures of democratic accountability, we encourage further reforms to ensure a basic level of public transparency at US military installations, including Fort Hood.

Establish training for military leadership on soldier-care and respect for physical profiles.

- Establish an oversight body responsible for hiring trainers and overseeing the training of Army commanders and NCO's (levels E-7 and above) on issues and policies related to soldier care and physical profiles.

Fund longitudinal studies to investigate the long-term effects of traumatic brain injury, to inform the development of treatment protocols for service-members and veterans.

Provide proper long term care for service-connected injuries and illnesses, regardless of discharge status.

Initiate a review into the Army's use of discharge protocols since the advent of the drawdown beginning in 2012; and their impact on soldiers' access to care for service-connected injuries and illnesses.

Amend military insurance policies to ensure coverage and support for ex-spouses and dependents for a transitional period after the divorce of a service-member.

Ensure service-members' and veterans' access to quality medical and mental health care, and anticipate the costs of treating service-connected injuries and illnesses when authorizing military and war budgets.

- Implement policy for all branches of the US military ensuring they fully treat mental health and traumatic injuries suffered by US service-members. Funding for these services should be allocated as an integral component of any future war budget. This should include funding for long-term health care under both the DoD and Veterans Affairs. Without adequate health care, the high costs of war and everyday military service are being paid by injured soldiers, their families, and communities.

Testimony of Fort Hood Service-Members and Veterans

Service-members and veterans of Fort Hood testified with the Operation Recovery research team throughout 2012 and early 2013, and a selection participated in additional follow-up interviews in January 2014. The testimony presented here has been distilled from the original interviews, edited for clarity and readability, and converted into a first-person narrative format. In order to protect the privacy of all soldiers, veterans, and family members who testified anonymously, most identifying information has been either omitted or changed throughout.¹⁴¹ This includes most geographical locations associated with the testifier's life history, excepting those associated with their service at Fort Hood and life in the surrounding region. Where narratives included in-depth timelines of events in their own and others' lives, key dates and surrounding details have been omitted or changed throughout, in order to protect the privacy of testifiers as well as those involved in their stories who have not consented to appear in this archive.

Much of the editing done to transition the testimony interviews into the narrative format presented here is left visible through the use of certain punctuation, such as ellipses (...) where multiple words or lines have been omitted, and brackets around words and phrases which editors have added in or changed from the testifier's original speech, for clarity. Many of these editing functions were necessary simply to transition the transcribed testimony interview—a record of spoken language—to a readable text document. Other instances of editing served to clarify the testifier's meaning when their speech referred to parts of the interviewer's questions, which are edited out. Where significant contextual information present in the original interview is not reflected in the testifier's own narrative, it has been presented throughout the testimony in editor's notes, which appear in italics.

Testifiers who chose to participate anonymously are identified by aliases, which is denoted by an asterisk (*) next to the name presented. In addition, other individuals appearing in the testimony

who have not consented to testifying publicly are also identified with aliases. The names of all military personnel below the rank of O-3 have been omitted or changed throughout as well, aside from Fort Hood's commanding generals and higher ranking Army, Department of Defense, and Veterans Affairs officials of national public notoriety.

The anonymity of the testimony presented here is intended to protect active duty service-members and veterans from retribution from within the chain of command, or any adverse impact to their ongoing access to treatment or benefits. The testimony is likewise presented to highlight the effects of military policies, not the actions of individual service-members.

1 Cory Williams*

Editor's Note: Cory* is an active duty infantryman who has been on two deployments. He did not identify his race. He is undergoing medical treatment for a knee injury and spoke about issues of profile violation.

I am stationed at Fort Hood. I am a soldier on profile. I have been undergoing mental treatment lately, and I have knee issues. I am also pending a Chapter 14-2 Bravo¹⁴² for behavior caused by my mental status.

My profile is for my right knee. I have a 3.88cm ganglion cyst. I went to orthopedics, but they said it's inoperable due to the location and proximity to everything else. They would have to tear apart my knee to fix it, and they said they would cause more problems than they would fix. My profile's pretty much a 'broken egg' profile. I can't bend, stoop, do any exercises on my knee, run, or walk. I've been prescribed a cane to assist me in my walking. I have also been issued a Texas handicap sticker because of the prescription for my cane.

In the past, when I was in the line unit, before I was on rear detachment, my unit would frequently make me, and other soldiers, do things that worsened our condition. One of the main reasons I was recommended to the MEB process is because the physical therapist and the provider at the Monroe Health Clinic both agreed that due to the nature of my job as Infantry, plus being in the military and the nature of the way the command treats their soldiers, that there was no way my knee could possibly get better while I was doing that. Because any progress I made would be too slow to be noticeable, due to the nature of the work.

One example of this is when my unit was getting ready to deploy. Typically in the military, you do a rotation at the National Training Center. As the rotation was coming up, I had an appointment with my medical provider at Monroe beforehand. I was talking to him about my knee injury, asking how it would affect my performance and my ability to do everything at NTC. And he said, "You're probably not going to be able to do anything. They're gonna put you on what's called white cell, more than likely, which is where you do administrative duties or cleaning duties around the base." I said, "Why even send me then?" And he said, "Oh, because they need the numbers."

That's a huge problem in the military. They not only lift peoples' profiles that aren't ready to be lifted, but they frequently deploy soldiers that aren't ready to deploy, that aren't mentally capable of deploying and are not physically capable of deploying. They deploy them to bolster their numbers. When I was first put on rear detachment, I went on leave, because I'm Jewish and it was one of our many holidays. I can't remember which one it was at the time, due to memory loss. I had several NCOs from my line unit come and bang at my door at six o'clock in the

morning. They told me to pack my bags, that I'm deploying. I questioned them, saying, "I'm undergoing an MEB process, it's not even possible for me by regulation to deploy. How can I clear SRP, how can I physically do anything over there? What am I gonna be able to do, when I can barely walk?"

They said, "We don't give a shit. Pack your bags, have them ready by Monday," which is when my leave was supposed to be over. Two hours later, two more NCOs from my line unit showed up banging on my door and said, "Have your bags ready by noon. You're deploying." I said, "What about the MEB process?" They said, "We don't care." I said, "I'm on leave, what's up with that?" They said, "The commander rescinded your leave because it's more important for us that you deploy."

I said, "Since I've only been on leave for two days, what about the 15-day leave that all the other soldiers were able to take before they deployed?" They said, "It's too late for that. You don't have time to take 15 days, so you can't do that. You're deploying, end of story. Be at work by noon."

I packed my bags with my wife's assistance, and proceeded to go to work. When I got to work, I questioned everybody about what was going on. The nature of my leave was religious, and I asked why that was being violated. The EO¹⁴³ officer said, "I don't give a shit. They need you to deploy, so you're going to have to suck it up. Your leave has been rescinded." So I sucked it up, my leave was rescinded. I then brought my bag to the motor pool, with the help of several other soldiers. My memory is kind of bad, so bear with me here. At this point they took me to SRP, after my bag was secured in the Connex.¹⁴⁴ I'm a rather intelligent person, so I pulled aside the guy that was doing the briefing outside before they let anybody in, and I asked him, "Hey, I'm pending an MEB, am I even going to get past SRP?" He said, "No, you can't even be here. You need to leave."

So then, my NCO went to the parking lot and called his platoon sergeant. They talked on the phone for approximately five minutes, and then the NCO decided, "Hey, the platoon sergeant wants us to go inside and sneak you in, and clear everything you can." At that point, we went in, we did the legal ID card, and all the stuff we could do that didn't bring up any red flags with medical. As soon as I got to medical, they asked my NCO, "What the hell is he even doing in here? He can't deploy, his medical status is Red on AKO.¹⁴⁵ He can't even do a PT test, what makes you think he's okay to deploy?"

The day after that, they did a PT test for a record for the company—this is a big example of them violating my profile. My profile said I can't do sit-ups and I can't run, but they told me to come to the PT site anyway. When we arrived at the PT site, I did the pushups and then they told me, "You need to do at least two events, so now you need to do sit-ups." I told them, "I can't. It's on my profile that I can't." They said, "We don't care. We need a number of people to pass. We know you're a capable soldier, so we know you can pass." I passed by one sit-up. The whole entire first minute out of my two minutes doing the sit-ups was me and another soldier holding my feet, trying to bend my knee into a position where I could even do sit-ups, because they couldn't even count them unless my knee was at a perfect ninety-degree angle. I had lost 98% of the mobility in my knee, which makes that a rather difficult task.

Frequently, throughout my military career, the issue comes up of, "Why didn't you go on sick call?" There have been several times where I went to get on sick call. But to go on sick call you have to, first of all, have approval from your squad leader and your platoon sergeant. Then you have to fill out the sick call slip. After you have the sick call slip, they have to have it signed by the first sergeant. A lot of the time he's not even there—or any first sergeant I've ever seen—isn't there early enough to get that signed for the soldier to be able to get to sick call on time. And this becomes now really apparent, now that I'm actually going through the MEB process, and they're asking me, "What's wrong with you?" and I'm trying to make my VA claims. They keep asking me why I haven't been to sick call more.

Beyond that, there's a huge stigma of, "Oh you're weak, you don't need to go to sick call. Suck it up, suck it up, suck it up." The nature of my knee injury would have never been as bad as it is if it weren't for that stigma. When I first injured my knee, I got twisted up in the gunner harness of the MRAP.¹⁴⁶ I went to the medic, and he said, "You hyper-extended your knee, here's a one-week profile." With that week off, it got a little better. I did ice therapy on my own, and that kind of stuff, when ice was available to me. When we got back to Fort Hood, everybody went on spring break, and those of us that didn't go on spring break were doing normal PT. While I was turning around doing sprints, I twisted my knee again. And when I went to sick call the next morning, they said, "Oh, you hyper-extended it again. Here's your one week profile." After a week my knee had actually gotten worse this time, and I went back there. They said, "It just takes some people longer to heal than others, but we don't think you need to be on profile anymore."

At this point, we had Expert Infantry Badge training coming, and that's something that takes precedence over all kinds of other stuff. It's a pretty huge skill to those of us who are Infantry. My knee was constantly giving me pain. I sucked it up, as is the norm in the Army. Suck it up, it doesn't matter if it hurts, you're a soldier, soldier it out. So we go through the EIB training, which means doing 12-mile marches on my own. I was doing 12-mile marches with the company, frequent other marches with the company, plus all this other extra PT, and going out to ranges all the time. My knee was getting worse very quickly.

When I did the EIB the first time I did it, I was in another brigade, because I was once considered a 'squared away' soldier, a soldier who is really on top of his game. I've been in the horse detachment. I've been in the color guard. I have been studying for the E-5 and the E-6 board, both since I was an E-1, because I had a really good squad leader when I was deployed. So I took EIB as something very important for me to do, and I gave it my all. But they said, "You're so squared away, we're gonna send you with the other brigade that's doing it first, that way you can come back and train our soldiers." When we were doing the run, due to my knee, I missed my run time by six seconds, so I didn't pass the EIB standards, and I wasn't able to get it then. When I went with my brigade, I once again failed the run due to my knee being all jacked up. After that I felt like EIB wasn't an issue anymore, so I decided to go to sick call. Sick call said, "Tough luck. We can't do anything for you, because it's a previous injury. You're gonna have to set up an appointment."

I immediately called to set up an appointment. But the medical staff at Fort Hood is so

overwhelmed that my appointment was a month out. So we were doing a company run a couple of days later, and my knee swelled up to about the size of a grapefruit, and I had to stop running. The whole time I had NCOs calling me a pussy, and saying, "Fuck you, what's wrong with you? Fucking keep running, don't you fall out. You're a piece of shit soldier." So I started running again, with a severe limp, and I had one NCO come over and say, "Hey, I'll run with you," and he told the other NCOs to back off. So it's not absolutely every person in the Army that acts like that, which tells me this can change. As it stands right now, I would say about 95% of the NCOs in the Army all have that mentality of, "You're a soldier, suck it up. Why are you falling out? You're supposed to be better than everybody else, you're a soldier."

After I finally got my doctor's appointment, I found out I had a 3.88cm cyst in my knee, proximal to my PCO,¹⁴⁷ that was pushing pressure on my sciatic nerve and an artery, which causes circulation problems. This explained why my foot kept randomly falling asleep, and why that foot would get colder than my other foot. It explained a lot of stuff. After they read the MRI, the provider at Monroe said, "We're going to send you to pain management, and see what they can do." Pain management ordered for it to be drained, which is a pretty standard procedure with a cyst. They stick a needle in, pull the plunger, and it drains the cyst, and there you go, pressure relieved. Well, they went to stick the needle in and they couldn't get it into the cyst. Due to the length of time it had been there, it had calcified, which basically means it had turned into bone. The only option to get it out at that point is surgical. So they sent me to orthopedics. This whole time I'm doing physical therapy as well. Orthopedics said, "Because of where the cyst is, and because of its size, we would have to completely deconstruct your knee to be able to fix it. So we are not going to do surgery. Surgery is not an option."

I went back to the physical therapist and they said, "You're improving, but not as much as you should be. You're on profile, but your company's got you doing all these details." They had sent me to NTC and put me on kitchen personnel the entire time, which is longer hours than most soldiers work. You assist the cooks, wash dishes, wipe the tables down. It's not the hardest work ever, but it's the type of work that someone with my kind of injury should not be doing. So at that point, that's when my primary care manager and my physical therapist both concurred that an MEB was due.

I took a lot of pride in being a soldier, so this all makes me depressed. And the way the chain of command behaves to a soldier that's quote-unquote "broken" really causes me a lot of anxiety, too. I've already been diagnosed with PTSD, which causes me a lot of problems. I've developed insomnia really badly because of that. In October, I was late to work three times in one week. Toward the end of September, I had noticed that my insomnia was getting worse and worse, so I went to sick call. They said, "Tough luck. That's mental, we don't do mental stuff. You're gonna have to set up an appointment." So I set up appointments, one with my primary care manager and one at the R&R Center.¹⁴⁸ Both appointments were over a month out. So when it happened that I was late three times in one week, the rear detachment unit I was in decided, "Oh well, you're a piece of shit because you were late, so we're gonna give you an Article 15."

I've never been in any kind of trouble in the Army, the entire time I've been in. The fact that I had that Article 15 worsened my depression, and worsened my anxiety, because I have to look at

these people, I have to see my peers looking down on me because, “Oh look at him, he's a shitbag, he got an Article 15.” I received help for my sleep issues, but that was after the fact. They just said, “Tough luck. It doesn't matter. Just deal with it. You're a soldier, soldier it up.”

This caused a domino effect, and I started having problems at home with my marriage, which caused me more depression, more anxiety, more stress, and worsened my PTSD. Little stuff started adding up at work. I started slipping on my annual report, I started getting in trouble for random stuff. I would completely forget that I had an appointment. I would stay up for three days before I would finally fall asleep—and that's with the medication.

So now, the chain of command has decided that because my behavior was off, they are going to Chapter me out. Since they've made that decision, I've made progress. I've improved my condition. Because I've gone through a divorce, the marriage isn't an issue causing me stress anymore. The MEB clinic has issued me a cane, which helps relieve pressure off my knee, and makes the pain less of an issue. The command climate hasn't improved at all, but you can only hope for so much.

Another really important thing is that in the line unit, they say that if you get any kind of mental condition on your record, you're going to get kicked out of the Army, and you're not going to be able to get a job as a civilian. And while I know none of this is true now, back then it was all I had to go on. That's what I heard from the people that were in charge of me, the people I had to look up to and listen to. So I always thought it was a bad thing to get mental status, which is why I never received treatment for having ADHD, which now I'm receiving treatment for.

I talked to other people in the military, and this isn't just me. It's a regular occurrence. This happens all the time with soldiers all over this post. I haven't had much exposure to soldiers on other posts, but going through my own experiences and looking online for solutions, I have run across numerous forums and other soldier chat-rooms, where I've talked to soldiers at other posts that are going through the exact same stuff that I am. That helps a little bit, it makes me feel better knowing I'm not the only one. But it doesn't change the fact that this is a severe problem, which needs to be addressed and fixed.

I'm still pending the Chapter, trying to fight that. Everything that happened in the Chapter was within one month, while the rest of my military career before that and afterwards has been really good. They've re-done the Chapter packet four times now, because I've already beaten it three times. And that should tell you how determined these commands are to get rid of soldiers by any means necessary.

2 Chas Jacquier

Editor's Note: Chas is a white active duty soldier and Non-Commissioned Officer in his late twenties. He is a father to two children and previously deployed twice to Afghanistan as an MP. At the time of his testimony, he was negotiating the medical evaluation and retirement process due to injuries he sustained in an RPG attack, including a TBI. After being injured and receiving a medical profile, Chas was given a poor NCO evaluation on account of not being able to perform the physical training component of the evaluation. Chas discussed his own struggles securing adequate care and his concerns after having witnessed the differential treatment of other soldiers. He also discussed his concerns that soldiers are being disciplined for infractions that occurred before deployments or as a result of traumatic injuries.

Chas discussed his own struggles with PTS and how it has affected his family and outlook on life. He discussed the roles of multiple deployments and PTS within his unit and during deployments, including suicide and other issues. Chas provides several examples of the effect of military stigma in accessing mental health services, but is also concerned with the mindsets necessitated by multiple deployments may leave soldiers themselves unable to assess their own needs.

I had a friend from high school who was a year older than I was. We were on the football and wrestling teams together. He got into the service and deployed to Iraq. He came back and I could see that he was struggling with what he went through and was having a hard time with it. I saw myself as being mentally strong, so thought I wouldn't have issues with [deploying] and I would be able to help others go through it. I thought in my head that the answer was to go be a part of it and try to help out

Obviously, September 11 was still fresh. The war in Iraq had basically just started. I joined in April 2004, so the Iraq war was about a year old. It was almost a patriotic duty for me as a young American to go and be part of that and to support and defend my nation. When you watch mainstream media, that's how the whole War on Terror was seen at that time.

In April of 2005, I deployed to Afghanistan until April 2006. In April of 2010 I deployed again and was there until April 2011. In 2010, I was ambushed and got hit by an RPG—received shrapnel, blew me up through the air, damaged my neck, my back, TBI, traumatic brain injury—all these



Chas at home in January 2014

different kinds of things took place. I was med-evaced out for four days. I was there with two of my other soldiers that had been med-evaced out as well. They had some guys that were more

seriously hurt, so we were put on the backburner. They just did the bare minimum, "Ok you're here. Go over here for observation at the TBI clinic because we have to handle this stuff." Which, obviously I'm okay with. I don't want soldiers dying.

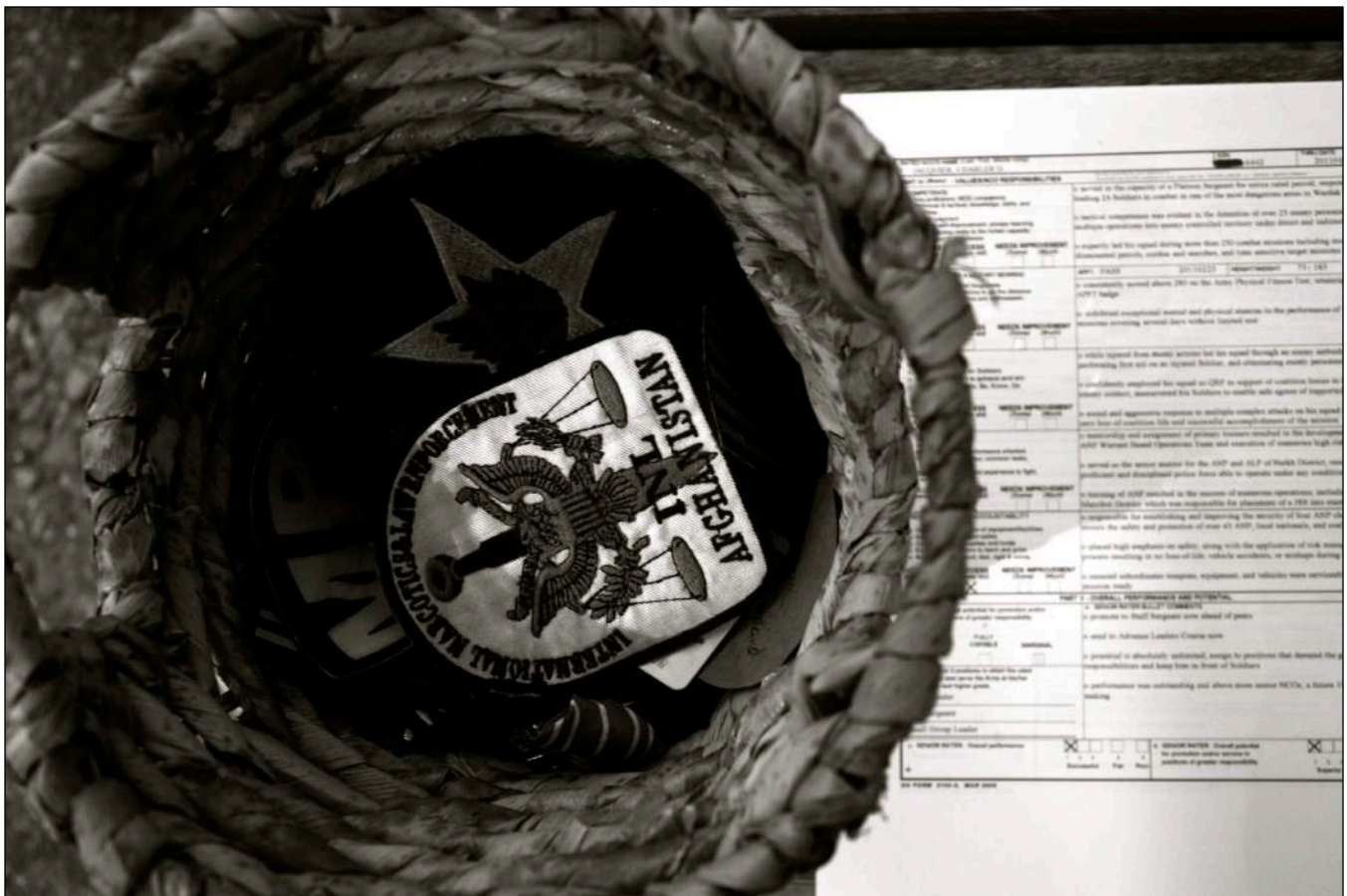
They basically enabled us to make our decision on whether or not we wanted to stay or go forward, and at that point, I was a senior enlisted guy in charge of 25 soldiers. I didn't want to leave my soldiers behind, and so even though I was struggling with what was going on—having a

hard time with it—I made a decision to stay. They didn't even really seriously check me out there. There was no serious evaluation done all the way until I got back home. It was basically just "Here's these medications." I was getting shots in my lower back and in my buttocks to be able to deal with pain constantly and having to pop pills and everything in order to mitigate the pain that I was feeling the entire time.

Upon returning at the end of the deployment in April and going to actually get help, I had missed being paralyzed by an eighth of an inch in my neck. I completely ruptured multiple discs in my back—all these serious injuries that I was causing more damage to by remaining there. We should

be taking the medical capabilities out of the commanders' hands, but we also need to look towards the soldiers. We need to be making sure they're able to get that care and they're not able to be stubborn and just be, "Well, no. I'm gonna stay here because I wanna be hardcore."

I look at it now and think about the mental state that I was in underneath the amount of medication that I was having to take and the risks that I was putting myself and my soldiers under by being in that state. I justified it to myself—that even on my worst day, I'm still better than half these guys—talking myself up in my mind to be able to justify that. But I look at it now, and if something had gone wrong—if I had lost a soldier after that point—what kind of mental questioning would I have gone back through with myself, wondering, "Did this happen because I made a poor decision based off these drugs?" or "Did I not react as well as I would have based on being slowed down from these injuries?"—and just having to live like that.



Chas's patches and memorabilia from deployments to Afghanistan, with NCOER paperwork in background

When I was back home, I made the decision that I was going take care of myself finally. I'd run out of all the medications that I'd gotten downrange. I didn't have my medic to just go to an aid station and just get me the stuff that I needed. I had to go through the whole system that the Army normally has you running through. Jumping through those loopholes—I just couldn't do it. I was just in such pain all the time. To the point where I'd be crying—literally in tears in the shower with my wife trying to rub my neck out and everything—and my head, it's like my brain is swelling.

I felt horrible. To have to go through that for a month—a month and a half? There is no priority list with the way the military does things. They don't take something like this as a serious case. It just goes into the system and you're basically a number at that point. They tell you they have 24 or 48 hours to respond back to you and you don't get a call. You can call them. You can leave a message on the answering machine, and nobody calls you back.

Why am I having to jump through hoops to get care after being through all that? It shouldn't be that hard. It took me having to do something that a lot of soldiers wouldn't do, because I was yelling at people who were senior to me. I basically got pushed into a corner to where—I mean, I was in so much pain I could hardly walk. It took me getting with the military liaison and losing my mind—losing my military bearing—being like, “What do I have to do? Do I have to come back with no legs? Do I have to come back in a casket for you guys to actually care?” I got some people to actually make some calls and bump me up in lines. I finally got help.

Editor's Note: Despite his struggles accessing care, Chas felt strongly that he was fortunate as compared with other soldiers. He generally felt his own command respected his injuries, but became disheartened when the time for his annual NCO evaluation came up.

I will honestly say I'm probably one of the luckiest people I've seen in the military. I had a great direct command and leadership. Because of the things that I did, and the sacrifices that I made, they really took care of me. One of the soldiers who was in the RPG incident with me and was injured and everything—he still now has conflicts with trying to get appointments. He just gets treated as a lesser soldier in a lot of these cases when he's [hurt] just as bad as I am, but he just wasn't one of the guys they looked at positively. That is how a lot of things are with the Army. You have got to be able to separate the commander's ability to do that, because why are my needs medically any different than his?

Now I'm on a permanent profile. I've been in for eight and a half years. I've served honorably. I've never received anything less than a one-one on my NCO-ER. My whole career. 300 PT guy. Expert weapons qualifications. I get back and I'm injured. And based off this profile, I'm not able to do a PT test. I'm not able to put on all my gear to go fire at a range. The way the Army's system is established is that I automatically lose my promotable status because I didn't submit a new PT record.

To come back, after working in a pay grade slots two above my own when I was in Afghanistan for a year—to come back here and then get slapped in the face? Basically, it's like saying, “We got what we wanted out of you and now that you've been injured and you aren't able to do these things that the Army requires you to do, we are going to take your promotable status away.” After spending the amount of time that I have in the military, when you get out you expect to have achieved certain things. To have that taken away not because of any fault of my own—but from injuries that happened in combat—is just kind of ridiculous.

Everything I went through and I did—staying down there and getting injured and all that—I did for my brothers and my sisters. I was willing to die to help keep them alive. To say that I need

improvement in that area is just absolutely ridiculous. The message that we're sending to our soldiers coming back after being wounded in war is that they are no longer of the same caliber—that they're no longer of the same worth that they were before.

Editor's Note: Chas went on to reflect on his own responsibilities to his soldiers' wellbeing as a Non-Commissioned Officer, and how these sometimes conflict with the demands of the Army.

I think that all Non-Commissioned Officers, if they actually care about their soldiers and are willing to sacrifice their own time, they will look out for their soldiers. But the problem is, you're going to run into mission constraints and you're going to run into the fact that the mission comes first from the senior side.

And so you're basically gonna tell your soldiers, "Hey you guys can schedule your appointments this week. This is a week where we have some openings where you guys can go do these things." Then all of a sudden something gets back-billed or moved and adjusted and they have to cancel. And you push that soldier's care off here or there based off of what the military is desiring you do.

There's this real bad stigma around—that if you're going to go get care during the workday, you're just trying to get out of work. And I'm sure there absolutely are some soldiers who do that, but do you condemn everyone who is legitimately trying to get care?



Chas holding pieces of shrapnel recovered from his body after an attack in Afghanistan

If you're an NCO who is actually worth anything and you're paying attention, you're gonna be able to identify the fact that an individual has Army values that are missing. There are ways to help a soldier who's struggling through those things. That doesn't happen most of the time. Most of the time it's, "Hey you're a dirtbag. You went to go get a profile because you sprained an ankle. Fine, you're gonna do CQ now for the whole time we're in the field."

Prior to going, our unit was so low in numbers that we actually took soldiers into Afghanistan who were on crutches. We're walking fifteen, twenty cliffs a day at 10,000 feet elevation through the mountains. The guy just got off crutches and you expect him to be able to do that? I mean he lasted a couple of weeks and we had to send him back because he reinjured himself. And then you're undermanned.

Basically. It show soldiers that they don't care. The Army didn't care about whether or not he was okay. They didn't care if he was ready to be there. Him having to walk a little slower—I can deal with that. But what I can't deal with is him having to try to run or pick somebody up and carry them off the battlefield, and he can't do it because he's physically not capable of it. What message are you sending to his family? His family has to know back in the states, "Hey, my son is going into war right now at seventy percent. If my son dies right now, the United States Army sent him to war at seventy percent." That's not a message that we need to be sending to the soldiers, to the families: That our priority is so war-driven that we've lost humanity. We've lost our touch with humanity and the basic needs of people.

We took two soldiers who had popped hot on a urinalysis. They were pending an article 15 but, they need to go to Afghanistan because we needed those numbers. We punished them. We had them go do extra duty there at the FOB, filling up sandbags, while the rest of us went out to the combat outpost. I thought they had basically served their time by doing their extra duty. But when

they finally got their article 15 reading, they told me to start actually ordering their extra duty. So, they had to do their extra duty on the combat outpost too—which is like double punishment.

These guys were E-1s for two years. It happened before we deployed. Some young soldiers, right before deployment, went to a party and did something incredibly stupid. Two of those soldiers were with me when we got hit and both earned purple hearts, but the Army didn't give them combat action badges, so they are still E-1s. They have no combat action badge saying they were in direct combat because they were flagged. They didn't get an end of tour award, and the Army still holds this thing over their heads.

One of the kids is trying to get medical care because he was closer than I was to the RPG. He is trying to get help, and they are still holding his UCMJ paperwork over his head and saying that if

he goes to get medically chaptered out, that his packets will go up to the commanding general. They will push his UCMJ packet at the same time as his med board packet, and it becomes that one individual's choice on which way to go—whether this guy will get out and have medical benefits and be able to take care of himself and his family based off having PTSD, TBI, shrapnel

wounds—whether he's going to be able to receive any care falls down on this one guy making the decision.

That happened two years ago. The Army said, “Hey, you're still good enough to go on this deployment. You're good enough to go kill people”—which he did. He's good enough to almost die. After going through all of that, now that he's trying to receive care and trying to take care of himself, there's a possibility he may get chaptered out on an other-than-honorable discharge—and receive nothing and hurt his chances of being able to be hired on the outside. To me, that's just disgusting.

I think there's a huge correlation between soldiers and their use of alcohol upon returning from deployment. There are numerous soldiers who are in my unit right now who were specialists or private first class on the deployment, who are now E-1s. They are all alcohol-related incidents. And they're all the guys who were in most of the fighting and who had the hardest times. We've got to be able to evaluate that there is some direct correlation between this stuff. It's not an excuse. You're not excused to be able to go and do whatever you wanna do—but are there other means trying to actively help these individuals, as opposed to going straight to UCMJ?

Part of the problem with the way the Army does things, is you get back from your deployment and the first thing is they purposely disperse you and spread you out, because they feel you became too close and tight knit down there. So, they take NCOs who know their guys, who would be able to identify the fact that there may be a serious psychological problem going on, and put them somewhere else in charge of someone else's soldiers.

You could also have an NCO who has those problems and it might be one of his lower enlisted that steps up and goes and tells someone higher: “My team leader is having some serious issues. This guy is not able to act and deal with things the way that he did before.” When you split those teams and that continuity up, you lose all that ability to compare.

I think the reverse SRP process is a very poor process. The way it's done, everybody wants to get in there and get out of there. And it's done right when you touch down. It's done way too fast, inadequately. If they had more people, they could actually give people the ability to have a one-on-one interaction that wouldn't hold up the line.

On two instances, they had some civilian counselors that the military hires come to our unit and talk. Both times, same scenario where you have everybody wait in line outside the office. It was basically done to ask, “Hey, do you have a problem? Is there something wrong?” Not like, “Hey, I'm here to help you.” It comes off as you being a number, stacked against the wall, waiting in line to go into the office, sign the clipboard, and get out of there so we can be done with this type thing. It's a horrible approach to actually trying to get someone to get healthcare for a mental issue that they're having. We shouldn't demoralize that. We should commend people for identifying the fact that they have these problems and that they're actively seeking help for it, not condemn them for it.

PTSD has become such a hindrance on commands that they talk down on it in formations now.

When we got briefed to go in, they were mocking, like, “Hey, the counselors are here again. If you plan on being in there for a while, stay at the end of the line so everyone else who doesn't wanna do it can go first, and sign, and get the hell out of there.” When you come off and say that, who wants to be the guy at the end of the line who is actually talking about something?

Like I said, in my unit, you have soldiers who are receiving UCMJ action. You have soldiers who have gotten divorces now and have all kinds of depression and sleeping issues. This last deployment was traumatic. There was a lot of killing involved. There were people getting shot on both sides—our guys and theirs—children being killed in the mix with it all. There were a lot of things that were extremely dramatic.

I don't think that the Army identifies that that adrenaline in itself is a drug. You get so used to being on that high all the time—24/7 on alert—getting into those fire fights. While we were down there, the only way you could handle it was to love it. When we got in a firefight, people were making jokes. We would literally be laughing and joking around in the middle of firefight—bullets flying all over the place—dirt kicking up on you and everything as you're stuck underneath the berm that is two feet tall and barely big enough to cover you—and we're just sitting there laughing about the fact that these guys are shooting at us and that we're almost dying.

At one point, I remember the interpreter was just like, “What the hell are you guys laughing for? Shut up.” But that was a coping mechanism for it all. You just get so tuned to the adrenaline. That's all you have and you look forward to it. Then you get back here, and you have got to sit down on the couch and deal with a wife and two kids, and it's all gone. You don't really have a slowing down period or a real chance to let that all go. It's just gone all of the sudden that you are back.

I think that's why you see so many soldiers coming back dying doing stupid stuff—taking out a motorcycle and driving it 200 miles an hour, just so they can try to get close to having that rush again, that adrenaline. There have been a bunch of soldiers who have come back and just done crazy stupid stuff, but there's no way to mirror being shot at. You can't do it. We don't have any kind of tool or setting to reintegrate people back into what reality is here. It's just—cut-off line. End of deployment. You're on the bird. Have a nice day and welcome back.'

It's almost sad to say: You get back home, and the first thing you wanna do is go back [on deployment]. You want to go back down there. It's almost easier, because you don't have to worry about all this other stuff. All you have to worry about is doing your job. And you get that adrenaline rush, that fix that you want.

So, I really see multiple deployments as almost like waving a heroin needle. That's where you see so many guys waiving their dwell time. They may have PTSD. They may be injured. They might not have their family set up and taken care of, but they want to get back to that needle so badly, that they're willing to go. There's no way the Army is going to know how you're doing with your wife or your kids or what your exact financial situation is. But they don't take any of those things into account, because you're just a number. It doesn't matter, as long as they're getting what they need for this next deployment. They'll let you sign that statement and hop on that bird and go

take off.

I think the number one thing is for the military, as a whole, to admit that there is trauma. To admit it, and then to embrace it. Not to make it out to be something negative where you're viewed as weak for trying to get care. I've literally been dealing with a new senior enlisted person at work and you can tell there's an underlying idea I'm one of those dirtbags that's getting kicked out of the Army through the MEB. Then when I actually talk to them and they find out my story, they are like, "Oh, you're one of the guys who got hurt in combat. You have a legitimate reason to be hurt and be going through the MEB." Had I just gotten in a car crash here and had those exact same injuries, it wouldn't be the same thing? It just shouldn't matter. If I'm hurt, I'm hurt. Obviously a medical personnel has gone and evaluated my records and evaluated what is wrong with me. You have to be referred to the MEB process. It's not something that you can just one day decide you are going to go sign up for. Somebody has to say, 'This person's medical injuries are bad enough for them to be reviewed by an MEB and be removed from military service.' And so this stigma just needs to go away.

The Army needs to address the fact that there are people who are going to get hurt in war and there are going to be people who get hurt doing everyday stuff. Out in the civilian world, you get hurt at work and you get worker's comp. As an employer, you can't go and be like, "Hey dirtbag, what are you thinking, getting hurt?" You would get sued. So why do we authorize that in the military? It makes no sense.

It [the MEB process] has been an absolute nightmare. It took me six months just to even get into the process. And then since I've gotten in, I'm sitting at almost a year now, and they're saying another seven months or so before I'm actually out. They switched around who was supposed to be taking care of me and didn't tell me. Luckily, I found out through the grapevine.

Don't you think people should know who is supposed to be taking care of them—especially when there's someone going through these types of injuries in this kind of seriousness? The Army doesn't keep you informed. If I didn't keep somebody informed as a Non-Commissioned Officer—God help me! I'd be in so much trouble! But if it's the Army, it's okay. It's a contradiction of policy.

The Army now is looking for reasons to get rid of people. I agree that we should not be allowing soldiers to come in overweight. But if you've already allowed that soldier to come in overweight, and you've already deployed him two or three times overweight and haven't done anything to fix the problem in the last five years, how are you going to try to kick him out for being overweight now? You can't use and abuse him.

There is one kid who is six-five, three hundred pounds. He's a big boy—maybe twenty three. But, he was good enough to go on two deployments over the last five years. He's got a year left in the Army, but now they are trying to process him out because he's overweight. I'm sorry, but he was overweight for the last four years. If he was good enough this whole time, he's good enough now. Let him finish up his time, serve honorably. Bar him from re-enlistment if you want and explain to him ahead of time he's not going to be able to reenlist due to the fact that he does not meet the

Army's standards. But to say that you aren't allowed to finish your service honorably or receive the benefits that you have earned is absolutely ridiculous.

I'm still about seven months or so out from finally getting out. I know Texas has the biggest back up as far as getting and receiving VA benefits right now, which is definitely worrisome. I'm just basically ready to get out one way or another. I'm lucky enough to have a wife that's working and making good money. We've saved up money. We've been smart with everything we've done. So we're lucky we have no debt whatsoever other than a home and two vehicles. We're in really good shape compared to a lot of people. If I wasn't in that position, I would be scared out of my mind.

Waiting as long as I have for the last year, and then having the VA still not give me: "This is what you're going to get. These are your benefits that you are going to have." There's a difference between medically retired and medically discharged. And so until you get those results back and actually know which side you're going to fall on—it's a different sets of benefits. It's different amounts that you'll receive from them. It determines whether or not I will just receive medical benefits or my entire family will receive medical benefits.

I might not know [what is going to happen] until two months before I'm going to get out of the Army. So if it's the lesser end of all of that, that is going to dramatically change how I have to approach things. Like, I might not be able to go to school full time to finish my degree. I might have to go do something else. It shouldn't take that long to get that answer. I should not have sixty days to plan the rest of my life. That's pretty poor planning by the VA and by the Army in the way that they run the system.

They have every one of my medical records right now. They've got that. They have had it for a considerable amount of time To have all those things and then not be able to give me an answer with it—it shouldn't take sending a packet to San Antonio—to have somebody put a stamp on it and send it to Washington DC—to actually get an evaluation and a rating sent back to San Antonio—put on a different piece of paper, and finally send it back to us. I mean, that's just crazy that it has to go through that process.

There's no reason that somebody at Fort Hood, Texas should not be able to do that. A medical professional hired by these people should be able to evaluate. They have set criteria for how much all these things are worth. They could definitely set this process up to where it would take a quarter of the time that it's taking right now. Veterans would be able to get their benefits and get out. The biggest thing that they hold over your head is that while you're going through the process, you're not able to get any more surgeries. You're not able to go and get any help because it would change the amount of benefits you might receive. Right now, with the injuries I have in my back, I could have screws put in my back and a metal rod run up through it. Well, I can't right now, even if I wanted to. If I said, "Yes, that's something that I want to go through with," I cannot do it because it would start my whole process all over again. And they tell you, "Just go ahead and wait until you get out and the VA will take care of it then." And like I said, Texas right now has the biggest back up for VA benefits of any other state. Right now, it's taking like a couple of years for you to be able to get those things. It's just crazy.

I don't know if I could go and effectively be on a work force and not feel like I was letting my employer down and cutting corners on my fellow employees by being there one day and then calling in sick. I still get crushing headaches. It's a mixture from my neck injury and my head injury. It just feels like my brain is going to explode out of my head—worst pain I've ever had in my life. I've never cried from pain before, even when I got blown up, I didn't cry. It's just something that you can't escape [the headaches]. The only way to get away from it is to drug yourself up to the point where you basically pass out.

Unfortunately, it's one of those things where there is no timing or controlling it. I don't have any warning. I could just be sitting here having this conversation and then all of the sudden: Bam! That's it. And as far as having a job and going out and driving a long distance somewhere, it affects you as far as being able to do those things. Eventually, when I am out of the military, I could be at work. How do I explain to an employer: “Hey, I have to go right now. This is going on.” And then, hopefully, be close enough to be able to drive back to my home to get to a shower to and take my meds and just try to get my muscles to relax.

When I first got back, I didn't know how to deal with my situation. I didn't know how to adjust to being back here and being in the situation I was in. I had to go on leave and take a month away from everything just to find myself. I was depressed about how my body was—with having to be on drugs all the time.

I couldn't be there for my kids. The kids are running around you—all this stuff, and I'm just sitting there so drugged out and in pain that I couldn't address it. You can't pick your kids up and play with them or do the things that they remembered you doing before you got hurt. All those things definitely are a huge deal. They give soldiers training on PTSD but the thing is there's no training for spouses on it, really. There's no way for them to really know and understand how to deal with us coming back and having the kind of emotions that we have, the distance that we have and all that.

And my wife basically got to the point where she just blew up on me at one point.

She tried. She was trying. She just got to that point of breaking where she was like, “Fucking stop.” She was just so upset with me not being who I was before. She understood I was upset because I was extremely athletic before I got hurt. I did all kinds of sports, and for me to come back and not have any of that as an outlet drove me crazy. She didn't know how to deal with it. But through the FRGs [family readiness groups] and things that they have, they definitely could really try to reach out more for those types of things.

I know while we were gone, the FRG was doing movie nights, stuff for the spouses to get together. And that's great. They should be doing that, but they also need to really be trying to focus on things may cause issues when a soldier get back. Financial classes for soldiers and their spouses. A lot of times you can't communicate down there [on deployment] so you don't really have that ability to be like, “Yes, that's a good idea. No, that's a bad idea—relating on that.” You can't make it mandatory for a spouse to do something like that, but offer. Like I said, you go

through the reverse SRP process, but they don't ever offer, "Hey, we're gonna have an FRG meeting. Bring your spouse in. We're gonna have counselors here to be able to talk to you guys." Or trying to offer counseling for your marriage to be able to ensure that you guys are staying strong. That's why the divorce rate is so high in stinking Army. It's ridiculous how high it is compared to everywhere else.

They have marriage retreats and stuff that they send these people on. And it's totally run by the Chaplain. And it's supposed to be good for them to just go and get away, relax. I think if they were to encompass some form of an Army fund for that, to specifically be able to provide counselors at the retreats—once you get that free time, the counselors are there for people to be able to go and actually talk.

I think that there needs to be more funding for it. It needs to become a priority. I think we need to shift from militarism—we need to shift from buying bombs, wasting 26 million dollars on a spare jet engine that the pentagon doesn't even want—and take those types of expenditures and turn them back over to taking care of our soldiers. I look at what's happening right now and it makes sick. All the 9/11 veterans are being made the priority and we're taking Vietnam vets and telling them that they have to wait in line. Again, we don't prioritize based off of the injury. And it makes no sense to me that we would hold off on anyone who is a veteran. If they need help based off of whatever their injury is, and that is confirmed by a medical doctor, then we need to have those things available for them and allow them to be taken care of.

Just because you have PTSD doesn't automatically mean that you need to start taking four or five different drugs to deal with PTSD. That's not the answer. Basically, all you are doing in that point is making it a disorder. You're making me feel there's something mentally wrong with me. Well, I'm sorry that I have a problem with taking somebody else's life. I'm sorry that seeing a child dead bothers me. But, wait. No. I'm not sorry. Because if I didn't have those problems, I would be sick. I would be the one with the disorder at that point. The whole policy of, "Let's just drug and medicate now and we'll deal with the rest of it later" just doesn't work.

Even when there are instances in the military where things go the most extreme route—an individual with PTSD goes and takes their life or kills somebody else—part of the problem with the whole thing, is that the military doesn't even address that. It does not even identify that that's what happened.

A lot of times if [a suicide] happens downrange, the person died of quote unquote "non-combat-related injuries." They don't go and disclose the fact that this individual had serious issues and because of those things, they took their life. One of the two key instances where that's happened, the Army has gone out of their way to portray it as something other than what it was.

My squad leader on my first deployment had already been on either four or five deployments when he was there with us. He basically just lost it. He had PTSD. He had us driving through known mine fields. He kicked an individual off a motorcycle and beat him up right in the middle of this village that we worked in. It turns out, he was an off duty Afghan national police officer who was going home with his duty weapon. So he beat a cop up in the middle of the city that he

worked in. He bit me to where I was bleeding. He was sexually harassing some of the females that we were there with. He was just doing all kinds of stuff.

At the time, we ended up using the open door policy. There were seven of us that used it, and went and talked to him. We went to the inspector general, even CID—the criminal investigation division. They looked into it and started doing some stuff. But they basically all came to the conclusion that we were two months or so away from going home—so just suck it up and deal with it. When we got home, we were all going to be separated, go our different ways anyways, so we wouldn't have to deal with him anymore.

Editor's Note: In the remainder of Chas's account of his former squad leader's story, he describes how after failing the psychological evaluation needed to become a drill instructor, the same squad leader was sent back to Iraq on another deployment, where his actions allegedly resulted in the death of a lower-enlisted female soldier, as well as his own suicide. We have redacted this portion of the account out of respect for the soldier's family.

The other one is a kid in Afghanistan on my first deployment flat out told people he was going to kill himself. They took him away, put him on two down-days. Private first class. Said he was gonna kill himself and they took him seriously enough to take him away, because he was just doing guard duty in the towers. Twenty-one years old, had just gotten there. Said he couldn't handle it and was going to kill himself. They pulled him out, took him for two days, took his weapons away. Then after those two days, they said, "Okay, well you're good. Go back out there." He still told them: "I'm not okay with being here. I want to go home." And they didn't listen. They sent him back out there. They put him on guard duty with another soldier so that he had to be quote unquote "supervised." Well, the other soldier went to go utilize the restroom real quick and left him up there in the guard tower alone with his nine mil. The soldier went and killed himself while the other soldier was in the restroom.

They gave him two days of down time to be able to rest, recuperate, mentally recover, and re-energize and sent him back out there and let him die. I was going home on leave to go and see my daughter be born, actually. I saw it as a military police officer. I ended up flying next to his casket all the way back to Germany sleeping on the floor next to his casket with the American flag draped over the top of it. And it's just kind of sickening. You obviously didn't need him there in the tower because it was a one person tower. You only need one person to be there, so you had him there as a second person anyway. They could have kept him out longer. They could have offered help in different ways. This young kid actually verbalized, "I need help," which a lot of the times doesn't happen. He was strong enough to be like, "Hey, I've got serious problems." For the Army to then be like, "Well, we're sorry about you having problems, but mission needs to get done, so suck it up and just get on with it."

It directly resulted in the same thing: non-combat related death. The way it's marked up, nobody talks about the extent of it. I saw the story because I went and looked for it afterwards, after having that connection to the case. I saw the news releases from it. It doesn't talk about how he died, or in some cases it eventually came out that it was a suicide, but then it never mentions the fact that he had tried to cry out for help, that we knew that he was struggling. Those parts of the

story never get told. It only gets told that this individual took his life, and a lot of time people view that as a selfish act.

I think the reason why they don't inform you that these guys went out and tried to get this help is it makes the Army look bad. And with my squad leader, all these people had come forward and been like, "Hey, this guy is mentally not capable of being here right now." We wrote 28 official statements and provided it to the inspector general documenting things that were happening: going through known minefields, kicking this guy off of the bike, biting people, sexual harassment—all these things. Nothing was done.

At one point, we were the second vehicle on the convoy and we were driving through his tracks through this minefield. There's stuff marked around the minefield because they're actually building a road going through—but he wanted to go see these buildings, so he decides to just cut off the road straight through the minefield. We're driving—I'm looking from the gun because I was gunner at that point—I'm looking down and I could see anti-tank mines right next to where our humvee tires are. And I ducked inside, thinking that was going to protect me—my soft shell humvee had the armor kit put on it at that point—Little pieces of armor that with sandbags at the bottom because we had no armor on underneath—We would have all been dead had we hit one of them. I said to my driver: "Dude, we're gonna die right now. Stay in the fucking tracks." And tried to get him to do it. You can't see. There's dust flying everywhere. He's doing the best he

The image shows a military performance evaluation form (NCOER) for Chas. The form is tilted and shows various sections with handwritten notes and checkboxes. Key sections visible include 'OVERALL PERFORMANCE AND POTENTIAL' with a '1' marked in the 'Superior' box, and 'AMONG THE BEST' with a '1' marked in the 'Among the Best' box. The form also includes sections for 'RATER' and 'SUPERIOR RATER' with checkboxes for 'Fully Capable' and 'Marginal'. The bottom right corner of the form has the text 'Page 2 of 2' and 'APO PE v6 00ES'.

Chas's NCOER before his injury in Afghanistan. At bottom left, it marks him "among the best," and at right, rates him "1" for Superior performance overall.

can, trying to drive in these things. The three of us just sat there and accepted it: We're going to die any second. We're driving through a known minefield right now.

All those things got documented. I'd be the first to admit: When I originally told on him, I told on him not because I wanted him to get help, but because I wanted him to get in trouble. I was like, "This dude just about got me killed." I was upset about it. Now, looking at it—the guy was sick. He needed help. But however they addressed it—it didn't have to be that they took UCMJ—they could have gone and got him psych help. All these different things could have changed and would have changed had the Army taken some responsibility for it.

The only thing that soldiers are asking for is the respect and dignity that they deserve for their actions and for them to be able to receive proper healthcare and benefits for the things that they've done. When you go into the military, you have this concept that you're going to get taken care of. I am signing this document and this contract stating that I'm going to serve knowing full well that I'm going to get paid garbage. I'm gonna work extensive hours. I'm possibly going to deploy off to foreign lands, and I may go to war. I may have to kill somebody. I knew that signing that contract. I understood that was a reality. But when I signed that contract, I also understood that I was going to be able to be taken care of. That that was going to be a priority. That people were going to ensure that the injuries that I had are taken care of and that I was going to be able to provide for my family, and if I was in a situation where I could not, that the Army would be there to take care of me.

Put yourself in the shoes of those people who are living that life. Make your decisions based off of your integrity. Not dollars and cents. I think if more people led that way, the world as a whole would be a better place.

Editor's Note: In 2014, we met back up with Chas to hear updates on how things had progressed for him. He was in the process of going through a painful divorce and his wife had taken his two children to the West Coast. He had processed out of MEB approximately nine months before. Chas described his relief at being out of the Army:

I miss my friends and the camaraderie, but not the mental trauma of the military. And now I get to be responsible for me, instead of twenty other people.

Chas was still having severe headaches every two-three weeks and mild headaches every day. He was very unhappy with the care he was receiving at the VA:

All they do is prescribe meds. I couldn't get a follow up appointment after a CAT scan and then next thing I know, they send me medication in the mail with a note telling me to follow up if the meds don't work. They hadn't even told me I was being prescribed. There was no consultation.

Chas had opted to take himself off the meds and was pursuing alternative therapies. Particularly painful was the fact that a judge had ultimately held his decision not to take the meds against him during a custody hearing.

Chas stressed that the undue length of the MEB process takes a toll on soldiers. After returning from Afghanistan in Spring 2011, it took him until October 2011 to enter MEB and he did not finally leave the Army until March 2013—nearly two years after returning injured.

During that long stretch of time, another mandatory annual evaluation had come due. Chas still felt a great deal of bitterness about the final NCO-ER on which he received “needs improvement” because he could not complete the physical aspects of the evaluation. He felt the evaluation could prove a hindrance when interviewing with employers who are familiar with the Army’s evaluation system, and he stressed that the evaluations should include “could not be rated” scores for soldiers on profile:

In my book, the last thing I see after nine years of service is a bad NCO-ER. That’s what I’m sent into the civilian world with. It’s almost like they want people to have PTSD. You are just a number to them. Once you are no longer good to them, they will toss you aside and refill your shoes.

Chas had spent the previous months doing work in Central Texas opposing US military action Syria. He was sorting through custody issues and hoping his children would ultimately return to Texas. He was living in the house he and his wife had bought with his best friend, also a wounded veteran. When he felt well enough, he planned to enroll in courses and pursue his teaching credential in history.

Chas's NCOER before his injury in Afghanistan. At bottom left, it marks him "fully capable," and at right, rates him at "3," a lower mark than prior for overall performance.

3 Anja Perry*

Editor's Note: Anja is a white active duty soldier in her late twenties, who is married to an active duty soldier. They have two children, and Anja speaks to their difficulties raising children amidst multiple deployments. Anja went on her first deployment when her son was only a year old, and said she never wants to have to leave him again, but believes that she will almost certainly be deployed at least once more. She was exposed to blast pressure on deployment and currently experiences unexplained headaches, but has never received any pre- or post-deployment screenings for TBI. She also spoke about her experience of being sexually harassed very early on in her Army career by an NCO she was under, while her husband was deployed.

I always knew that I wanted to be in the military, but I joined in 2006. [It was] pretty much just for the experience, and of course I'm the only female out of my family to do it, so it was like I had a point to prove.

When you try to make an appointment, it takes something like a month to get you actually seen. This is for medical health, I never went for mental health myself, but from what I've heard it takes about just as long.

The way that they have it now is if you miss your appointment it's an Article 15. So, you are responsible for making your appointments. You're given the time and you're punished if you don't.

[The health care] has been good and bad, it depends on your doctor. If you finally get your primary care, and they're not crazy busy that day, and they actually have the time to sit down with you and talk about stuff, [and it's good]. But other times if you go in for sick call or something that they think is minor, it's in-and-out. [There are no] urgent care appointments, you have to go to the ER. Or go to sick call, but nine times out of ten, if you go to sick call they tell you to make an appointment, it takes about a month to get in.

Whenever you come to PT and you have a profile, they'll be like "Oh, well why are you on profile?" and you tell them so it's not like they know [about your medical conditions]. They have to ask for themselves.

From the commanders it's usually, "Okay." From NCOs, it's usually like, "Aw, that's BS. What,

really you got a profile for that? What?" Sometimes you're given a hard time.

I have a permanent profile for no running, because I have compartment syndrome on both my legs. I've had it for four years. Sometimes they give me a hard time about it, but I just brush it off because it's like whatever, you can't do anything, so...

I don't think [pressure to violate my profile] has been directly towards me. But I do feel kind of like I'm looked down upon because I don't run. There's one soldier, she basically has a profile for everything but breathing. And they're like, "Well how do you have a profile that you can't walk in PT? You walk every day, you have to walk. How can you not pick up something? You pick up your kids." So, it's things like that.

The profile that I had, it was a three and if you have a three, you can't deploy. But if you have a two, you can. I myself went and said, "Hey I need a two," for the simple fact that I can run under combat situations, but not for everyday PT or PT tests. So I went and did it myself. No one else was trying to make me do it.

The people with the profiles that have been given a hard time, of course yes, they know [about MEDCEN-01]. And you have your barracks lawyers who are always like, "Oh, they can't make you do this, they can't make you do that." But as far as them seeing in black and white, or it being put out to soldiers, "They can't make you do this," I don't think [the policy] is out that way.

[My profile] was issued in 2008 and my primary care had sent it up to one of the majors. I cannot remember his name but it was over at Darnall. It's only a major or some type of officer that can issue a permanent profile. So he had to evaluate the situation and everything before.

Especially in Cav, [there is a lot of stigma]. I had a friend, he was like, "I hurt my ankle on a run and I got a profile and my NCO is like, "What the heck, I twist my ankles all the time." I don't know think it's about one company, one person or one post. I think that's just how it is.

Definitely medical, like physical profiles, [I have seen people ridiculed]. Mental, yes and no. It's like the soldier who's on psych meds and is also on sleeping pills. They wouldn't be like, "Oh, so they can't come to formation at these times because they need a lot of this time to sleep." And then, whenever they come to work you can't say anything to the soldier. It's like, "You can't make the soldier do this, this, or this because they're going to flip out on you." But I don't feel that they're actually talking to the soldier and finding out what mental issue they have. I think with soldiers like that they just kind of brush them off.

Lately, I really think [mental health profiles] have been taken seriously. But...before my deployment, nothing was really hardcore. Getting the soldier [to get help] is where the issue is. They take it serious after they've been to the doctor and they have paperwork saying it.

It's a pride thing. You're a soldier. A soldier is supposed to be able to deal with everything. And then they're also too afraid to go and talk to anyone because they don't want anyone in their business. They don't want anyone to know this kind of stuff.

They just don't want to be seen as weak, a lot of people don't understand that just because you have this on your shoulders bothering you, that doesn't mean that you can't be a good soldier. Some people definitely are like, "Oh, how's a soldier have PTSD from getting in a vehicle accident? They've never been downrange."¹⁴⁹ But the people who've been downrange and seen stuff are like, "Ah, you know, he's got a legit reason." They understand that just because you haven't been downrange doesn't mean you can't have PTSD or have issues.

I don't know where [the stereotype] comes from, it's just kind of there. Some people you can definitely tell that they have some issues. Because they'll finally talk about it. But you have the lone soldiers who think, "Oh, I can get out of deployment if I play crazy." But then you know that that soldier's doesn't have those issues, so I think that's maybe where it comes from, because you have the legit people and then you have the fakers, so to speak. [The legit people] are like, "I don't want to look like a dirtbag like this other person." But they really may need the help.

We were downrange and there was this one soldier who just really didn't want to deploy, who was like, "Man, I don't want to be here, I don't want to do this." Doesn't have kids, doesn't have a spouse, anything like that. Just didn't want to go. Next thing you know, we're over there for three months and the soldier's flipping out. "I can't take it, I can't take it. I can't take it." That's what he's telling the NCOs, but you as a fellow soldier see him. "Man, I'm going home. I'm going home."

But then you have another soldier who's away from his family for the first time. He's kind of older, not making the same amount of money. His wife is back home like, "I can't deal with you being gone." And that just keeps building, building, building and he finds out, "Oh okay, his wife wants to leave him now." She's going to leave him, take the kids, stuff like that. And then this soldier's really, truly flipping out.

You have the one that you're witnessing going through crap and then you have the one who you know just wants to go home. So, I think that's where they conflict. A lot of people just want to be like, "Ah, you're faking, you just don't want to be here."

You do have the soldiers who just never say anything. Who just snap. I think that right there's from not wanting to speak up [to seek care]. Maybe they've got a big pride thing going on, or they don't know how, or they're scared. But then, it's also, "Oh, I don't want to be like him. I'm just going to try and deal with it on my own."

You do have your good NCOs who put stuff out like that—if you broke your arm, would you just walk around with it dangling and say, "Oh, it will get better?" No, you're going to go to the doctor! So, you know, your head's a little off. Go to the doctor and get it fixed.

You have very, very few NCOs who are actually about soldiers now, that I've seen. As I progress in the Army, I see that less and less. Especially now with them trying to downsize and everything. It's pretty much every man for themselves and those NCOs—they've already been in for so long, they don't know what they're going to do if they get put out so they're trying everything they can to make themselves better. And then they've got the soldiers in the background going, "Oh man, I

just got in the Army because I came from hard times and now I might be facing getting put out. I need a mentor, I need someone to help me." But there's no one there.

Editor's Note: The interview transitioned to talk about Anja's experience in SRP and on deployment.

You just go in, get shots, do vision [at SRP]. I don't really remember if they ask you about your mental state—I'm not saying they didn't, I just don't recall. It's very rushed. During the initial SRP, you know the deployment's coming. That's how I see it as a soldier. You already know if you're going to deploy or not, so those people who go to SRP, nine times out of 10 are actually going to be your deployers. So, it's like, "Okay, these people are already good."

I think the first day I do remember you have to have all of your MEDPROS¹⁵⁰ and stuff. Everything has to be green for you to go. They stop process right there if you don't have all your MEDPROS updated and that's anything from a DNA sample to if you're pregnant—everything. After that it's definitely rushed. It's get you in and get you out.

[People do get pushed through] but I think it's because it's those soldiers who want to go—I don't think I've witnessed a soldier who actually could not do the deployment that they made them go. I haven't seen that.

Downrange, we were really supportive of each other, oh my goodness. We were considered one of the worst units in the battalion. Because we were the unit that stood up the last. And we needed people, so whenever the unit stood up the assigned major was like, "Hey, we need this many people to go." And they're like "Oh, let's send [my unit] all our screw-ups. Let's move all our screw-ups down there," you know, where you've got DUIs, failed drug tests, AWOL soldiers, stuff like that. Any kind of issues they had with those soldiers, they sent to us.

And then you had the new soldiers coming into the battalion, so you had your ones that should not have been in the Army at all mixing with your brand new soldiers coming to Fort Hood. So it was a total clash. Because you had your ones that didn't care, and then you had the ones who were just coming who wanted to care but didn't care because they saw what they came to [for others].

But we got all that weeded out before we deployed, the people that didn't need to be there, they didn't come with us. And then we came together and it was actually very surprising. I was like, "Oh my god, I do not want to deploy with these people. I'm so scared," on my first deployment. But once you get in county it's like everyone's just one big family.

We had like three people in our unit [who dealt with substance abuse], but other than that we really didn't [on deployment]. But our gun truck unit, they were high all the time, drinking, everything. The sad part is that we didn't know until we got ambushed. And then they were like, "Why didn't you shoot anything?" So then we all got drug tested.

We did have one suicide attempt, he OD-ed on his malaria pills because somebody from the

FRG¹⁵¹ had said on Facebook that his wife was cheating on him, and he couldn't get in touch with his wife for whatever reason. She was with her family or something, she wasn't cheating. But he just flipped. And that was all [in] a matter of two days—and then he tried to OD. But he was okay. Came through everything and they sent him back home and they're fine, him and his wife.

...When you're deployed, it's a bunch of he-said she-said stuff. And especially the spouses back here are like, "Oh, I seen this person with that person," it's how the telephone game works. And then it got to him, he couldn't get in touch with her. And all he had was her, she was like his support system. Nobody really knew about it in the unit until he took the pills.

I think [hearing the rumor] is what brought him over the top, because everyone deals with stress differently. Me, I was stressed out if I couldn't get a hold of my son. But you got to think about the time change, what were they doing at that time here, and then you're always on the road. You don't really have that much personal time, so you get to make that phone call home and if you don't hear the voice, it's just like "Ahhh." That's my total stress relief, it can be two weeks, but that's my breath of fresh air. So I could totally understand where that would bring him over to the top. But yeah, there's definitely a lot more other stresses [on deployment].

He actually was an awesome soldier. He was a really, really good soldier. My husband and him were good friends, too... He wasn't one of those soldiers who show symptoms over a period of time. Just like, total flip.

It kind of blew [the command's] mind because like I said, he was an outstanding soldier. Afterwards, after all that went down, the Chaplain came, he talked to us, we had our little brief. Everyone's had their like, weirdness, and they would talk about stuff...for like two days. And then it just went back to normal activity.

[Reverse-SRP] is pretty much the same. You just come back through, you update your paperwork, make sure you don't need any more shots, ID cards, stuff like that. Then you go and take a little survey, and it tells you about your health. It has questions like, "Do you feel that the air you were breathing affected you?" And then, "Have you witnessed anything that would make you feel depressed?" That whole ordeal. But it's a number sheet. And then they follow up with you based on that.

You do take the survey, you do sit down with what they say is a physician. But you sit in a little cubby and they ask you "Are you depressed? Have you hit your head? Have you done this?" And that's it.

I think you maybe have 90 days to get it done. Honestly, I don't think that you would even know that you had those symptoms until you've been back for a while. You're not going to know that the first week you're back. For the mental part, that's too soon. Actually, for any of it that's too soon, because you don't have time to get sick. You can't even get a cold in that time.

It was just [for PTSD or TBI], "Have you hit your head in the past however many days? Have you been knocked out? Have you had nose bleeds?" Stuff like that. Basically, have you had any

trauma to you? ...It did ask about headaches and stuff like that.

I don't think [everyone answers truthfully at R-SRP]. I think a lot of people just take it for granted. Just be like, "Oh, just circle five for everything, you know, and get it done."

It was from pressure to get there and get it done... And we were actually told whenever you do this, make sure you tell them everything. And we were told because we lived by a sanitation pond. They're like, "Make sure you state that." The commander's like "I should hear about every single soldier saying what they said on that paper." We were told, you know, to take it serious. But, of course there's soldiers who don't.

...They have to give you one [PTSD briefing] quarterly. Your suicide prevention, domestic abuse, PTSD. PTSD is involved in both of them. And when we had safety stand downs, which is once a month, that's always implemented into it. Vehicle safety and PTSD. Those were the two big, big things. But, you go and sit in an auditorium and you watch it, some people get it, some people don't. But it's put out there and they are changing it to make it more interesting, to where you're going to want to pay attention to it. So it's not like death by PowerPoint.

I think they've been more serious [about PTSD] since I've been back. I definitely have seen more out there and it's definitely enforced a lot more.

I've had symptoms of PTSD, but I don't feel that it's on the level where I need to be medicated. Because whenever you come back to country, those first couple months, it's rough for everyone, whether you sat on the FOB and did nothing or you were out on the road. It's a hard transition, and like I've said a thousand times, it depends on you, how you deal with it. But yeah, sometimes you hear a gunshot or something go off on post and everyone flinches a little bit. But, then you recover in a couple seconds and you just go on.

I have really bad driving. When I came home, if I'd see a wreck I'd freak out and I'd have to pull over. In the first two months, but then... I think I'm okay.

I had a friend commit suicide from [PTSD]. One who just got in a really bad accident, totaled his car. You have other soldiers who just kind of close themselves off.

I think it takes somebody on your same level sometimes, to get you to open up instead of just going to the psychiatrist and sitting there and being like, "Okay, what questions are you going to ask me?" Like my friend who just, totaled his car... You try to put yourself in their shoes, or what you think is in their shoes, to try to get them to talk about it. And then, they just open up. And then you're like, "Okay wow, now I know how this side of you really feels, so this is what I feel I can do as a friend to help you out."

Editor's Note: Anja's deployment to Iraq shifted to include a deployment to Afghanistan directly afterward. She switched into her present unit after this deployment, and the unit as a whole had been on one deployment thus far. She said that many soldiers in the unit and the company had been on multiple deployments as well.

...My friend who just got into the accident, this was his third deployment. His first one was really rough. There were like foot patrols and stuff like that. His second one...not so bad, I don't think. But I think his third one, it really hit him, because he was like, "I didn't want to go back to what I had already experienced." You're already putting yourself in that state of mind that you're going up to a really messed up situation, where it wasn't that bad this time. Nowhere near as bad. It's a long flight over there, you're thinking about all kinds of stuff, and if you've already put yourself in that state of mind, you're done for the rest of deployment. If you scare yourself on the way there, you're going to be scared the whole time you're there.

Besides physically, being blown up, I think listening to other stories of soldiers who've done prior deployments [causes soldier trauma]. Me, I was scared because I'd heard about everybody else talking about their deployments. And I'm like, "Is this what I'm going to have to witness?"

But then, what affected me even more was I was a single parent at the time. My son had just turned a year old. And so I have to worry about that right there, along with, "Am I going to see him again?" Things like that. So I think it's just a combination of what you've got going on back at home, what you think you're going to go to and then what's actually there. All of it into one.

The coming back, I was excited, I couldn't get there fast enough. I was like, "Okay, let's go home, get it over with." But a lot of the soldiers who were married, they had a lot of issues like, "Oh, he's cheating on me," or, "They took my kids and left." And, "I don't have nothing when I go home." So a lot of them are angry. They're angry because...they want to go home. And then you get home and everything's chaotic.

Home life is a big, big deal, a big, big part of [the trauma]. Because you're always going to be worried about your family. You could be married to the same person for like 10 years, and you go on a deployment that you've been put on four times. But you're still going to be worried. Like you hear, "Oh, my kid is sick." And you feel like crap because you're a parent and you can't be there with your kid. What was going on back at home affected me a lot more than what was going while I was there.

I don't really feel like you can do anything about the pre-deployment [stress]. You're always going to have the vets telling you stories. I don't even know if you could do that either, if you could find out what the area is like whenever you go there. Because, when I went to Iraq, everyone knew. We were working during the day, or doing missions at night, regular stuff during the day.

But when we go into Afghanistan, nobody knows anything about it. And it's like, can you do a little bit of research, can you talk to the units that are there, find out what's going on or relay some information to us, so we kind of know what we're getting ourselves into? I think just maybe trying to educate yourself about it before you go [would help]. And then, the company educating you as well. If they don't just throw you in there and be like, "Oh, you're going to go here and that's it." They tell you as much as they can, but I feel that they could maybe find out a little bit more than what they're telling you.

[Downtime] depends on your job, we were given as much as we possibly could, but we were on

the road every single day. If you have a lot of missions, you got to get the mission done. But then when you come off of a mission, they'll be like, "Okay, we can only give you guys a day, but take advantage of that day. Get your laundry done and call home, do whatever you can." If they had the time to give to you, they gave it to you. But that's not your NCO or your company. That's just the mission. You got to get the mission done.

Definitely [it affects soldier's health]. Because you don't get sleep. If you're up all night long, and the next day you can't function, well, try being in the desert where it's 120 degrees, driving a truck.

You take your iPod. You could listen to music, or I was studying for the boards.¹⁵² So my NCO, he would be asking me questions. The first couple months I was just so scared there was no way I was going to fall asleep. There's just no way. I had too much adrenaline from being scared.

But you find ways. You stock up on candy, just whatever. Just try to eat the whole time. You figure out different ways.

To be honest, TBI is not really put out that much. I found out what TBI was because of the self-structured development courses that you have to do for your rank. I've heard soldiers say, "Yeah, I got a TBI," and I'm like, "TBI? What is a TBI?" ...But then there's one course, all about PTSD and TBI, but mostly TBI... And then my husband, he went to the doctor during that same time, and they said, "Oh yeah, you have a skull fracture. We think you have a TBI." So I more or less educated myself on that. They don't normally talk about it too much.

I honestly think you're more likely to have a TBI than PTSD, because you don't have to witness something happening to you. You could be working on one of the trucks or you could just be getting out of your car and smack your head. I think they need to definitely put that out more.

Editor's Note: Anja testified that she did not take the ANAM test before she deployed. She was exposed to blasts during her deployment, and did not receive any TBI screening after returning home.

It was always put out to us, if we witnessed an IED or we were in the range, we're all asked, "Hey, how do you feel? You okay? Your ears ringing? Your head hurt? What's going on?" And then of course the people who are actually in the blast, they got medical help, other than just saying, "If you feel okay, then you're okay."

The mission commander, the NCO in charge of the whole mission [asked those questions]. We had our medics there and they would tell us it was basically like concussions. Emphasis on vision, ringing in the ears, dizziness. If you were out to where you couldn't get back to the FOB, then of course you stayed with the medic the whole time. You weren't driving, you weren't doing anything, you were with the medic. With injuries and stuff like that, they actually were really good about it downrange.

...I don't know the policy 100%, but I would think [there was follow-up] because I do remember

one of the questions on the paper was, "Were you involved in an IED blast?" It was on the Reverse-SRP, they ask you things about "Were you in any kind of accidents? Did you hit your head?" The whole medical paper.

I have been having headaches more frequently this past year than anything. I haven't gone to the doctor about it, but I mean, they would say like, "Drink water."

Until right now I never even thought about getting myself checked [for TBI]. Because with a headache, you're out in the motor pool all day and you're not drinking enough water, you get a headache. So that's what I associate mine with. I've never thought about it being any more serious. Probably should. Because I don't think it's that common to have headaches like that.

...One soldier, she would have crazy bad headaches and mood swings, bad mood swings. And she was constantly leaking fluid out of her ears and her nose and her eyes. And they said that was because of the TBI. So she would go to the doctor, and [supervisors] are like, "Oh, you don't have the paperwork documenting this right now so you have to come to work." And she's like, "I can't even drive myself. Are you going to come get me?" She was given a hard time about it because the doctor didn't state "You need to be on quarters for this amount of time." It wasn't stated on the paperwork. I don't know for sure what was on there. I remember them making a big, huge ordeal about it.

[MST trainings] were quarterly classes, too. And it gets put out every Friday in your safety brief. "Don't do this, don't do that. If you have this kind of stuff happen to you, please report it up." They point out who your individuals are that you speak to, the NCOs and stuff. It's put out who you need to talk to, and open door policy.

[Sexual assault] happens all the time. All the time...[to both women and men].

To be honest, I really don't know [what should be done about it]. Because it's all situational. You have your people who joke around with each other, where it can be a male to female soldier, and they're just close and they could be joking around, saying things that a new person coming in would take it offensively and be like, "Oh, that's sexual harassment." But also, you have your soldiers in the motor pool or whatever who are joking around and grabbing each other, and they think it's okay, but then the other soldiers don't think it's okay. So you have your jokers and you have your serious people.

And then you have your really serious cases, too. I don't really know how to prevent it unless you're going to be like, "Don't do this to me." And then you take it up. But you don't have too many people who do that.

They're scared of repercussions. They're afraid. Like with new female soldiers, you have your other soldiers who are like, "Ah, these are new females." Or even guys. "Oh, you have your new soldiers coming in. Oh, I'm going to do this, I bet I can do this, this and this." ...I don't think [soldiers] know coming in what exactly their rights and their capabilities are as far as stopping it.

[Reports are not taken seriously] all the time. No. The situation with me, I don't know, because I was being sexually harassed by my NCO. And me being the only white female, and the only female working in the office that I worked at, it got pushed under the rug. I was told no for something, for some question. And then it was used as being a racial thing. So it turned out I was being racist against that NCO. It was nothing like that at all.

It's a big deal, because sexual harassment I think leads to sexual assault. Because if you don't put a stop to the harassment, that person is going to think that they can just keep going and going and going, until next thing you know, you're getting raped or you're having this crazy stuff happen to you. I think sexual harassment needs to be emphasized more because I think that's the cause of sexual assault, in a lot of cases. But of course, you do have those crazy ones where someone is just going to come snatch you up.

I reported my situation to my first sergeant. I did my sworn statement. The paperwork was done, I was told, "Hey, be waiting for an investigator. It's going to be an officer you've never met before who's going to come up to you and they're going to want to talk to you about what happened. Make sure you tell them everything." I was told I couldn't PCS, I couldn't deploy, I couldn't do anything until the investigation was closed. I never saw anyone. No one ever asked me any questions about it and I deployed, came back, tried to follow up on it. Nothing ever came of it.

...I haven't heard anything. No one even knows anything about it now. So what happened to my paperwork? It was one of those things that just disappeared.

Editor's Note: Anja tried to follow up on the investigation after coming back from deployment. She had also seen other soldiers who experienced MST made to deploy with someone who assaulted or harassed them.

No one knew. No one knew anything about it.

Right now I have a friend, her and her roommate were talking about how they wanted to work out, and this person would meet them at the gym. At first they thought, "Okay, it's a male NCO walking with us." You got to have a male with you most times anyways being deployed. So they didn't think anything of it. And he was like, "Oh yeah, you guys should try these exercises. It will help you tone." It started off really nonchalant, just everyday soldier talk.

Next thing, he was bringing a thumb drive to their room and was like, "Hey, take pictures of you in your sports bra and your shorts and put it on the thumb drive. And then just do it every week and I'll monitor how much weight you guys are losing and how toned you're getting." She's like, "Have you lost your mind?!" She says she told him no. "You need to stay away from me, I'm not about that." Put her foot down right then.

But then he just kept on and kept on. "Oh, well, your roommate wants to talk to me." And the roommate was one of those soldiers who liked to be the center of attention and was okay with what he was doing. So finally she did have to bring it to higher-up. And then all that stuff was done. A no-contact order was put out. And now she works in the orderly room and that NCO

comes in very frequently. The commander had to be like, "You know you're not allowed up here. So don't come to this office anymore, you're not allowed up here."

...I know that they put [MST care] out there. They have their helplines, and they tell you who to talk to. But you don't hear about it as much as you would things like suicide. You hear more about suicides than you hear about people reporting sexual assaults or harassment.

...I didn't feel like [I had any options]. Of course my First and my NCOs would be like, "If you feel like you need to talk to someone, come and let us know." But I was a brand new soldier. I'm assigned to that company but I don't know any of you. And here I am, the NCO who I work with for the past year who has been nothing but professional. Knew my husband was gone at the time, I was just there with my newborn baby and then I have him stalking my house and calling me and then now here you are, brand new. I don't know anything about you and you're males, you know? You think I'm going to trust you? No! So yeah, I wasn't told, "Oh, you can call this person or that person." I didn't know I had any of those options right then. I was a scared little girl for a little bit.

Before, I wouldn't go anywhere by myself at all. And now, of course, I'll venture out. But certain places I don't go, because I know that individual still goes there. They are no longer in the Army, but I know they go there, so I don't.

Editor's Note: The conversation turned to Anja's experience with how the Army is handling health care and discharges during the draw-down.

...The past couple months, not being able to get into the doctor like you need to, because they are cutting back and you do have to go through medical screenings before you can get out of the Army. And then you do have a lot of people who are going through Med Board.

I have a soldier right now who's about to get chaptered out for missing his PT test by 15 seconds on his run. He's been in for a year and a half, has been given two PT tests since he's been here. Two PT tests of his whole military career and missed his run by 15 seconds. They're chaptering him out. Outstanding soldier, never had any kind of negative anything against him at all.

He's going to get honorable. It's going to be the best discharge that they can give him. It's not going to affect him negatively, I don't think. Well, of course it will in some aspects. They say he can come back in within six months.

...People with DUI or failing a drug test [are getting Other than Honorable discharges]. The worst I've seen them get was general discharge. That's not even cool. With all the cutbacks and changes being made, our battalion commander puts out every single time he can, "If you come to me with any of these kind of issues, if you're brought to me by the cops, dishonorable discharge. You're out." He's like, "I don't care. Any trouble you get into, I'm not putting general on anything. You're dishonorable."

Mostly it's soldiers who do have PTSD or some kind of a psychological issue, and they have to

take sleeping meds, [who are getting disciplined]. That's the biggest thing right there. "You were ten minutes late for formation." "I have paperwork that says right here that I'm on sleeping meds." "Okay. Well, on the weekends, I bet you're up late. But, you know, this is not [okay]." But then again, it's back on the leadership.

Editor's Note: Anja further testified that she had seen some soldiers discharged dishonorably, who she believes were probably experiencing symptoms of trauma. She also spoke about whether the Army is helping soldiers prepare for work as civilians, and the stigma and sexism she experiences as a female soldier married to a male soldier.

I know they definitely enforce you doing your ACAP,¹⁵³ your process to get out of the Army. But I don't think you have a lot [of support], because you need to have a mentor if you're going through that process. Because if you're ignorant to what the Army has to offer you, even that late in the game, then you're not going to know. Like the soldier who's getting chaptered out now, I'm like, "Hey dude, make sure you go through all of this stuff. Make sure you do." I told him every bit of everything I knew. And he was like, "Well thanks, because no one has told me."

Not that many [people know about that stuff]. There's so many things that the Army can still do for you even after you're chaptered out. And people don't realize it. They think, "Oh, well the Army's done with me now."

...[As a woman] you definitely have something more to prove. I'm going to prove my point, I'm going to prove that I can do just as much as you can... But I'm also soldier enough to say, "Hey, I got to go get this taken care of." Like marriage counseling—I was like "Hey guys. Sorry, I can't do this, I got to go to marriage counseling." And they're like, "What?" Yep, I'm doing it.

But then too, being in the Army and especially being married, you know, "Oh, you need marriage counseling. You know, your husband..." You're put down on the level of a civilian spouse. "Oh, your husband—he's cheating on you, he's lying to you, he's doing this, that. That's why you need counseling." They don't think of it being as, "Hey, you're dual military. Maybe your husband doesn't know how to deal with you being the same, equal." Or, "Hey, I have two kids and my husband, he's not used to dealing with kids, or you know, we have a newborn baby." They don't look at it like that. They're just like, "Oh, cheating. Cheating. Yeah."

I feel like the only time [female soldiers] would need any more or serious care is for female issues, and then having a child. I think afterwards, having a baby and going through your postpartum and things like that—I think they do need to be more sensitive for things that could go wrong with you. They tell you, "Oh, within six months, you're going to be completely healed, your weight's going to be down." So they give you six months and then you're supposed to be back up on your feet ready to go.

I think they need to be more sensitive to it, because you cannot recover physically in six months from having a child, even in the civilian world. It's not that easy. And now they have your annual physical that you're supposed to do every year. You have it every two years now because they don't think, "Oh, well, unless you have some issues going on then there's no reason for us to

check you." So, I think in that aspect, I think they need to be a little bit more sensitive. But other than that, it's okay.

You can request [a female doctor] and if they have one for you, then they can give it to you. But you don't keep a primary care doctor more than four months. I'm always getting letters in the mail saying this is your new primary care. I don't go to the doctor unless I absolutely got to and then I try to ask for someone I know that's been there forever.

...You hear it, "Oh yeah, the reason why he's going crazy is because his wife is cheating on him." Or, "Yeah, well, her husband is doing this and this, her husband doesn't do anything but sit at home and she's the sole provider." You definitely hear it. Or you have the whole, "You don't understand what I went through" type deal. "So you're supposed to be my support system but you're not there for me because you can't relate with me."

My son, he was only a year old when I deployed and it was rough because his father and I, we were married for a very short time. We were only together pretty much for the pregnancy and then he deployed when he was a month old. And about two months before he returned, I had to deploy. So, my son went to his father's grandparents because financially they were the best people to go to and they're great people, so I knew he was going to be taken care of. But also I'm like, "Okay, I don't know his doctor that he's going to be seeing." He did get really sick while he was there. So it was just like—are you sure you're doing the right thing, because that's my kid. You can't take care of him like I can.

And then whenever I came back on leave—it was like December when I left, August when I came back—he didn't want anything to do with me. He was like, "I don't even know you. Like, get away from me." And I actually had to be in contact with his father. He actually had to stay at my mom's house for two or three days so my son could get used to me again before he left. So it was just like, I don't know, "Look at this guy. But I got to be civil with him, because of my son." And then when I left, he was with my mom and had nightmares. So, it was really rough, that period was really rough.

As soon as I got back, my mom told me that this was going on. She was calling around to pediatricians. We were just trying to research if this was normal. It was pretty typical, so it that made me feel a little better. But now coming home, being here for two years—he's four now, just turned four. I don't ever want to leave him again. And I have a daughter who's one. So it's really, really hard.

[I am not deploying] next year, but I just reenlisted for four more years. So I'll definitely be going again. It's hard, because there's so much that you have to do in those couple months before you go. Not saying you don't pay attention to your children, but it's so much you have to do for work. And with his doctor, I just had to trust that his grandparents were doing the right thing.

Other [spouses I know have gone through domestic violence], like my friend who totaled his car. Apparently... None of us knew this until his wife told me the night we were all in the hospital making sure he was okay—that there were a couple times that he would push her. But mostly just

throwing things, tearing things off the walls, punching the walls right next to her face, stuff like that. But she never told anyone. She was like, "If I can't help him, no one else is going to be able to help him." And I'm like, "But what about helping yourself?"

And then another friend of mine—her husband would like lock her in the bedroom. "You're not leaving, you're not going back to work. I don't want you to get in trouble." Stuff like that, just because he was a man. They're from Guam, the man's supposed to be the sole provider in that home and the woman's supposed to stay at home. Roles were turned, and he didn't know how to deal with it. He was just like, "No, I'm about to do anything I can to make sure you get in trouble." And then you have your really, really crazy ones. But mostly it's all because of drinking.

I honestly think that the spouses should have mandatory training, just like we do. I think that they should have mandatory training classes to educate them on what their rights are, because a lot of them don't know.

And then, you also have the ones who take advantage of it. I just think that they need to be sat down, they need to have their annual trainings just like we do and be like, "Look, if this happens, you have the right to do that." Or, "You don't have the right to do this just because you're mad." Because you have some spouses who think, "Hey, you know what? I have pull over you, no matter what, because it's my word against yours." And a lot of times, that's what it is. But then you have your other soldiers who think, "There's no one that can help me because it's going to be his word against mine."

I definitely think we need more education on it. And it needs to be like mandatory. It doesn't need to be, "Hey guys, we're having this class. Please just join." Your spouse needs to be here. Sign in on this roster.

Editor's Note: In the last part of the interview, Anja described what she thinks should be done to provide soldiers the care they need.

More doctors, designated ones, for soldiers who have PTSD, TBI, issues that need to be addressed. They need to have their own little section, like this building is strictly for your guys. These doctors are strictly for you. Not the R&R Center, not, "Go to the ER, go to the 5th floor," whatever it is. But just a spot for them that they can go to and get the care that they need. And then have all the other physicians, or primary care, for just your everyday whatever.

Like my husband, in order for him to get a psychiatrist, had to go through the primary care, and primary care has to give you a referral. You get your referral but then you don't see the same doctor—over and over again. You have to keep telling them, "Hey, this is what I'm here for." Your next visit, you're there thinking, "Okay, I'm going to go from where I left off last time and start from there." No, you're starting all the way over.

I broke my foot on deployment, not even knowing. I didn't even notice what was wrong. So it was broke, my foot was hurting... And then my toe stopped bending. It would get stuck up or stuck down, and I'm like "Okay, let me go to the doctor." The doctor, thank God, he was an old-

school doctor and was like, "Yep, that's not normal. I'm going to give you this medicine until your referral goes through."

It was a civilian doctor but because he was working in a military installation, you have to go through all those things. So, "Alright, I'm going to try putting you on this medicine." "Okay, is this medicine going to make my toe bend?"

"Okay, I'm going to try and give you cortisone shots in your toe." "Is that going to make my toe bend?" Finally the fifth time me going in, "Oh yeah, we're going to give you surgery. You need surgery because it healed wrong." So it's like, "Oh my god, it took me almost two years to get surgery on my foot."

And I'm just like, "Take an x-ray, and the first time you will see that it doesn't look right. Okay, this is what we need to do to fix it." Too simple... But it was like he had to try all these things before he could just say, "You need surgery," when he already knew, "Hey, you're going to need surgery."

4

Dan Michaels*

Editor's Note: Dan Michaels* is a white active duty soldier and Non-Commissioned Officer in his early forties from the southern US. He did not deploy to Iraq or Afghanistan, but previously spent time in Bosnia. His wife, Debbie,* is an African-American medically-retired NCO and veteran of Desert Storm, as well as the second Iraq War. She is also from a major city in the South. Debbie had several duty stations prior to Fort Hood. She worked for fifteen years as a nurse and five years in chemical. After working near burn pits in Iraq, Debbie's health began to deteriorate. While in the process of being medically retired in 2009, Dan got orders to come to Fort Hood and Debbie came along.

Debbie has developed avascular necrosis, and is severely disabled. Debbie encountered numerous barriers to getting her medical concerns addressed after transitioning to Fort Hood, and Debbie and Dan found that many civilian providers were similarly unprepared to care for her illnesses. Due to the amount of advocacy and coordination involved in meeting Debbie's care needs, Dan assumed greater and greater care responsibilities while also working full-time for his unit and looking after his own injuries. Dan spoke of being fiercely devoted to caring for Debbie's health, both as a matter of duty as a husband, and as a matter of responsibility towards those who have served in combat. Most of Dan's unit was in Afghanistan at the time of the interview, and he had stayed behind with his unit's rear provisional, which was often short-staffed. Dan was grappling with the ways in which his decision to prioritize his wife's health needs had negatively impacted his career advancement in the Army.

Dan also shared many reflections on his wife's transition to VA care. He expressed concerns over the quality of care in general, but praised new initiatives like the Veteran Caregiver program. Dan shared his reflections on his own experience with military sexual trauma early in his military service, as well as his efforts to support lower-enlisted soldiers in his role as a Non-Commissioned Officer.

I joined the Army because I grew up as an Army brat and wanted to be a part of what I saw around me. And both [my wife and I] wanted to be part of something bigger. We both joined in the early nineties.

We got to Fort Hood in November of 2009 and Debbie had just retired. Our former primary care manager had given her enough pain medicine, he thought, to last us until she got a primary care manager here. We came here under the Exceptional Family Member program. Coordinations were supposedly made so that her records would be transferred from [the last duty station] to Fort Hood. We had spoken with the EFMP coordinators here at Fort Hood before we ever left. They said “Yes, you’ll be assigned a primary care manager immediately upon your arrival.” So when we left [our previous duty station], we felt comfortable that we would go from one PCM to another seamlessly. That was the whole point of the EFMP program: continuity of care.

It turns out that that is not the case. Debbie had fallen down the last two of our stairs and she was hurt badly enough for me to bring her to the ER on post. They triaged her, gave her a bit of Motrin, and sent us home. Two days later, we received a letter in the mail stating that she would not be seen at Carl R. Darnall hospital again. They did not give a reason why. They just stated that she would not be seen. On the reverse side of the letter there were several off-post providers that they recommended. Being in the EFMP program, they are not supposed to accept a soldier’s family at an installation unless they have someone who can treat her condition, or someone in the immediate area who can. They have no one here who can treat her condition. Her primary condition is avascular necrosis. Bilateral hips and knees. There’s a doctor [a provider off-post] who has the ability to care for her, but refuses. Really, the only treatment they can give her is a hip replacement. They don’t want to do it. Yet, I know of two soldiers in my brigade that have the same condition and they have been treated. They are walking. Debbie can no longer walk. She can walk briefly, but if she takes more than ten or fifteen steps, she is on the ground. They have treated these soldiers, but they won’t treat her. They would not treat her when she was active duty. And now she is retired and, again, they will not treat her.



Dan and Debbie Michaels, * around the time of Dan’s interview in 2012*

We never got a reason [for her being denied care at Darnall]. I brought the letter to my chain of command. They made phone calls and inquiries. They were given statements such as, “Well, she just needs to go find an off-post provider through Tri-care.” And we worked our way through virtually every provider in this area. But nobody was comfortable treating her. We have seen at least 12 providers in the Killeen area.

[The medicines required to manage her pain are not just prescribed to anybody. But because Michael Jackson had died that Fall, the hospital wouldn’t give anything like morphine or Toradol or anything like that. What we were told [at the civilian hospital], was “Michael Jackson died. You are not going to get any morphine.” There is a big stigma...After we ran out of all the [civilian] providers, we were finally able to get her seen at Darnall [on-post]. And we have a really good primary care manager now. But the fact that it took two and half years for that to happen is unacceptable. Not just because it is Debbie. That is the thing. If it has happened to us, it has happened to someone else, or it will happen to someone else. To have to keep fighting and searching for other providers—She has been accused of drug-seeking. She takes less medication now than when she was active duty. And that is by choice. That’s a big issue army-wide. People are being accused of drug-seeking. And I get there are people out there who will do that. But you don’t throw out the whole vineyard for one bad grape.

My wife’s health issues are all service-connected. They are still debating what causes avascular necrosis. We have a pretty good idea that it is associated with the burn pits that everybody is being exposed to. I had never heard of this condition until I met my wife, but it’s becoming more and more prevalent. The more I talk to people, the more I find out that they were the ones standing there monitoring that burn pit. Plus, the fact that my wife was also [working in chemicals]. She was constantly exposed to different chemicals like super-tropical bleach and a myriad of other chemicals.

Editor’s Note: Dan also raised concerns regarding the unknown effects of vaccinations which were administered to, but poorly tracked among, soldiers deploying to the first Iraq War, Desert Storm, including his wife.

She was never somebody that went to the gym a lot. You hear about avascular necrosis among steroid users. She is very slight, slender. But she did have to monitor those burn pits almost daily. And knowing that there were lithium battery fires where she was in Iraq, and heavy metal poisoning—it is effecting a lot of people in their bronchial passages and blood streams and brains.

[When problems started] in 2005, people kept saying that it was in her head. That she was making things up. Because they couldn’t see it on a standard x-ray. And you won’t. Something that deep in your bones, you are gonna have to look at it on an MRI. [She got an MRI] after about three years. It was [civilian clinic] who discovered it. They are actually a major cancer hospital here in Texas. She went there herself.

By the time we met in May of 2008, she had been transferred to the WTU (warrior transition unit). At that time, the WTU just seemed to be a holding area for people commanders didn’t want,

people that were somehow physically injured, or what have you. Her PCM referred her for MEB and eventually she was put on a temporary retired duty list so that she could seek treatment. Then, of course, we got to Fort Hood and she could get no treatment whatsoever. So she was 100% retired the following year.

When she first received a diagnosis, her commanders responded the same way a lot of commanders respond to this day. You know, this idea that it is malingering. Just because you can't physically see what's wrong with a soldier does not mean there is not something wrong with that soldier. Her commanders were always putting her on day-on day-off staff duty. Twenty four hour shift, go home, then another twenty four hour shift. They treated her like she was the scum of the earth, especially when she had the nerve to speak up for soldiers' rights. God forbid you do that, or you are bucking the system.

Back then, you are in WTU for a random condition, and you are prescribed medications that prevent you from driving. Yet, you are expected to be at said location at said time and you live in government housing, or worse, off-post. How are you going to get to work? The unit is not going to support you. Now they have the WTU bus. The Warriors in Transition Transportation shuttle. A soldier has to have their medication to treat their condition, and you can't expect them to drive on that medication. You would have, at best, a bunch of DUIs. At worst, you can imagine what else—you see lots of accidents here.

The doctor prescribed this medication because he or she favors the benefits over the risk. So the medications are not really the root issue. The root issue is the lack of support from the units. I have got soldiers in my squad that I go pick up everyday, because I know there is no way they should be driving on the medications they are on. They have to take them, because if you don't take a medication you are going to be in trouble for violating a direct order. You cannot have it both ways. You have to take the medication as prescribed, and if you do not, you get in trouble.

Every NCO in the Army should be [supporting their soldiers]. If they are not, they need to be put out. I have got a soldier who is on a limited duty profile. She has a lot of appointments that she has to attend. She is the only one in her section. The majority of our unit is deployed to Afghanistan right now. We are the rear provisional. She goes so far as to publish her appointments in her outlook calendar and share it with her entire chain of command. And when a random soldier comes by and asks for random document, and she's not there, then the soldiers or others NCO or officers state that she is never at work. Everyone knows that's not true. But then the command does not back her up. She's been written up for this, and the commander and first sergeant make sure to do it when I am not around. You should not counsel a soldier without their NCO present.

I know that we need to support the draw down. Everybody understands. So when the order came out, basically to cut the fat, there was no guidance given with that order. Commanders were basically handed that ball and told run with it. People are being put out for the most random things. That is not what the intent of the army was. They are having to back pedal now and clarify that.

And there should be no unit so under-manned that they can't perform their mission, and at the same time, take care of the soldiers in that unit. Including that yes, units need to deploy, but you do not leave their provisional or their rear detachment so short of personnel that [they cannot function]. As a supply [NCO for my brigade], I am authorized a supply clerk, yet the S-4 took the clerk up to their area and refused to give him back. Now it is just me running this entire supply room. And how is one person supposed to support 75 people? There is no way. They are asking for failure.

When I approached them about it, they tried to make it a non-issue. "Oh, you've got it covered. You don't need a clerk." I have a wife to take care of. I can't be there 24/7. That is the whole reason we double up on soldiers. We all know there is stuff that needs to get taken care of. You can't just live at the office.

Some of Debbie's appointments, we have to go [forty miles away]. I have to leave with enough time. [Referring to interviewer's direct interaction with Debbie] You just saw her. It is not easy getting her into a vehicle and packing up her wheelchair to get her to where she needs to be, getting her dressed and fed and everything else. In that aspect, my chain of command is very supportive. But in terms of when I leave—the supply room is shut down. Nobody is getting anything. And you know, I had to finally come to the realization that if I do not take care of myself, if do not take care of my wife, I won't be able to take care of them. You know?

Editor's Note: During the course of the interview, Dan spoke about his own experience with military sexual trauma earlier in his military career.

In Korea on Camp [redacted], I was actually sexually assaulted by a female soldier. I was on sleep medicine and forgot to lock my barracks room door. I woke up and she was on top of me with her hands around my throat...I knocked her off of me. She ran out of the room. The MP station in the medical clinic was right behind my barracks and when I went there asking for help, I was laughed at. When I called my first sergeant, he said he wished that had happened to him. I had to live in the same barracks that she did. She was in [another unit], but I had to see her everyday. And I know I wasn't the only one that she did that to. I carried that around until 2010 when I was finally able to get a counselor that took me seriously.

The sad fact of the matter is, is that is still the response of commands. I was letting my former supervisor know that I had to go and see a counselor and at the time I had enough trust in her to tell her why and I went to my first appointment with Lt. Commander [name redacted] on west Fort Hood, and when I came back from that appointment, my supervisor was discussing what I had told her in an open forum in my unit. I brought it to my commander. She took it seriously. And eventually my former supervisor was removed from the unit. They were able to at least address it as a HIPPA violation. A buddy of mine brought me to the chaplain, who at least listened to me without laughing.

Aside from that, it's been something that to this day—I have issues even with my own wife wanting to touch me around my neck. If she is standing behind the bed, coming to wake me up in the morning, there are times when I'm just jumping out of my skin. I have made leaps and

bounds from where I was to where I am now. I had gotten to the point where I wouldn't let myself even be in this interview right now. I would have never let happen. I wouldn't go into any business or any room without knowing that there was another exit that I could use to get away from whoever was in the room. Life has gotten much better. It is easier to manage. But [stress from the assault] will not be taken into account [during benefits evaluations], because when it happened it was not taken seriously. It was not put into my medical records. It was not addressed legally, ethically, medically. I could have been given an STD and not have known it, because the medics at the clinic, they just, [long pause] —they treated it as some sort of a joke.

Editor's Note: When asked what the Army could do better to address soldiers trauma, Dan shared reflections from Debbie's return from deployments.

To put it in a nutshell, we spend all this time training our soldiers up. As my wife would phrase it, "Training for the big game." Then, when the war is over, you are not un-trained. You see it all the time in the news. They never put it on page one, or even page two. Check page six, or check the Army Times. Some soldier has reacted violently to some situation. Something has happened in their household that—this couple could have been married twenty years, never had a single altercation of any form—and a soldier comes back from deployment a different person.

There is a schoolhouse about a block and a half away. And on Sundays during the school year they'll test their fire alarm. If my wife is asleep when that sound goes off, she is hearing an alarm for incoming rounds. And I can't count the number of times she's thrown herself over me trying to protect me from some round that is forever incoming.

They don't give soldiers a chance to off-load. And when they want to counsel the soldier, they will ask, right when the soldier gets off the plane, "Do you need to talk to anybody?" It is, like, "No, I want to get home to my family." "Oh, well, okay, we can check the box here now." Instead of maybe asking in theater, once you make it back to your rear, "Okay let's talk about what happened." How do we not forget it, but learn from it and carry on? And that is the biggest thing, is carrying on. You can not just permanently unload something like what these soldiers are experiencing.

I was talking with a buddy of mine this morning during PT. We were discussing that if you ever want a reality check, go by the burn ward in San Antonio. But what goes along with every one of those wounds that you can see is four or five that you don't see...There are soldiers that respond well to counseling. Listening to my wife talk, I can understand a lot of what she has gone through. But at the same token, I can't. Because I was not there. It would be nice to be able to have a counselor that was in the environment. Even at the VA—The VA's gotten a lot better because there are more former soldiers, marines, sailors, in the VA now and that plays a big part. As well as better leadership. I mean, there is still much more to be done, but it is better than it was. The VA has made leaps and bounds from where it was. When we first got here and went to the VA, it was like every nightmare we had ever heard about the VA was true. From dingy grey walls to people being left on gurneys in the hallway. They were there when we arrived. They were there when we left. Over the course of two or three hours. You don't see that anymore. Not to say they are perfect.

One of the things that needs to be done—and this needs to be in every community, everywhere—you pull up to any establishment and there's maybe one, luckily two, handicapped parking spots. We are going to have so many more people that require those spots. It used to be years ago that there were always handicapped spots. But now. They are not prepared. Because what we see getting off of the planes and entering the hospitals today is going to turn into something worse long term. And they are not prepared for it. You cannot put a band-aid over a gaping wound.

When my wife applied for benefits, there was understandably a long delay, because there's a huge bottleneck in the system. At the time, they rated her sleep apnea as a greater disability than her avascular necrosis. Now, don't get me wrong, sleep apnea can lead to some debilitating situations. But AVN, because that's a progressive incurable disease, needs to be rated higher—especially if it is in your hips. All they can do is replace your hips. They cannot treat it. There is no treatment. Even now, they don't want to treat it. They just want to manage it. I could be wrong, but I think if they were to replace her hips after she healed, she would be in a lot less pain. I know two soldiers who have had it done and they are out walking around just fine.

What we really need, across the spectrum from active duty to VA, is continuity of care. You should not have to go re-live all of your experiences every time you go to an appointment. That is why we have medical records. If doctors and PAs would take more time to research their patients before the appointment, instead of trying to function like an HMO operated hospital where you are allotted fifteen minutes per patient—that should not be the case in any hospital, let alone a VA hospital. It makes problems worse because then you are left feeling and knowing that you didn't get appropriate treatment, that you weren't listened to. You may have been prescribed an incorrect medication.

Last week, we were to go to kinesthesiology in the VA on a referral for what's called a rollator. Basically it is a walker, but it has wheels and some hand brakes and there's a seat. It is to help encourage the patient to walk as much as possible. My wife could probably walk to the mailbox down the street, but she wouldn't be able to make it back. The rollator would help with that to an extent. The recommendation was put in for an electric scooter. Don't get me wrong. I absolutely love taking care of her, but I have my own back problems and neck problems and these things get worse over time. I hope to be able to, but I don't see myself being able to push her wheelchair twenty years from now. It would give her a little more independence to have a scooter or something of a similar design. That referral was put in by her PCM. Kinesthesiology cancelled that referral without ever seeing the patient. Just cancelled it.

The doctor didn't even show up for the appointment. I asked the tech why it was cancelled. She could not answer the question. We wound up back at the PCM's office and the doctor said that it is up to the kinesthesiologist to either accept or deny the recommendation or referral. I got that. That is that doctor's specialty. But what does it say to the patient when you cancel the appointment and one, don't tell the patient, and two, don't give her reason as to why? That's one way to really lose the respect of anybody. And it was very angering. It's a depressing situation, because it is kind of a recurring theme. If it has happened to us, it has happened to someone else.

Editor's Note: Dan is unwavering in his sense of responsibility to his wife. When asked how caring for his wife had impacted his own career, he felt he had been left with no choice.

I actually say that [looking out for my wife] has probably cost me my career. Because I've had to bring her to her appointments. What I was saying about the other soldier, about, "Oh, she's never here." That used to be said about me. I used to be the property book manager for my unit. I managed the property for the entire brigade. And I was proud of that. But I was taking care of my wife and I was also undergoing treatment for myself. I had torn the meniscus out of my knee. So I was, quote, "always on appointment." And that led to me getting a sub-par review. Which led to me not being picked up for [a higher rank]. So now, I am preparing to retire because I have no other option. I would love to stay in until the army said, "Hey, take the uniform off, grab your lunchbox and go home." But now that is not to be. I will be retired by October of next year. I won't be eligible for promotion. I went from being very proud to now, I'm a stagnant soldier. I can't progress.

Think about if I had gone a different way and said, "Wife, drive yourself to the appointments." And then something happened to her. Now I'm not taking care of my family. And I still get put out. You can never do the right thing. I know you can't please them all the time. But when you try to do the right thing all the time, you still wind up getting screwed.

Editor's Note: Dan described the occasion of one of his own injuries, when he tore a meniscus.

I was participating in PT and all I was doing was getting up from doing sit-ups. And the meniscus popped out. They call it a bucket handle tear. I drove myself to the ER. They wanted to do an x-ray, but soft tissue injuries don't show up. So they say, "Oh, you just sprained it. Take it easy for a couple days." Then my knee starts swelling up. I can't walk on it. I go back to the doctor, who hands me a couple Motrin. And so this was in October of 2010. They didn't even give me real pain medicine, let alone find out what was really going on with me until December 2010.

Monthly, every unit does the unit status report. And it covers equipment, personnel, shortages, goals that are met, goals that need to be met. And if a vehicle is dead-lined or is down for whatever reason, every commander will be up in arms. "Oh, you better bring that vehicle back up." But when the driver of that vehicle goes down, nobody gives a shit. Think about that. I'm the only driver in my company. Everybody else either can't drive, isn't licensed, or is a captain, or a sergeant major, or what have you. They aren't going to be driving. So, yeah, the vehicle is great, but the driver is screwed. And I asked that in the form of a question to my brigade commander. I said, "Hey, why is it that parts get ordered for that truck that goes down, but when the driver needs fixing, nobody cares?" And he said, "Hey, you are right." And I said, "Well, can we get on it?" Because I had been back and forth, back and forth to the hospital over and over again. And actually it took my wife, who at this point, was just blind with rage—she called up to my unit and—she was so upset. She spoke with the brigade commanding officer, the lieutenant colonel. And that actually got the ball rolling.

I finally got an MRI. Finally they realized what was going on with me. And then they did the surgery mid-December. Once they finally figured that there's something actually wrong with this soldier, then treatment happened very quickly. But it's getting them to do their jobs. You know, we're back to the fifteen minute rule. Fifteen minutes or less. We've had providers who have only looked at their computer screens. Never once looked at my wife. This is a neurologist at the VA. He wouldn't even speak to us. He would only go through his computer screen and we had hard copy reports of MRIs as well as the discs of those MRIs. He didn't want to see them. Only what was on his screen. And then he said, "Well, I don't think you have a TBI. You need to go somewhere else."

She does have a TBI. And it was a doctor outside the VA that ordered the MRI to determine. It never should have gone that far. It's hard to say what caused [the TBI]. She had a car accident some time ago, and I know that she was exposed to a blast in 2003. And then she also had a medication-induced seizure from two conflicting medications in 2005 and fell down. We had a two flight set of stairs and she fell down all of the stairs and hit her head on the first floor.

She wasn't screened for TBI until [the civilian pain clinic]. She was listening to me when I expressed concern. There are times, honestly, that I'm talking to my wife and it's like I'm talking to somebody who has early onset Alzheimer's. Because we can have a whole conversation and five minutes later, I find myself in the exact same conversation. First time it happened I thought she was just messing with me. I just went along with it, because I wasn't sure if she was messing with me. I didn't even see a hint of a smile or anything. And it happened again. And she is forever misplacing things. She'll see bright flashing lights when there are none. She also sometimes has issues remembering what happened. And so anytime that she's had a fall down the stairs or has fallen out of bed, I keep a log of that. And I bring it to the appointments because the doctors needs to know. She won't remember things like that. Just a number of things. I brought this up to the doctor, the [civilian] PA actually. She happened to be reading a copy of the Army Times and she said, "You know, what you just described sounds a lot like what I just read about."

I have gotten some good support through the Veteran Caregivers' program. We don't have very friendly neighbors. Matter of fact, we have a very racist neighbor to this side of us. Then the neighbor over here, you know, she's out of the home a lot. People come and go from these houses. We don't even know who lives over there. People move so often. Not a lot of people around here that we can rely on. There are times I feel like I'm on an island. I feel like I'm having to do everything all by myself. Which, I don't mind. That's my wife. I'll walk to hell and back for her. But, just knowing that I'm able to call their hotline if, even at a bare minimum, I need to talk to somebody or get advice. I know that I can call and request for someone to come, even to help her go shopping. Now this didn't exist before 2008. I can only imagine what family members and friends of veterans were going through then. There are definitely a lot more resources available now.

Editor's Note: At this point, Dan clarified that at this point, Debbie had some VA coverage and Tri-Care. For acute care and emergencies, she goes to Darnall. For routine care, she goes to the VA. The couple was in the process of transitioning to 100% VA care, as Dan was getting ready to leave the Army.

The VA didn't used to have case managers. You would just enter the system and blindly navigate and hope that you found your way through. Now they have a case manager at the VA. One of these people who has all the answers. Knows who to talk to and where to go for everything. And he's prior service. And that really helps a lot because he was able to sit down and talk with my wife and she felt comfortable with him because he was able to describe some of the same things that she experienced. And that is something that I can't do. It made her feel a lot more comfortable. A more trusting of the environment at the VA. They are more proactive in giving aids to help her living. And things that you don't really think about. Like the toilet seat. You know, especially for someone who has lost a lot of weight—and my wife, she lost almost thirty pounds very very rapidly—she has a lot of areas that are more bony than they used to be and it is very easy for her to develop a decubitus, a bed sore.

In fact, she had them on the bottom of both feet. You know, you think about—for the better part of the day, I'm not here. And she can make her way from the bed to the bathroom without a problem, but let's say she was there for five minutes—that can actually cause her harm. So they gave her an elevated and cushioned toilet seat so we don't have to worry about that anymore. Sometimes trying to get my wife bathed can be like a wrestling match. So a shower seat is going to save my back. The VA has provided her things to make her just a little bit more independent. They were even able to give her some inserts for her shoes that can help relieve—so she won't get those pressure sores. And they gave her these—I call them moon boots. They are boots that she sleeps in them to help off load her heels from the bed.

My current command, aside from how they have been responding to one of my soldiers—is supportive. It seems very oxymoronic. With the one soldier, they seem to be just gnawing at her, but when it comes to me, they are very supportive. Now, I have an idea that it's because I've forced them to be supportive.

Remember I was describing decubitus? The bed sores and how I document everything? The evening that I came home and found my wife's feet looking like that—I brought her to the hospital and took a picture. Smart phones are miracle workers. Then the following day when I had to tell my command about follow up appointments, at first they were like, "But—but—" And then I showed them the picture. "You want to take her? I mean, by all means, I'll give you my address. You can even use my vehicle if you want to take her. If you need me here that bad, you can take her."

There are times when if I didn't have the [release] documentation that I do, that I would have been violating HIPAA. Discussing my wife's health and her conditions with somebody who has the potential to do damage. You know, my unit, my brigade, has a hand in clinics on post. So they could very easily say or do something. Well let's put it into this perspective, take it away from the unit for a moment—if you've ever served in the military in any capacity, you will never receive life insurance from USAA. Ever. You are uninsurable. My chain of command knows stuff about my wife that our own son doesn't even know.

One change that the military needs to face in terms of the care of the individual soldier and the care of that soldier's family is—there was a healthcare law passed in 2008 that every employer must allow their employees to attend their appointments within a reasonable amount of time. And in addition to that, you are authorized two weeks of medical leave per year. So the army, as an entity, needs to look at more of a legal standpoint, in addition to a more holistic standpoint. You can't think about just the mission. You have to think about who is going to perform the mission.

I've had commanders who have had a negative impact on the entire unit because they themselves refused to seek healthcare. Two commanders ago, I had a commander who got into a car accident and her back was obviously messed up. You could tell just by the way she walked. She was not the commander we knew before. I kept pleading with her. "Go get checked out. Go, go, go, go, go." And then one day it got so bad that—thankfully by this time she had gotten married, and I guess her husband somehow talked some sense into her. So you get some people who try to be, "Oh, I'm so tough. Even though something has happened to me, I'll suck it up. Rub some dirt on it. Drink some water." What does that say to that very young new soldier that just came in? "God, what do I have to do? Lose an arm if I'm hurting?" It sets a bad example. We have the soldiers' creed. And it says, "I will maintain my arms, my equipment, and myself." And everyone seems to forget "myself."

That is something that I'm trying to instill in my unit. There are a number of things that are in this book, *The Phantom Warriors Handbook*,¹⁵⁴ I've explained to you the difficulties I've had in trying to get healthcare for my wife. Now, the installation commander at Fort Hood liked to push "family first." They actually have a memorandum dated May 20, 2011 Subject: the Family First Corps.¹⁵⁵ Their tenets of command always include family. Such as General Campbell's command philosophy (reading): "My intent is to establish a corps that can deploy anywhere and execute any mission by instilling a focus on teamwork, comprehensive fitness of our war fighters, and leader development and training. We must remain focused on accomplishing all missions while ensuring the resiliency of our family teams."

Beautiful words. But sadly, most of them just seem to be buzzwords. How can we call ourselves the "family-first corps" when we have soldiers that have to fight to bring their family member to an appointment? A family member that no less came here with an entire packet recognized under the EFMP program? How screwed up is that? It's like a slap in the face. And yes, the mission. That is why we joined the army. The mission. But we can't support the mission if we can't support ourselves. I've spent twenty years supporting the army, and I've had one person supporting me. And when I can't support her, I fail all around. Because it's in my mind: "Shit. I've failed my wife. She's hurting. This is going on—that is going on—" Now I'm not focused on the mission. Now stuff doesn't get done. That wheel of misery just keeps spinning. So how do we stop that?

We need more people to actually read that soldiers' creed and the NCO creed. The NCO creed says "Soldiers are entitled to outstanding leadership." But they are not getting it. And the soldiers have the creed, "I'll maintain my arms, my equipment, and myself." But they are not being allowed to maintain themselves.

5 Max Diaz*

Editor's Note: Max* is a Latino Army veteran, originally from East Texas, who served in a Cavalry unit. He spoke of the severe stigma he and other soldiers faced in his unit at Fort Hood for medical and mental health issues, both of which he experienced during his service. Max deployed once to Iraq, and once to Afghanistan, and described his struggle of conscience during and after deployment. At the time of the interview, Max had recently been discharged from the Army. He was granted student benefits from the VA, but due to paperwork processing delays he missed the chance to register for the current semester.

I walked right into the recruiting office and said, “Hey, sign me up,” in November 2009. [I wanted] a sense of purpose. I joined because I left my job as a police dispatcher, and after that a retail supervisor, due to current life events—break-ups and deaths. I felt like I needed to get away but I didn’t know how.

I am also big on being an individual, and I believe that freedom in its quintessential form is beautiful. I signed up thinking I would really be defending the constitution and the people.

During my active duty at Fort Hood, I sought out medical attention for my back. During deployment I received a laceration on my arm from a friend and his knife. As well, during deployment I sought medical attention on several occasions for my back. After deployment I sought medical attention for my back and for my mental status.

During deployment and after we returned, I tried to get my back looked at in-depth, but to no avail. It was pretty hard, seeing how everyone was in the “ready to get home mindset,” and were like, “Take care of it after we get back.”

[The care was] minimal at best. It all depended on the physician and their personal attitude. Some were cautious, like “Take it easy.” Others were, “It’s all in your head, get back in the game,” kind of personality.

They gave me prescriptions for my back after deployment. I sought [a diagnosis] but have never been given one, or an appointment to have my condition looked at more carefully. My immediate supervisors were aware [of my condition] and they weren’t too keen on it. I received better advice and help from a good friend and medic. My supervisors saw it as weakness, and the local response was, “I got that problem too, but I don’t cry about it or make a big deal out of it.”

I received two [profiles] in Kuwait for my back. They were temporary, and while they helped I would have rather been diagnosed or treated rather than told to relax.

I had several friends who were under extreme pressure to violate their profiles—whether because of work or “corrective action.” However, when the supervisor wanted to use it against them they would say, “You better not be violating your profile, I will Article 15 you for malingering!”

Soldiers in my unit were [aware of MEDCEN-01], but like I said, it’s hard to go by the rules when the people in charge don’t play by them. Plus, being called a “pussy” or “broke dick” or “profile ranger” doesn’t help them. [For it to be enforced], we need a total re-training of leadership. The problem is always in the individual leadership. We have to abandon this idea of machismo and become a more intelligent and capable military. Too many biases of individuals have spread throughout the ranks and affected many soldiers who need help or needed help before.

I received all [my profiles] from my interchanging battalion physician during deployment. The longest was for two weeks and it was a no run, no heavy lifting, no gear profile.

Editor’s Note: Max also testified that he was never re-evaluated before his temporary profiles expired, and felt he was always under pressure to violate them from his immediate supervisors (NCOs).

I was always told that I was broke, or the other soldiers were told that I wasn’t going to help, just watch them work.

I believe we are forcing medication down our soldiers’ throats, and patting them on the back, telling them they did good and to strive on. That is not treating the condition, that is pacifying it. There’s no shame in having a conscience, yet we treat it like an ailment.

It was generally a negative thing to be on profile. Our battalion had lots of soldiers on profiles, at many times. We were told by our commander to get help and get fixed. Yet the immediate platoons and supervisors would treat you badly because of it, or produce negativity toward you by turning the platoon against you.

Several times, I witnessed my best friends with serious conditions treated badly because of their profiles. Everything from name-calling to being assigned the most mediocre and humiliating of tasks, like guard duty for 12 hours at a time. Then after, it was ridiculed because all they “did” was guard duty. I can understand a combat environment, but this was a garrison environment.

[The stigma comes] from this machismo robot we have concluded is the American soldier. Several times I’ve heard, “In Afghanistan, in Iraq, we had to do it. So don’t complain.” Or, “Pain is weakness.” However, pain is a human emotion... It all starts the minute you begin basic training. Drill instructors love to yell, “sick call Ranger,” and, “Profile Queens.” We see those on profile as if they are on some kind of vacation while we slave away. It’s sickening how leaders can turn a population against another—it happens all the time to those on profile.

Editor's Note: When asked if this stigma has prevented him or other soldiers in his unit from seeking care, Max was emphatic that it had.

Even I didn't want to get help, because I knew all the way from my supervisor to the fellow soldiers in the platoon, and up to the physician, that I would be given a hard time.

[SRP was] very rushed, very get-up and get-done so we can get out early. I saw soldiers with physical ailments and even some with mental conditions pass through SRP. Some soldiers were sent back during the deployment because they mentally collapsed. Even though they had a history, so they should have never left [garrison].

While deployed, we had a fellow soldier who we had to guard because of thoughts of suicide and homicide. And we had a soldier kill himself in Iraq. He was in a unit stationed with us.

While we were on garrison, we had a soldier who was put on suicide watch. First it was needed, and okay. But then our immediate supervisors stigmatized him and turned the platoon against him, until everyone he was close-minded hated him. It was sick how they treated him. I stood up for him on several accounts, all the way even to a direct investigation by Brigade.

After deployment, I was given a questionnaire to "rate" [my] PTSD. That is sickening, rating PTSD as if it is a normal cold or flu. At that R-SRP, I answered truthfully. In the past, I answered falsely, because I just didn't care about the lackluster treatment they could offer, or the persecution that comes from seeking help. But I had had enough of the Army and its ways, so I answered truthfully, and was told to go to the mental health building. It didn't matter anymore, to me personally. I was fed up with what I had did for a year, and tired of the Army. I would not be stigmatized anymore.

[PTSD trainings] were dull, long, and trivial for the most part... However, there was always a section on malingering there, just for a reminder.

I find myself a lot more irritable now during random events. Every now and then, I have a dream of seeing the poor Iraqi families that were victims of our war there, and the small broken dying child that they brought to our COS for help, but we mercilessly turned them away. Also how blind and racist I was up to the halfway point of my deployment in Iraq, until I learned that they are living breathing human beings just like me, and they were only trying to live free.

Sometimes I get mad at close friends or siblings. After seeing a culture make due with nothing, you get sick of seeing first world problems.

Editor's Note: Max also reflected on what has been helpful for him in dealing with PTS.

IVAW. And Under the Hood coffee house at Fort Hood was amazing and very, very brilliant. Also just relaxing with friends.

Some [soldiers I know] are doing better than others. Some have nightmares, some like me feel deep regret and sorrow for the people, and some aren't affected by the crimes they committed at all.

I think [we need] an overhaul of the way the military works. And a change of leadership from the top to the bottom. We need to realize that this is the information age, and the age of acting like meat heads needs to end. We need to educate ourselves on what is right and wrong from every direction.

We had short, mandatory TBI briefings where they gave us a card and made it mandatory to have that card on us at all times. I did take the ANAM before deployment. I was exposed to blast pressure, but not nearly as bad as my friends who were directly exposed to it. I got no screening afterward. There wasn't even a record of me being treated for it... After being exposed, I was given an oral memory exam and a problem-solving exam.

We had long, dull briefings [for MST], where it felt like the person giving it was very lackluster about the subject. I think [MST] is very, very prevalent. Once again, [we need] a re-haul of leadership and the way we conduct business on the regular daily work day. The biggest problem I see is that we allow it to happen, whether jokes or assault. We see it and we shake it off as nothing. We need to change this mindset of sexism, that it is okay to view women as shells to be abused. And it works both ways.

Editor's Note: Max testified that he had known someone who was affected by sexual assault or harassment in the military. Then he continued to describe the effects of the draw-down on service-member health.

It was kept hush-hush by the leadership to avoid problems.

The higher ups talk a big game about getting stern on thinning the ranks. However, I have had friends who tried to go before the MEB board and were refused, or it was drawn out in a very lengthy process. I certainly have [seen soldiers chaptered out before ETS], for being over-weight, previous discipline problems. And it is disgusting, I saw soldiers who suffered injuries both mentally and physically that affected how they conduct themselves at work, and they were 'correctively trained' for it...

...I still feel massive amounts of grief and sorrow for the people I saw and the crimes I saw my fellow soldiers commit, everything from harassing Iraqis to destroying businesses.

6 Curtis Sirmans

Editor's Note: *Curtis is an African-American veteran in his late-twenties, originally from suburban Georgia. At the time of his interview, he had recently gotten out of the Army and was in the process of moving home from Fort Hood. He served nearly six years in the Army as a Cavalry Scout, including one deployment to Iraq. As a soldier who was on profile, Curtis is very concerned about the issue of profile violation and discusses how he came to begin educating his fellow injured soldiers about Fort Hood command policies concerning physical profiles.*

I joined back in 2006. The whole purpose of me joining was I was interested in seeing some actual combat in Iraq. I just wanted to get that experience under my belt. And I guess you could say I thought highly of the military back then. I was 21.

I was interested in going in pretty much my whole life. And then I finally got in. I had a medical thing that I had to get waived, that burned up some time there. And after I finally got it straightened out, I went in two months later... I pursued the process by constantly nagging my recruiter, you know, staying on him about getting in because I had to get a waiver.

...To be up-front, back then, I wanted to kill someone, pretty much. That's what I felt, at the time. And it sounds crazy, but that's where I was at. It was [for] purely personal experience.

...I got medically separated out of the Army because of arthritis, nerve damage, a series of things that are wrong with my ankles. And through the whole process of me trying to get help with the pains that I was having, before they finally gave me the red flag and said you're good to go, I had to fight to go to sick call. My leadership, at every level, would give me all kinds of crap about going to get help, and getting out of work, to go seek medical attention. And the doctors gave me a limited duty profile that says I can't do x-tasks, because of my injuries, and I got even more crap from that. And it was a constant struggle of, "Hey I got a profile," and then I would get treated differently because of that. That's my personal experience.

The first thing is, "Well, you know what, you're a shitbag. You're not as bad or as broke as they say you are or your profile says you are." They constantly poke holes in your argument like, "Well, I saw you walking fine a few days ago," or something ignorant like that. Or, "You're a shitbag, you're a bitch, you're a pussy," there's a rap sheet of names they could throw at you to deter you from using your profile or not doing work.



Curtis at IVAW's annual convention in 2012

This stigma is pretty detrimental to soldiers improving themselves or helping their situation out, whether it be mental or physical. The stigma needs to go away because it's not helping build the unit at all. It's just making soldiers get worse physically because they're not gonna get seen they're just gonna keep running on their injuries. And then mental health, we know how that works, it just snowballs until something happens. And this can be prevented if the stigma would go away.

Army-wide, it's pretty much the same thing. It's the huge stigma that's put out there towards soldiers who have issues, who have to go to the doctor, or go seek mental health. They give you all kinds of crap about it, and they treat you differently.

And that deters a lot of the newer soldiers from getting help. And then it comes down to the leaders, they put the stigma on the soldiers. And the young, impressionable soldiers, they pick the same stuff up, and they throw it back at their peers. So it's like this big cycle of stupid. It never ends. And all these people, who needed medical attention, or need to go speak to mental health, they never get that help that they need, then their problems just snowball. And the medical stuff is brutally obvious, to the point that it's like, really? Lots of times, injuries just go un-treated, and they blatantly should be taken care of. It's right in your face, but people just don't get stuff taken care of, until it gets so bad they can't do anything.

While I was still in, when I first needed to get care for my ankles, while I was at Fort Hood, the first person you'd see on the ladder of medical treatment is the Physician's Assistant. Usually they're a captain, or a lieutenant. And these guys, their main goal is to send you back to your unit as quickly as possible. So you're gonna get some half-assed treatment. There's no way around it. They don't really care, I think they're ordered to do that. They'll just rubber-stamp you. They'll give you a two-day profile, a three-day profile, you know, "No running." Something to, I guess, make your life a little bit easier, but it's not a real fix. So nine times out of ten, you're gonna end up needing to come back to this Physician's Assistant.

And I've seen some Physicians Assistants who are pretty dismissive to people, and they have some serious injuries. It depends how long your injury lasts, it'll kind of determine how the whole thing goes. If it's something serious, you're gonna have to keep going back. Hopefully you'll get moved to a different PA, who's gonna help push whatever you're trying get straightened out forward, because lots of times it's almost like a game. It's like, "Here's a one-day profile." "Here's a three-day profile." If you come back, "Here's a week-long profile." Maybe you get some pain meds. And that's about all they'll do for you.

...If you come in there enough times, they'll say, "Well, here. We'll go that extra step and give you x-rays." And you'll wait some time for that. And then, the biggest killer—which I've seen some seriously broken soldiers have to deal with—as you keep coming in there for these little rinky-dink week-long profiles, or three-days, in between those trips, if your profile expires, you're on your own, because your chain of command won't respect your medical problem unless you have the paperwork, i.e. the profile, to have you covered from doing whatever got you hurt in the first place. And even if you have a bone sticking out, or something ridiculously obvious that's like, "Hey, this soldier needs to not do this activity or work," nobody cares unless there's paperwork on it.

In my case, later down the line, the doctors ran through the gamut of different treatments for my arthritis and my deformed bone in my right ankle, and my bone spurs. And they said, "Hey, there's nothing else we could do for you," 'cause I continued to keep making those trips to sick call, "but we'll give you as much Vicodin as you want." And that started me on a trip on Vicodin, for almost two years now.

Editor's Note: Curtis clarified that he was prescribed enough Vicodin that he developed a physical dependency.

And I've seen the same thing happen to some other folks too. The pharmacist will give you a quick run-down about how the stuff is serious, and what-not. And then, certain docs, PAs, they're hesitant to give you the stuff because some soldiers will abuse it. So they'll give you a run-down. And then, they'll find out that I've been taking it for a long time, and they're like, "Well, if it's not doing anything for you, you should probably get off of it." I hear that a lot.

But I mean, it's kind of on the soldier to be responsible with the stuff, if it's prescribed to them. So the Army will cover their end by telling you that it's potentially addictive, and don't abuse it, follow

the prescription to the T. But at the same time, I mean, it's kind of a double-edged sword there, 'cause this stuff is addictive, there's no way around it. At the same time, though, they're hesitant to give you other treatments that could help you out. It's really a problem.

And then plus, you can't always see the same PA, so you might end up with a different one that doesn't want to give you any more. So one doctor will give you as much as you want. Let's say that prescription runs out, and you go to get more, and another one tells you, "I'm not giving you anything."

There is a lot of [problems with withdrawal], I was told that in my unit by a couple people. So then, it turns into you buying it from your battle buddy, who's messed up too. There's a lot of that.

I've seen other people on all kinds of stuff because of nerve damage, spine injuries. I've seen a lot, when I was in a Med Board platoon. All they said is, "Don't take that stuff before you come to work," even though it says on the bottle you're pretty much supposed to be taking them all the time, because of the ailment.

They diagnosed some of the things that're wrong with me, and then some other stuff, I told them about. And they said, "That sounds like nerve damage." For example, I have a burning sensation in the bottom of my feet when I walk. They said, "Hey, that sounds like nerve damage." But they never pursued it. They said, "You have flat feet," and left it at that.

So when I got out, and kept poking at the VA to get them to, "Hey, tell me what this is," they gave me the run-around. I used a TriCare referral, and then I finally got someone to diagnose this, and they said it was nerve damage. So I missed out on getting Med Boarded out for that, because that would've gotten me medically cleared, as opposed to separated. So I lost out on money because the Army didn't want to look into my problem.

A different PA on the Air Force base by my house, they told me I got screwed. Because flat feet and nerve damage are obviously two different things, and if I told them the same thing I told this other doctor, and one looks into it and another doesn't, and they find nerve damage, it's like really, somebody needs to do their job here.

So now, because I got screwed like that, I've only got six months of health care, when I was supposed to get it for the rest of my life. And it runs out in two months. If they would have diagnosed it like they were supposed to, I would have free health care for life. That's just a small detail, but that's how it's played out. Once that runs out, alls I'm going to get is health care with the VA that's service-connected. And at the moment, the only thing that's service-connected is my left and right ankle.

Two months left. I managed to get surgery lined up. I had to drive all the way across the state to get that straightened out. I've got appointments on both sides of the state, and I live right in the center of the state. I got some issues in the disc in my back. And I'm finally getting somebody to look at that. They sent me to a neurologist on the other, opposite side of the state.

Everyone that was ahead of me in their medical separation process kept telling me, “Yo, go to get a referral from your PA to go see a civilian doctor off-post.” And I got that advice, and I took it up. And what the civilian doctor was telling me was totally different from what the Army doctor was telling me. The Army doctor wants to give me as much drugs as I want. And the civilian doctor's like, “Hey, man, I can cut you next week, you know, give you surgery, give you this, give you that, I can give you better meds,” he gave me a list of options. And the Army doctor is like, “Pssht. There's nothing else I can do for you.” That's exactly what he told me.

Now that I'm home, and I'm talking to a real doctor, they're going to fix two problems at the same time. So it's way better treatment now that I'm going to a civilian doctor, outside of the Army.

The only thing [command] knew is what I told them, and what paperwork I presented to them from my PA. And they didn't really care about the details. All they wanted to know was how much work could I do. And as time progressed, my profile kept getting better, and more inclusive there, so that meant the less work I could do for them. And they would try me all the time. Because most soldiers fold to pressure. When someone of higher rank comes and tells them what to do, usually a soldier will do it, unless they think for themselves and assert themselves, saying that, “Hey, my doctor says I'm not supposed to do this, that, or this.”

...The commander is doing his own thing in his office. But the main issue is your first line supervisor, usually an E-5 sergeant, he's the one in your face trying to get you to do some kind of work, and you have to present that document to him. And then, half the time he'll try to ignore it. That's why I started to carry around the general's command policy on profiles, so I have to give them both of those documents at the same time, and so that will clarify some of the nonsense. And if you do that to them enough times, they get it, don't mess with this guy.

But if you don't go that extra mile and be confrontational with these NCOs, then you'll have issues, and you'll end up doing some work you're not supposed to be doing. And I've seen soldiers who already have severe conditions get hurt even worse, because they were pretty much forced to do stuff they weren't supposed to be doing. And of course, nothing happened to the NCO who made them work.

By the time I went to Under the Hood, and was with IVAW, and I learned more about how this whole process works, they would get a laugh at it, because I was quick to pull [the policy] out when someone would tell me to work. So I became that sarcastic guy, who's always pulling out command policies to get out of work. And they would laugh at it. But you see, the soldiers who didn't know the actual policy, and tried to pull out a profile, and some NCO just acts as if that thing doesn't exist, or they read in between the lines, then the stuff will get overlooked, and NCOs will just brush them off. So for me, it came down to the point to where they would leave me alone, but they would stay on the newer soldiers.

...Lots of times, I'll talk to a soldier—a new soldier, mainly, they're the main ones who are like this. I talk to them about, “Hey man, your profile says you're not supposed to be doing that. You should sit down and relax. You know what I mean? You're not gonna get paid any more or less by doing this extra work.” And then they say, “Well, I don't want to look like a shitbag.” I hear that

constantly.

These new soldiers have this idea that they have to try to out-do everyone else, and it's not necessary. So they kind of bring it on themselves, but I see other kids who are really hurt, and they're being pulled to do stuff they're obviously not supposed to be doing. This stuff wouldn't fly on any other job on the planet. Well, unless you're in prison or something. But I've seen guys on crutches be pulled to sweep a Motor Pool, where we park vehicles at. And they're serious. Or, guys who have back injuries, when they're walking funny, are told to climb on top of 13-foot tall tanks and do maintenance, and it's like, "Huh? Do we have to argue with these NCOs about everything? Are they ever gonna just step in and use common sense, and look out for their soldiers?"

Editor's Note: Curtis spoke about issues of medical confidentiality on post, and how profiles are interpreted differently with different leadership.

If you wanted to get out of work because of your medical issues, you are gonna have to tell your NCO everything in detail, and you'd have to have the same level of openness with your doctor as you would with your NCO, to get out of work. Because you'll tell them your problem, and they're gonna try to dissect it, and they're gonna use their limited medical knowledge to figure out what you can and can't do.

And it's ridiculous because you already had an Officer who wrote it up saying, "You're not supposed to do this." You got some 23 year-old E-5 trying to go over the Officer's head or saying he knows more than this Physician's Assistant. And this is not an individual thing, this is the norm. It's ridiculous. Sometimes, you might have to go back and forth between some E-5 about your personal medical business, and you'll end up having to do the same discussion the next day, when some work comes up. It's ridiculous. With the same NCO. They try and make you feel bad about it, too. They do this all the time. It's like, "Come on, man! You know you can do this. It's not gonna hurt you that bad." You hear that a lot.

I was on a permanent profile, for more than a year... In my case, I went through a bunch of temporaries. A week, a week, two weeks, three weeks, a month, a month, and I'd keep getting these renewed as they ran out. And eventually it became permanent, that's how it worked for me.

I can elaborate on [pressure to violate profiles]. It's a two-fold thing. Of course, prior to deployment you want to get as many people as you can. But generally the case is this: there's some work that has to be done. And it has to be done, no matter what, so it doesn't matter how many soldiers you have available. And then, lots of times, NCOs are like, "Well, I don't want to do it, but this private or specialist right here, he may be broke, but he can do the work so I don't have to do it." And that's when they extend all that energy to try to get you to break your profile, so some NCO's not outside doing some nonsense detail. That has a lot to do with it. And it's ridiculous.

Now, on the other side of the coin, prior to a deployment, they need X-amount of people to deploy. And it doesn't matter whether this person has no arms or legs, they just need a number.

So that's when they really start hopping through hoops to ignore profiles and what-not, because they need to get people on the plane. There's a story, of this one guy. He was having mental health issues, and he was going to a shrink prior to the deployment. And two shrinks, two different shrinks, said that this guy was not supposed to deploy, because of his issues. They made him go anyway. His captain signed off on that one.

And he ended up killing a contractor. And nothing happened to his commander, who ignored his shrink's diagnosis or recommendations. So this guy has been sent off to some mental health facility, and somebody's dead because of people just overlooking profiles, people not listening to doctors. They figure, "Well, this numbers game is more important than the soldier's well-being." And that's an extreme case. But other deaths have been attributed to that, too.

It's everybody who has authority [violating profiles]. Up the chain. Because sometimes they know, clearly, this guy's on a profile, but we need numbers for this detail, for this training, or the deployment. And then the more severe the situation—like, if it's deployment, some Officers are gonna sign off on that one. If it's a detail, some E-5 is gonna push that one. But it's everybody who has rank. A good number of them just don't respect profiles.

And it's not just a profile, people aren't looking out for their soldiers, period. Some people can't even get a profile, because of whatever issue. I've seen that happen too, and that's really bad. Like, they're backed up, so you won't be able to see the doc for two weeks. But your leg is screwed up and you're walking funny, so you're just gonna have to suck it up and run on a eight-mile run, when you can't even walk right. I've seen that happen too. And nobody cares. It's just ridiculous.

I would hand out copies [of MEDCEN-01] to my platoon, to let them know, since they were all on profile. They were all getting kicked out of the Army for medical reasons. And because there were only so many soldiers who weren't on that deployment, because we were the stay-behind guys, because we were getting out, they kept telling us to do work, all kinds of work that was coming out of nowhere, silly, frivolous work that had to be done. And since there were no able-bodied soldiers around, they were all in Iraq, they tried to make us do it.

Some soldiers got hurt because they were doing something they weren't supposed to be doing, and nobody cared. We had a lot of NCOs who were in the same spot as us, but they were in charge just because they were the only ones with rank. And they said, "I'm not gonna ask you to do anything that violates your profile, because I'm not gonna violate mine." But those guys were few and far between. The big guys who were left behind, who were running the show, they didn't care. They just went, "Hey, the work has to be done." Lots of times they'll say, "Hey, you're gonna stay here until the job is done. We're not gonna let you go home." And usually a new soldier will give in, and just do the work. But us older cats are like, "We'll play your game with chicken, because we live at work."

Editor's Note: Curtis reflected on what he thinks would need to be done for policy against profile violations to be enforced at Fort Hood.

The post commander, specifically on Fort Hood, he would just have to reiterate the policy. Because when he reiterates a policy, it goes on commander's notes, at every level of the chain. And that means all the leadership will go back over a policy. Saying, "Hey, I'm stressing this policy, and I need it to be followed." Just like when any other word comes down from a three-star general. And that will be on the forefront of everyone's minds, understanding that, "Hey, this kind of stuff will not be tolerated. This is serious." And the way it usually works is, when the general comes in, all of his policies get handed out again, and then it just stays that way until he gets relieved. And then, when the new general comes in, all of his policies get handed out again, usually it's the same policies, it's just a new signature on it. And things fall through the cracks. But reiterating the policy, just randomly out of the blue, that would help.

And then, punishing people who don't follow that policy. Bringing accountability into the situation. 'Cause as it stands now, there is none. Unless a soldier stands up, and calls his Congressman, I've seen results from that. Or calls the inspector general, there's a lot of that. And that's the only way that you raise that accountability, is when pressure is applied. Whether it be from the commander, or from an outside source. It has to be a good mixture of both. Usually this thing of reiterating a policy, this happens after a lot of people get hurt at the same time, or somebody dies. So whenever somebody dies in the Army, here we go again, they're gonna bring up some policy that's already been in place for some period of time. Usually, it's domestic violence, sexual assault, or DUI. That stuff comes up all the time. The policy gets read back to us, and the commanders are told to, "Make sure your soldiers understand the policy." So lots of times, we'll sit in a conference room, and they'll read us the policy verbatim, and then we'll talk about it, to be sure that everybody understands it. Now that's what needs to happen with MEDCEN-01.

...The thing is, they don't reiterate that particular policy. And yeah, you're gonna break years of stigma—you're un-doing years of this bad thing of ignoring profiles. But it takes just a little bit for the tide to turn a little bit. It's a step in the right direction, to bring that to the forefront of everyone's mind. Especially when, you know, soldiers always have profiles. There's always somebody who's hurt. It's just saying, "Look out for this guy, and respect what his doctor's wishes." That's all it is.

The Physician's Assistant [issued my profile]. Every battalion has a PA. And they do a sick call every morning, and then tell your doctors what's up. And they'll assess the situation, and you'll get your profile. It's not guaranteed, it depends on the severity of what is wrong with you. I've seen guys get turned away, when clearly they should've gotten a profile. Or, these new soldiers aren't assertive with talking to Officers. So they don't get their point across about how bad they are. Everybody tries to play tough guy, when they should be spilling the beans about what's wrong with them, so they can get that profile, or get the meds, or whatever they need. A lot of guys don't even want to go to sick call.

That's challenge number one, is to get people to man up, go tell your boss, "Hey, I need to go to sick call." He's gonna cuss you out, because you're gonna miss work to go to sick call. But, really, do you want to get fixed or not? Do you want a break? Or do you want help, or not? And I had to counsel a bunch of soldiers about this, and tell them like, "Look man, the only person who cares about you is yourself. The only one who's gonna take care of you is you. So don't worry

about what everybody else thinks, and go take care of yourself.” I've been telling people that for a long time, and some people listen—and it helps your case, too, once you go for benefits, after you get out.

...Generally, everyone hates that soldier's guts [who's on profile]. Sometimes people you think are your friends, if you're on profile long enough, they're probably not gonna be your friends. It's almost childish, how people just get angry at you or jealous of you, because you're not slaving away in the field, or doing the same work they're doing.

A lot of it, too, is the accusations of being a malingerer. Just almost, pretty much if you say, “Profile,” somebody immediately calls bullshit. They don't have to know anything about the situation. They could see you get hurt! And sometimes they'll still call you a malingerer. Like, “Oh, you're not that bad. You can do this, and you can do that.” Everybody's trying to push you to the limits of your ability, or the limits of your profile.

It's your peers and your leadership. And your peers are just mimicking your leadership. And they're almost encouraged by their leadership, because some NCO is gonna say, “Look at this shitbag. Look, he's getting out of work when he could be out here helping you guys.” Your leadership encourages your peers to turn against you, because you're not doing the work that they're doing. I see this over and over and over again. It's preschool stuff.

Leadership sets the pace for everything else. This has been going on ever since like, the Roman Empire days. So really, it's engrained into Army culture, especially in combat arms. And that's the only place I've been, so I can't attest for support units. But, in combat arms, it's always been that way. You could always push yourself further, tough it out. There's nothing wrong with you.

And as for change coming around, once again, that'll come from leadership. Because once they set the tone of, “This guy is hurt. Leave him alone. I'm not gonna push him to do crap,” the new soldiers will see how the profiles and injuries are supposed to be handled, and they'll learn from that, and when they become leaders they'll do the same. But lots of times too, I'll give some of them here some credit, I'll hear them say this, they'll say, “Hey man, I know you're hurt. And I wouldn't ask you to do this. But this staff sergeant above me says he doesn't care about your situation, and he wants you to go do this.” I've seen that a lot too, if you find a good NCO.

[NCOs] don't have very much power. I mean, you'd have to go to that outside source to be the intermediary, to step in and tell the guy [to stop]. And it really depends on your NCO if they're gonna go to bat for you. I've learned in my personal experience that if you want an NCO to go bat for you, you have to go to the NCO on the side and explain to him in detail about what's wrong with you, what you need from him, and establish good rapport with that NCO. And it works. And I've had NCOs cover for me because I would explain my whole deal.

But if you're not on their favorites list, no one's gonna go to bat for you. And alls you have is a piece of paper with some captain they've never met before, and they're just gonna laugh at you, and you're gonna end up slaving away doing stuff you're not supposed to be doing. 'Cause once you get hurt, you're already at the bottom of the barrel anyway. You can't even run anymore.

You're pretty much useless to everyone. So no one wants to be bothered with you. They'll give you some task that's not that physical. It's like, "Go guard this." So you'll get caught doing that stuff.

Editor's Note: Curtis reflected on the issue of soldiers being ridiculed for being on profile.

I've been called worthless straight to my face. They'll call you every name in the book. They'll go all out when it comes to name-calling and making you feel bad, and making you look bad towards your peers, so your peers don't go do the same thing and get profiles. You could play the system, if you do enough physical exercise, everybody's gonna get hurt, and in the Army there's a lot of hurt people walking around acting as if they're not. So if everybody went to sick call, they could probably come back with a profile, legitimately. And that's why they try to discourage any one person from getting one, because then everybody would do it. That's another reason as to why they do this nonsense.

But me, I've had every name you can think of, that's been thrown at me. I remember one time, I was in between profiles. One expired, and I had to wait three more days before I could get a new one. And in that three days, I got smoked for half a day. I had to do corrective training for half a day. I didn't argue with them, but it was just a matter of I wasn't going to push myself, because I was hurt. And I was waiting to get a new profile. And I couldn't get one 'cause the doctors are backed up. So they stayed on me, and I think I still had to run that day, too. So that was a bad day for me.

It was a punishment, pretty much. They had me rolling around in the dirt, and low-crawl, and all kinds of crap. I didn't argue with them, 'cause I'd been in that situation a long time ago, before. So I know to keep your mouth closed, and that they were just giving me crap, because I wasn't going to give it my all, because I was hurt. And you see me today, I'm still hurt from the same injuries.

The difference is, they were a little bit nicer [in the MEB unit]. The NCOs within the platoon were more understanding, because they were hurt too. And because they were hurt too, that kind of took off some of the slack. But anyone who wasn't delinquent in that platoon would still treat us the same. They would give us tasks that obviously you couldn't do. Like, "I want you to get on full battle-rattle, and go do this or do that." Like, we got people who've got broken backs in IEDs, we got people that've been shot, we got a whole gamut of all kinds of injuries, some mental health stuff too, but they would come at us and still try to task us to do stuff. When you're in a regular platoon, there's less broke people, so they're not so desperate for people that they're gonna go tell you to do crazy stuff. They will, depending on the NCO, but it's less likely. You'll just get a lot of extra crap, verbal abuse.

And for the mental health side of the fence, those guys who don't get help, lots of times they'll end up getting in trouble. Either outside of work or at work. Because instead of going to go get treatment, they end up saying or doing something crazy.

...I didn't [seek mental health care] 'til I got out. Because of stigma, and I thought that it wouldn't

do anything for me, until things got so bad, I eventually realized, “Hey, I’m running out of options here,” you know. “I’m out of the military, I’m at home, so I give up, I’ll go talk to somebody.”

I didn’t want someone in my business, following me around, or telling me I can and can’t do stuff because of whatever is wrong with my mind, or how I was feeling. And because I knew that I was going to be stuck in the Army for a year and a half, to get medically separated out, it was like, “I don’t know when I’m getting out of here, and I don’t want to be babysat.” I’m not gonna kill anybody. So I just didn’t need that additional problem... I regret not getting help earlier because I lost money out on that. And then too, maybe it could’ve helped. I see how the help I’m getting now is beneficial. It’s not perfect, but better than nothing.

The SRP process is kind of like a series of stations, where you check off all the things that need to be taken care of before you deploy... I remember in 2-5 Cav at Fort Hood, they were trying to send soldiers to SRP who obviously shouldn’t be there. Soldiers on crutches, soldiers with profiles, soldiers with all kinds of medical ailments, or reasons why they shouldn’t deploy. Valid reasons that would stand up anywhere else on the planet, except in the Army. And they would send them to SRP, and try to get that stamp, so they can get on the plane. And in one case, SRP folks, the civilians that were here had to step in and say, “Why are you here?” Like, “Yeah, my NCO says I have to be here. Even though I’m on crutches, obviously.” And she made some phone calls and took care of that. Another guy, this guy walks on a cane, he had I think a profile that says he wasn’t supposed to go. But they came to his room, and scooped him up, and made him go up there anyway. They made some phone calls and got his stuff fixed.

We asked General Campbell this question during the first town hall meeting, back in January of this year—we asked him how soldiers slip past the SRP process, if they were non-deployable one day, and all of a sudden you needed them, now they’re deployable? How is that possible? And they said that, “Well, those individual cases go to the Brigade Surgeon, and he’ll sign off on that if he thinks that it will be okay for them to deploy. You know, you have a profile, but you can deploy.”

And then, I think that we talked amongst a bunch of soldiers, and we said, “You know, we’re not buying this.” Because it’s another one of those cover-your-ass statements. And later on, I think I asked a question, worded it differently, and I got a different answer on my Facebook than from the town meeting. And they said, ultimately, profiles are just recommendations. And if the mission comes up, the mission comes up, and commanders will act accordingly. They said something along those lines. Wow! I wished I would have saved that answer to that question. But pretty much, that’s the way they look at it. If the mission comes up, they’re gonna scoop you up. And I told you earlier about that case of how a guy who had mental health issues, that deployed, and you know, he ended up killing somebody.

I had a back issue [on deployment], they gave me some muscle relaxers. But we were so short-manned, I still had to pull security while I was on muscle relaxers, that didn’t work out that well. I was really, really high at work, with a loaded gun. But, we didn’t have any bodies, so I had to do what I had to do. But a profile, no.

I never got a profile [on that deployment]. We were so short-manned, and we had this E-6 for a doc. We were in the middle of nowhere in Iraq, we didn't even have electricity for a good amount of that tour.

When I came back, I changed units, changed MOSs. That was everything. 'Cause the new unit I went to, we did more PT, and I ended up getting hurt and just went downhill from there.

...We had guys [in Iraq] that had families back at home, and they're having a hard time coping with that and trying to do a constant, non-stop job there. But from my memory of that whole year, for the most part, we just had those guys who were having a hard time...

Most of that [deploying people with injuries] I saw was here at Fort Hood, sending guys to Iraq. When I was in Germany, and we were sending guys to Iraq, that wasn't so much of the case. But here at Fort Hood, I saw a lot more of that. Now, there was a medic that got shot in the foot from his last deployment, he was still messed up and non-deployable, but they sent him anyway. They were trying to scoop up everybody.

And as for morale, I don't know how they felt while they were in Iraq, I talked to them before they left. And they were pissed off and were like, "Ahh, clearly I'm messed up, why are you trying to send me?" They tried to fight it, but they got sent anyway. I don't know how they held up while they were over there. I talked to one guy, that same medic, and he says he's doing physical therapy in Iraq. And the only reason why he could do that, is because he worked in an aid station, 'cause he was broke anyway. So he just did his physical therapy while in Iraq.

When I was at Fort Hood, there was a lot [of substance abuse]. Usually prescription drug abuse, because there's such an abundance of it, and everybody has had medical issues. And a lot of us are taking the same stuff. Some people got stuck on it. And they would have to buy it from other soldiers, and what-not. But generally, you had spice, a lot of that going around. And then, of course, the usual alcohol abuse in the Army. That's a normal thing. [In Iraq] people were smoking weed and drinking too.

Some guys who were relieving us toward the end of our deployment, the day some guy showed up, he tried to kill himself. There's plenty of attempted suicides. I had to do a lot of suicide watch, and watch people because they couldn't be trusted to be alone. Because I'm on profile, so, "Hey, watch this guy. For like, 24 hours straight, or 12 hours straight." A lot of that... my neighbor, when he was in Iraq, one of the guys that was in his platoon killed himself. And he was the first one to get to him.

Editor's Note: Curtis continued by reflecting on what the command response to the suicides and suicide attempts was, in Iraq.

Of course, the ridicule, the whole stigma deal. You're only doing this for attention, or you're either trying to get out of work, or trying to get out of deployment. It's always some nonsense stuff they throw out there. I don't think anybody even bothers to really assess the person's situation. 'Cause generally, you just become a giant headache and a hassle to the chain of command, and

everybody in there, because it's like, now we have to do an SI, that's a serious incident report, we got to explain to the man above the commander about what happened, and it draws attention to your unit, so everybody gives the person crap. Nobody really cares about the actual soldier who tried to end his life. That's irrelevant. Just look at all the hassle that came on him. And then you have to babysit the guy, and make sure he gets to the shrink. And it's not a hassle to me, but it is to everybody else. I understand that the guy needs help. But to everybody else it's like, "F-you."

There's no support. That's why I didn't even bother saying anything until I got out. And then, when I went to go put in my claim, the VA, they're like, "Why didn't you seek treatment before you try to put in a claim?" And I was like, "Yeah, I just didn't want anybody up in my business." That didn't help my case at all. In fact, my claim got denied.

...When we came back from Iraq, we did the same process [in R-SRP], going through all the different stations to be sure that your pay got started back up, and all that good stuff, you were checked out. And then part of that was to go and have a little sit down, one-on-one with the shrink, just to see if you needed additional time to talk. She would ask you a series of questions. "Did you fire your weapon? Did you see any bodies or blood, or anything like that? Are you feeling okay?" That whole deal. And it's pretty much if you have some issues about what you saw or did over there, there's your opportunity to say something about it. But we were encouraged not to say anything. Because we were told that if you were to say something, your leave would get held up. They wouldn't let you go on terminal leave.

So generally, we didn't say anything. In fact, I remember an E-6 told us before we went, he told us the same thing again. I had a friend who said everything he had to say, I think he went on his leave no problem. But we were just encouraged not to say anything. They figured they were doing us a favor. By, "Hey, if you want to go home, for 30 days straight, without any interruptions, or no hold-ups, push through this, so you can finish up and go."

...At the time, I was fine. And I was anxious to get the process over with. You were gone for a year, and you finally get home—well, not home, but your Army home, and then it's like, "Hey, we're about to get some time off, let's push through this." I answered truthfully. Because over time the stuff starts to grow on you, and you realize things aren't really the same. And I've talked to other people, and I was like, "Wow. They're going through the same thing I'm going through." In my case, I was fine, as things unfolded. The later down the line, stuff grew on you, and you see how it actually affected you.

...Every guy I talk to says the same thing. And it surprises me, 'cause I'm not expecting them to say it. Like, they'll bring it up to me. That's happened in conversation. Like, "How in the world?" I'm going through the same thing. It's like, "Okay, this makes sense now." I thought I was paranoid.

I don't know [what] would really be beneficial. Just because the way the Army does things. When the Army asks you, "How are you feeling?" Those things never work. It's pretty much, they should encourage soldiers to be vocal about how they're feeling. You know, "Hey, if you want to talk to somebody, here's the resources to do it." And then, when they do decide, don't give them any

crap about it. That is the best way to handle that.

But if you try to push it on us, push it on everybody in a blanket-style fashion, a lot of people are gonna say no. Because then, people are gonna know—they might know that you're talking to somebody, or the consensus of the group is, "Get out of my face," and "I don't feel like dealing with this." But if you know something's not right, and then they introduce you to the resources available, then you could hop on it, assuming there's no stigma attached to it. If there was no stigma, a lot more people would be getting mental help and medical help.

When I think about it, there is never really a briefing about [PTSD]. What it is is individual symptoms that would get you hemmed up. They want to tell you to look out for those, to avoid you doing things that would get you in real trouble. That's what the main thing is, the Army covering their ass again. 'Cause I mean, PTSD isn't something that's just thrown around at work. You don't talk about PTSD. Even in briefs. It's always, "Don't drink and drive." "If something's gonna piss you off, walk away." So practically never does PTSD even come out of anybody's mouth, at least from the command. [With soldiers] it comes down to individual symptoms of, "Make sure your battle buddy doesn't do something stupid." Actions which are probably caused by PTSD.

When I put in my claim, back in early 2011, I went to a shrink. He asked me a series of questions. I don't remember. I just know I didn't get a diagnosis of PTSD, I got a diagnosis of anxiety. And most of the questions weren't even deployment-related. It's pretty much, "How do I feel about this, and how do I feel about that? And does this make you angry?"

When I went to my shrink at the VA, we really delved into it. He just gave me the opportunity to talk about how I'm feeling, and how things affect me. And that's when I got a diagnosis of PTSD. And I go to his group once a week, and I got an appointment with him tomorrow. But while active duty, the phrase 'PTSD,' that didn't come up real often. There's no real diagnosis for it. Nobody really looks out for it. It's more like actions that would get you in trouble that may be caused by PTSD, that's the main focus. Like, excessive drinking, and then, what happens when you drink too much. Getting into fights, and blowing up on people, that kind of stuff. That's what they're concerned about, making sure that soldiers don't do something that gets them in trouble, because then that comes back on the chain.

Like, literally, PTSD doesn't come up at all. Every safety brief, before a weekend, they'll say, "Hey, if you need to talk to somebody," they'll throw out the resources that are available to you...

I can't sleep. It's been that way for more than a year now. Like, I stay up until I crash, and that's the best way to avoid getting angry and having panic attacks, and spazzing out, pretty much. And I've been doing that for months now. And I went through a gamut of different sleep meds, but I'm tired of the way they make me feel. 'Cause they don't make me sleepy, they just make me feel heady. So I'm lying in bed, spazzing out, feeling groggy, and it's like, I don't need to do this anymore. So I just stay up until I can't stay awake any longer. And I've had sleep problems while I was still active. But it got a lot worse since I came home. And I got anxiety, and increased arousal, is what the shrink calls it. You know, sounds scare the mess out of you that wouldn't bother a

normal person and what-not.

It's weird. Because while I was in, I didn't notice a lot of these things. I just stayed in my room. And I felt like I had control over the situation. I was fine, the best way to call it. Or I thought I was fine.

And now, I get out and I'm sitting in this room all day, 24-7, unless I'm at an appointment. It's weird, because I'm always thinking there's things outside, and I get this increased arousal 'cause of noises outside. I stick to myself. I don't do anything but go to appointments. The rest of the time, I'm sitting at the computer, literally. I went six days without leaving my house, or pretty much talking to anybody, except my mom and my dad, who live with me. And generally, I don't talk to anybody, and I don't leave, unless it's for an appointment.

So you got the separation, and then you got all the little stuff. Like, the shrink talked about re-living stuff you saw. I deal with that. It's not a straight-up flashback. And then, I don't feel comfortable around crowds.

I'm going to school in January. I'm going to try and get as much of this VA stuff done before then, and then I'll go to school in January and use up all my GI Bill, and just take it from there.

Really I lost any desire to [make appointments or prepare for school]. I do the VA stuff because I understand this is how I'm going to make money. And I could use the help too, because I'm really tired of the whole sleep deal, and the paranoia about sounds, and then being really uncomfortable with crowds and what-not. And being in a new place—I'm tired of dealing with these symptoms. So that's the reason why I get help. I guess if I was to have a job, I'm sure this stuff would affect me.

I go to PTSD group once a week. My shrink has offered me some meds, but I don't really want to take any more meds besides my pain meds. Group therapy [helps] because you hear these other vets saying the exact same stuff that happens to you. It's happening to them too. One guy, he broke down a scenario, and I was in the same scenario, on my own. And I was like, "Wow." What happened to him happened to me. The whole deal about feeling like a spotlight is on you when you're in a big crowd, and what-not. And it was extremely uncomfortable.

I mean, I keep to myself, and I go to group, and that's about it. And that's only so helpful. The shrink said time is what's gonna fix my problem. Acknowledging that I have a problem, and time.

Some guys blow up a lot. They get angry... In group, those guys are a lot older than me, for the most part. There's some Vietnam vets, depending on what day group I go to. And all these guys say they've been arrested. They're having flashbacks, or instances where they've blown up because of their temper, and what-not. Like, there are about 30 guys in the room, and more than half of them have been arrested for having flashbacks and what-not.

Editor's Note: Curtis was asked if he has ever dealt with thoughts of suicide.

I have. And it's gotten worse since I've been home. And why, I don't know. I think it has to do with me having trouble sleeping. And because I can't sleep, I end up lying in bed for hours on end, and it's a bunch of craziness, that's the best way to put it there.

I just had more control of the whole situation overall [while active duty]. I don't know, it must've been a subconscious thing. I had my own barracks room. I went to formation every day. And now I'm home and things are so different, you know.

You get ostracized [for being suicidal at Fort Hood]. Your whole chain of command hates your guts because you just gave them a huge headache and what-not.

...[Multiple deployments] is nonsense, of course. As opposed to looking at that individual issue, I like to analyze why people are being deployed, period. Why does this take such a long span of time? I think everybody should play armchair general for once in their life, and analyze the situation, and they'll see that some things don't add up. Just think for yourself. Don't go off of some general, or some guy on Fox News's opinion. You should think about it for yourself, look at the facts in front of you, and just figure it out.

...A lot of married guys, once they deploy, they have issues too. That's like, domestic violence stuff...you hear about it at work. And that's why every Friday, or right before a three or four day weekend, they add that into the safety brief, "Don't beat your wife. Don't beat your wife. Don't beat your wife." They say, "Spousal abuse? You're a coward." They throw out all the stuff to discourage us. But it pretty much happens every weekend.

...If you've been on multiple deployments, you've been in for a minute. You're probably married, and you live off-post...[there are] all these additional factors that come into having multiple deployments. If you've been on multiple deployments, you have rank. So you're not going to get in trouble for a lot of things that a new person would get in trouble for. Like being late to work. That puts another factor into it, too. Plus, the new soldiers live in the barracks. And I see all the dumb stuff they're doing with my own eyes. So once again, the married guys, these NCOs with the multiple deployments, they're off post, so they are better covering up all their mistakes.

And they don't always vent to soldiers, who talk about their issues. I'm sure they have as many issues as new people, it's just that they're covering it up. I wouldn't say dealing with it, it's just more like they're covering it up. And like, the medical stuff, sometimes you can't even cover that up. And they'll tell you. You see NCOs ducking and hiding to get out of physical stuff because they're broke, but they have too much pride or whatever, so they won't go to the doctor. I'm like, "Hey sergeant, why don't you go to the doc? You got this messed up hand, and nerve damage. Why don't you just get out? I mean, you can't even use your arm." And like, "No, I want to retire." And I'm like, "Oh-kay." I saw a lot of that stuff. In fact, my platoon, we didn't have any E-6s, 'cause they're all broke. They're all on profile. Either wounded in combat, or just messed up. They tried to stay in for as long as they could, and then they got pushed out into desk jobs. So then, these new E-5s, these 23 year-olds, are in charge. And they're the biggest purveyors of the stigma for medical and mental health that I was talking about. And they got like, 30 brand new kids that they're in charge of. And it's a giant shit-storm. And that's what I saw with my own eyes,

in the scout platoon.

Back in '09, back a little bit in the past, a few years ago, things were more hectic than they are now. And because it was a year-on, year-off kind of thing. So as soon as you come back from a deployment and leave, you're starting to cycle all over again to prepare for the next one. So you're pretty discouraged from going to get help. People would slip through the cracks, and get a surgery here or some help there. But it wasn't really encouraged, for you to go get help. People would, but still not like people really getting serious about taking care of themselves, that never really happened. Until you just couldn't really deal with it anymore, and you had to.

I think any mental health issue you have just gets compounded [by multiple tours]. I mean, it depends on who you are as a person, how you deal with those problems...the more deployments you have, the more intense your PTSD is gonna be...

And the families—there's a big difference between a married soldier and a single soldier. Single soldiers stay in the barracks, and we all kind of know everybody's business. But married soldiers, they're on another planet. They don't have to stay at work as long as we do. They're kind of just a separate entity. The only time you really hear about their business is when they screw up. Then, their business comes to work. We're told not to repeat their mistakes, pretty much. It's hard to engage how the multiple deployments affect families.

Editor's Note: Curtis also reflected on how multiple deployments affect the military, and its impact on US society at large.

Some people quit. Some people decide not to re-enlist because of it. Some people would rather be deployed than not deployed, and I understand that because I said the same thing when I was younger. Because garrison life isn't that great.

It doesn't affect society at all. 'Cause society doesn't think about this war, and the media doesn't really talk about it. Unless there's some incident that affects peoples' emotions, for example, some Marine pissing on a corpse, or somebody got raped, or there's a rape scandal. That's the only time they talk about the military, and most people have either forgotten about the war, or it's in the back of their mind. So really, multiple deployments don't affect society at all. You know, if your brother's in the military and he's been deployed four or five times, if you're in contact with him he'll tell you about what he's been dealing with through all those years of his multiple deployments, so it might affect you. But society as a whole, it doesn't affect them at all.

It's not on their mind at all. I've been working with these clown Republicans here in Georgia since I got out. I'm a Libertarian. So I tried to steer that party in the right direction. And these people, they're really pro-military. But when it comes down to the well-being of the soldier, they don't care. And that's how a lot of people are. Everybody supports the troops, but when we go to say what we have to say about the government, then they look at us like we're crazy. When we point out the short-comings of the military, when it comes to taking care of people, people aren't putting it together to formulate that picture of what the military's really like.

The rigors of deploying, combat, that's a huge cause of trauma there. That, with a little bit of military culture, and all of the downsides of the culture. I think those two things are the biggest, right there. Toxic leadership is the third one. Those three things are the biggest causes of trauma there. Because if something happens to you and you have good leadership, that incident can't go from being traumatic to nothing, but it could be a learning experience. Something bad could happen to you, you could learn from it. But if you have a horrible leadership who's not supportive to you, then it could turn into the most traumatic thing in your whole life. I mean, that's how important leadership is.

War is war... I know that counter-insurgency is a harder type of war to fight, just because there's no real gauge of progress. At least, most people don't recognize the things to look for to gauge progress. Because you're just moved around all the time, and for your average soldier to really understand it, they'd have to care. And generally most people don't care, they just do what they're told, and they don't look at the whole picture. But really, it's hard to gauge progress, that's the biggest thing. There's no line. You're not taking dirt, really. And if you do take dirt, you're gonna give it right back.

If you really look at it—and most people don't—it kind of feels like your work and your effort, your blood sweat and tears, are wasted. Because you're working with people who don't want you there in the first place, who aren't that helpful, and probably work for the other side, it's almost guaranteed. And it's like, “What are we doing here?”

After my guys got blown up in the second month of our deployment, that's where I began to say, “What in the world are we doing here?” I started to question every individual mission. And I was looking at the purpose of every individual mission, and it's like, “Okay, well let me go check on the Iraqi police to see if they need anything.” And in the process of doing that, going from our FOB to their outpost, we're probably gonna get blown up. There's a good chance of that. So it's like, why are we even risking ourselves? These cops are dirty, they fire their police chief every month because the one they hired is dirty. And then the new one's dirty, and the new one's dirty—that actually happened two times. And it's like, “Well, what's the point? Why are we even doing this?”

To cut the trauma, you have to just stop the wars. On every front, pretty much. And this doesn't even include Military Sexual Trauma. That's a second battle altogether.

There's actually a lot of injuries depending on what you're doing. That's why I was hesitant to do certain kinds of work there. There's always somebody who's more willing to do work than I am. So I'll let them hop on it. Like, messing with vehicles and what-not, and moving armor. When I was in artillery, we messed with these hundred-pound hallitire rounds, they're a hundred pounds a piece, and we were moving tons of ammo by hand at any one time. And I watched people just fall over, 'cause they couldn't do it anymore. And they would just push them out of the way, and get somebody else in there to move it. I've seen guys get their fingers smashed up and all kinds of stuff. And nobody really cares.

TBI is interesting, because I didn't hear TBI briefed until a few months before I got out. And when I got it, I was actually impressed, because the only time we'd talk about TBI was at Under the

Hood. We would talk about TBI, and it would come up in conversation, when we're talking about the Operation Recovery campaign.

So finally, for about five years of me being in the Army, they finally had them give us a brief about TBI. What to look for, how you could get it, symptoms, what you should do if you think you got it. And then, they started asking questions. "Have you been hit by an IED?" They would get people to sign their names if they'd been hit by an IED, and the time-frame in which they got hit, so they could start assessing who potentially had TBI.

Now, we'd been in this war for 11 years, and let's see here—2006 all the way until 2011—2011 is the first time they ever gave us a TBI brief, no joke. Before that, you had to come to them. And that's just soldiers talking amongst each other to say, "Hey. If you've been hit by an IED, go check to see if you got TBI." And that was like, in the Med Board platoon, 'cause at that point we were all trying to ensure we dotted all our I's and crossed our T's, to get our percentage up, to get medical retirement. So we would be sure we didn't have that, for guys who had been hit by an IED.

I have not [taken the ANAM]. I never have been hit by an IED. The guys in our brother platoon, they got hit. We helped them out. But I, personally, was never hit by an IED.

...We would get [sexual assault] briefs, rather often, and eventually the Army switched over to just having these DVDs, where they would pitch the scenario of soldiers at a party, and there's a female soldier there. And there's a scenario where the soldiers didn't intervene, and then what happened. And then, they had another scenario with the same soldiers remembering the incident that happened, and this time they did intervene, and how that made a difference. Kind of similar to how we should look out for our battle buddies, and that whole deal.

But through the whole time I was in the Army, we always treated this whole topic like a joke. No matter what the training elements or aids they used to try to convey points to us, we always treated it like a joke. The only person that took it seriously was the guy giving us the brief. 'Cause he had to keep a straight face and tell us this stuff, just to say he'd did it. We would sign papers saying that, "Yeah, we went through the training." And lots of NCOs, the guys with rank, will pop into the room and sign the paper saying they were there. And then they'd just leave, while everybody E-4 and below would have to sit through it. And part of the problem is the fact that the whole culture of treating it like a joke. In a combat arms unit, everybody's a male, and we're talking about sexual harassment, and we're like, "Get out of here." You know, "This is nonsense." Nobody takes it seriously. That's a big part of the problem.

It's kind of hard to gauge, just because I'm in a combat arms unit, and there's just not that many females around. And what happens outside of work, unless somebody screws up, for the most part I didn't hear about it coming back to work. They would tell you when you show up at Fort Hood how bad sexual assaults are on post, and you'd be wary of that even if you are male. And then, we would keep getting briefs about it, but we would never take it seriously.

There's already a no-tolerance attitude [for sexual assault] by our chain of command. I guess, the

only extra thing that I could think of is just to reiterate that it's not a joke, we should take the training seriously... Now, outside of what I saw with my own eyes, I know that sexual assault and Military Sexual Trauma is a serious problem, and I hear of cases where leadership sweeps it under the rug.

Editor's Note: Curtis was asked for his reflections on how the command handles cases of sexual assault.

I look at the way our chain of command handles every other situation, and how they just miserably fail. Just to ensure they don't look bad, they sweep things under the rug all the time. I've seen officers straight up lie, and have NCOs get busted for their lies. So it wouldn't surprise me at all to hear them sweep a whole incident like that under the rug. And, in my eyes, no Commissioned Officer gets any credit until they prove that they are a legitimate person.

On my own, I took the time to research resources that were available to people for other things, and they also cover that side of the fence too. And they would tell us our resources available, but the only time when the specific rape counselors or more counselors who handle that stuff, that only came up during the brief that we had that pertained to that. So that information wasn't as widely distributed as some other stuff.

The military, they take Military Sexual Trauma more seriously than they do actual combat trauma. Hence, how we actually have briefs dedicated to that topic rather often. And everybody moans and groans and tries to get out of it, but if you're a soldier E-4 and below, you ain't getting out of it. If you're an NCO, you can pull some strings. Combat trauma, you're not gonna get a brief on that one. We just recently just started having those TBI briefs, one. I don't know how often they're gonna have them.

The VA, my shrink was telling me about he was appalled by how much he hears about it, from female vets...he sees a lot of it. And he's there to help people with it. So when it comes to mental health stuff, the VA is available. You might have to wait a little bit to get to see the shrink, but they're there. And while you're active, there's resources that are available to you pretty much 24-7.

Editor's Note: The interview turned to address Curtis's lengthy process in MEB, and his continuing struggle to access care after discharge from the military.

[My MEB] started with bilateral arthritis in my left and right ankle. And then, the Army says I have flat feet, and that's what they pushed me out on. It started with the temporary profiles, because it wasn't going away, obviously. And I had to keep getting them renewed, and renewed. And as I was renewing them, they would tack on additional steps to help me out, like, "Here, we'll confer to analyze what's bothering you, and we'll give you x-rays, okay? We looked at these x-rays and you came back to us, so you know what? We're gonna give you a MRI. And then you came back to us again and hey, you know, you're jacked up, we'll send you to the podiatrist, and we'll send you to physical therapy." And the podiatrist appointment was way out there, and I ended up going to physical therapy first. That made me worse, of course. And I saw the podiatrist, and they're

like, "Oh, no!" No, it was the MRI, that's what it was, the MRI. I finally got my MRI results one day, and the physical therapist looked at that and said, "Oh, no. You're not supposed to be here, because this will make you worse." And I'd been going there for a while.

But as I'm going through this MEB process, I went through all these steps, and eventually the podiatrist said, "What do you want to do?" And he gave me three choices, "You can get surgery, which I strongly don't recommend. You can change jobs. Or you can get out." I picked get out. Because I'm not trying to keep up with some 19 year-old kid when I'm broke. It's just not happening. And at that point, I was done with the military anyway, because I saw the nonsense in Iraq. In addition to that, I see how they treat people who are hurt, even people who were wounded in combat. They treat them like crap. Finally, I was done. So I chose to get out. That started the MEB process.

It really started the last week of 2010. And there's just so many steps, and so much waiting. I can't even remember everything that happened there. But through that whole time, from after I went to the podiatrist and said, "Hey, you know, I give up, and I want to get out," I didn't get any treatment. From the time I said, "I want to get out," until the time I got home to the VA, I didn't get any treatment. All I got was drugs. I did get ankle braces, and I did get inserts. But once again, that's not really treatment. I didn't get any treatment. Until I went to the TriCare doc—I got a referral off-base to the hospital in town [from the podiatrist]. He offered all kinds of treatment options, but at that point it was already time for me to get out of there, so I couldn't take him up on all of his offers.

The PA, the first guy you see, referred me to the podiatrist. And this is after several trips. This is me not working the system, but really dotting all my I's and crossing the T's, because I had a goal, pretty much. Because I knew I wouldn't heal up, and the doctors told me this later on, "No, you're never gonna get better. You're never gonna get back to where you were." So I was like, "Well, if that's the case, I'm getting the hell out of here." So I had to continuously stay on them, and keep going, for them to figure it all out and realize, "Hey, this guy's messed up and he needs to go."

The confidentiality's on you. If you want it to be a secret, sure, you can keep it a secret. But if you want to avoid being put through all kinds of physical hassle, and being sent to the field or being sent to Iraq, you better start talking, to put out that you have something wrong with you. So really, there's no confidentiality in the Army. If you're female and you have female problems, I think maybe you can get the confidentiality, but if you're a Joe in a combat arms unit, oh no. Everybody's gonna know your business. In fact, it's in your interest for them to know your business, 'cause then they'll leave you alone.

...I had to get my commander to fill out a survey on me, to figure out how messed up I am from his perspective. And I read it, and this guy pretty much said there's nothing wrong with me, I need to be returned back to duty. Yet, I got a stack of medical evidence saying otherwise. Saying I got deformed bones, and bruised ligaments, and all this other stuff. And he didn't even know the situation.

I don't even know why they bothered to give that paper to the commander to fill out. In fact, I had to practically hand-carry it to the man to get him to fill it out. And you know, he didn't even know me, that's another thing, too. He's a captain in an office, I'm a dude who works out in the field. So he just checked some boxes and said there's nothing wrong with me. And that's the commander, and then you work down to all these different levels, first sergeant, platoon sergeant, squad leader, first line, and they're not supportive either. I had a first sergeant in the beginning, he'd understand, you've been in for a minute, you're hurt, whatever, here's your profile, that whole deal, I respect that. But then I changed first sergeant, and that shit went downhill. Plus, my platoon sergeant, he wasn't supportive with anybody. He cussed me out big time, several times, because I couldn't hang in the rounds, because I got nerve damage in my ankle. But that didn't bother him at all. That's when I was going in between profiles and what-not.

...The WTU at Fort Hood, that thing was filled up. They weren't taking any more people—they sorted through all the cases of people who'd applied, and there's too many broke people, people who're wounded and what-not, screwed up. And they just weren't taking any more people. So that meant that our unit was in Iraq, and all us broke folks had to be the Rear Detachment, who had to stay back in our unit. Now, we couldn't do anything, but we were left behind. And because we were left behind, they kept tasking us to do normal unit tasks. It's like, "Well, on paper it says you got a hundred and two guys here, so they're capable of doing everything," that's their assumption. And they know we're messed up. They don't care. So they just pass it off onto these battalion commanders to force us to do stuff.

Looking at the resources the WTU was using, and then looking at the resources I was using, we're sharing a lot of the same medical resources. Medical care would've been the same. But my day-to-day life, while being injured and going through a Med Board process, would've been totally different. Because if I had been in a WTU, I wouldn't be responsible for any maintenance of any vehicles. They wouldn't try to violate my profile because they understand that, "Hey, I'm messed up and I'm here for a reason."

In 2-5, you have to explain your existence every day. It's like, "Look, I'm hurt, this is the reason I was still in the Army. My Med Board process is here"—you got to constantly explain yourself, every day, to the same person sometimes. And it just goes in one ear and out the other, and you have to explain to them again later on. 'Cause they're expecting you to back down, because the whole Army is run by intimidation. So they keep trying to flex on you, and if you don't flex back, you're gonna be in some crazy situation. But yes, you would be way better off in WTU if you were messed up, and not everybody could get that.

Editor's Note: Curtis was asked if his injuries were determined to have been incurred in the line of duty.

Yes. But I didn't get them in combat, so that meant the money situation changed because of that. They paid me a chunk of money, but I have to pay it all back, because I wasn't hurt in combat. And it sounds far-fetched, but it's pretty legit. 'Cause I owe the VA \$18,000 now.

I have to pay back my severance pay. I have to pay them back the money they gave me. 'Cause

they gave me a lump sum...it's a lot to explain, but the best way to put it is like this, if you're 30% disability, you're medically retired, and you get free health care for life, and you get whatever 30% equals out to. If you're less than 30%, they're gonna give you a lump sum of money. And then another stipulation of that lump sum of money is if you're hurt in combat, you get to keep it. If you're not hurt in combat, you have to pay it back.

Oh yeah, and then if you're less than 30%, you only get the health care, TriCare, for six months. It's a raw deal. And I found out that I should've qualified for 40, at the minimum. That's just counting one thing that's wrong with me, not including anything else.

That's how it stands at the moment, but I just put in nine claims, two weeks ago. I've spent six months working on these claims, gathering evidence, appointments every week for months. So I'll be alright, it's just gonna take a year, maybe a year and half, to finally get that pushed all the way through. And some of that stuff may get kicked back, and then I have to do more—get more evidence, and fight that stuff. And it's gonna be a long battle, but I'm not at a complete loss. It started really bad, and I did lose out on free health care for life—or really, the title of medically retired, 'cause I still might get that free health care, if I get my percentage up. It's just gonna be a fight, and it's gonna be some time.

And then, I'm not getting any money until I pay back that \$18,000. And really it's \$20,000, but I've paid back a chunk of it by now, a little bit of it. And what it is is it's being paid back at the rate of about 240 bucks a month, so I got a document from the VA saying that they will be paid back completely by 2019, at the rate that I'm getting paid now. So I won't receive any disability until 2019, and I can't get unemployment until November, so I'm broke. Honestly, I'm living off of a credit card.

Part of that, too, was me being irresponsible with the money that they did give me. But really, I mean, considering everything that's wrong with me, and the money they gave me, it would be a difficult thing even if I was responsible.

...I'm messed up for life. I really can't do much. In fact, alls I do is sit in a chair all day long. Not that great.

Editor's Note: Curtis also shared some reflections on how the draw-down is playing out in combat arms units.

...They doesn't necessarily say, "Hey, I'm gonna save everyone some money by kicking this guy out." What it is, is they want to thin the numbers out anyway. And if they have a reason to cut somebody, and they don't want them, it's a point for them. Some people, some leaders, just take pride in firing people, pretty much. They brag about it—they put that shit on the NCOER, their evaluation report. That, "I canned eight soldiers in a month," like it's an accomplishment, no joke.

Some soldiers, obviously they do need to get fired, and the Army's not the best about firing people. Again, I've seen the process evolve since I've been in. If they're stepping up again on firing people, they're kicking out guys that they group as being overweight, and those who have

patterned misconduct, there's a lot more of that than when I came in. 'Cause when I came in, they would take anybody. Felonies, whatever crime you could think of, it didn't matter, they would let you in. And now, they're kicking people out left and right. And including people who are wounded, and are trying to get medically separated.

Because they're trying to push people out, 'cause the Med Board process is long, and you can't do anything, so they just want to push you out as fast as possible, and they threatened us with that all the time. Saying that, "Oh, you Med Board people think you're untouchable. You're not." And I saw several guys who missed too many appointments, and they get Article 15, and you miss another, you get another Article 15. I bet it came out to one appointment, one Article 15. And they'd try to kick people out for missing three or four appointments, it was that serious. Some guys actually had PTSD, and they had TBI, and they were having issues remembering and what-not, or sleeping, that's another thing. I saw that a lot. Guys on crazy medication, not being able to show up to work on time, getting handed up.

We had a Med Board platoon, and we had a chapter platoon. And the chapter platoon, we had some pretty bad kids. And bad kids in the sense that they were constantly messing up. They were so bad that their platoon sergeant told them, "Look, if you guys come to work on time, I won't make you do any work all day. You don't even have to stay at work all day, you just have to show up on time, that's all I ask." So us Med Board kids with profiles are looking at these guys like, "How come you guys are in civilian clothes in the middle of the day, and how come they never have to come to work?" And their platoon sergeant gave them that incentive, just to get them to cooperate. But yeah, that's the deal with those chapter kids. And the chapter kids get kicked out for all kinds of reasons. And there's more than what I saw earlier in my Army career. A lot more, what I saw in 2-5 Cav, than I did in Germany, in my old unit. I have seen some legitimate cases of guys with PTSD doing various things that lead to patterns of misconduct.

...I don't think any of us are really prepared [to work as civilians]. And I'm speaking, once again, from the combat arms perspective. Because it's not like people are trying to hire a bunch of Infantrymen or scouts, or anything. Generally, all those combat arms guys have to get new skills, if you didn't have skills already. If you weren't mechanic or something, you know. So pretty much as soon as we get out, we're already screwed. We have to immediately go get new skills, unless you go back to the job you had before you came in, or something.

Most of the time, I like to talk to new soldiers, to figure out, "What on earth caused you to join this organization?" And they'll say the same stuff all the time, you know, "Uh, I needed a job." I hear that a lot. And then, every once in a while I meet someone like myself, like a version six years younger, that says dumb shit like, "I want to kill people."

...I have a unique view on racism. And it's kind of like racism only exists if you let it bother you. I understand that there's situations where it could really affect you, because someone over you is racist, I get it. But generally, 99.9% of the time I'm in the Army, almost a hundred, I didn't experience this crap. And there's a lot of minorities who scream, "Racism this! And racism that!" But really, whenever that comes up, I guess the person who calls racism needs to do a self-check, and evaluate themselves, and see where they could potentially be wrong, to see why

somebody would come down on them, if they have more rank than them. And that's just how I feel about that one, racism.

And in terms of gender, once again, I'm in a combat arms unit, so there's practically no females around unless they're in a support kind of role. And well, the consensus is none of us like females at work, but that's just the way it is, because obviously, they're treated differently. They got different standards they have to adhere to, and it's like, the Army's supposed to be equal, but there's different standards. That's how that works in a combat arms unit.

It's a fact that minorities get extra points when they get up to the rank of E-7. They get an extra bonus when the Department of the Army looks over their records there, to see who they're gonna promote—it's not affirmative action, but they try to balance those numbers out. So that the senior non-commissioned officers, the minorities are represented in that structure. So you're always gonna see more minority senior NCOs—not more than your average white person, but you'll see more than represented. What that means is, you'll just see more of them in the force. You'll see more black E-7s than black E-4s. Depending on what job you're in, that's another thing. In combat arms land, in my first unit, there was three black privates in the whole battery, that's like, a hundred-plus soldiers. But we had three black platoon sergeants, and the first sergeant was black. So that is set up that way. More minorities could join, enlist in combat arms, but they don't. And to have representation in the senior NCO ranks, those minorities get boosted up.

Pretty much almost my whole time, except the last six months, Don't Ask Don't Tell was in effect, and pretty much most folks always kept that stuff to themselves. So I never saw that kind of discrimination, 'cause no one ever came out. And me personally, it doesn't bother me at all. And most folks don't really care, at least the smarter folks understand, “Guess what? They're here, whether they out themselves or not, so just deal with it.” We're more concerned about the possibility of females being put in the same positions as us, because that would be a problem. At least, that's the way most of us see it. Just because it would change some things... I believe in equality, but I also believe you should have the same standards.

Because those standards are pretty much why we're getting cursed at and screamed at all the time, is 'cause either we're not meeting the standard, or we're not meeting the fantasy, made-up standard, 'cause there's a lot of that. In combat arms units, they just make up these crazy standards that we're supposed to adhere to, and we're all supposed to be on this level that's way better than what the Army expects of us. So if you have some other demographic in there, and they're on a different set of standards, then it doesn't make sense.

...You're always told while going through Med Board process that, “Hey, if this is bothering you, you can get that fixed when you go to the VA, after you get out.” They kind of push you off the VA before you even get out. That is the biggest crock of nonsense ever. It doesn't work that way. You are supposed to get everything, as much as humanly possible, even if you just think you have something wrong, you get it looked at while you're active.

The VA service is just as bad as the Army's service, really. Sometimes it's even longer wait times, and then you gotta factor in the fact that the hospital isn't down the street because you live on

base. Oh no, the hospital could be hundreds of miles away. That's something you gotta factor in there. And then, you gotta factor in there's a trillion vets that are trying to get the same service as you, so I had to wait four months for an MRI, and I couldn't get anything done for that issue until I got that MRI. I had to keep calling and nagging, and I got it bumped up to three months.

...I'm going downhill, honestly. Because I got my PTSD symptoms that came out of nowhere, practically. My sleep issues have flared up more. It's been a rough adjustment [to civilian life]. It's not as easy as you would think it is. And with my medical condition and my mental health conditions, really I'm not even that excited that I'm out. I'm getting nothing out of being home, really. Just bills, and debt. Because I don't have a job anymore.

...I feel like I got so many issues that my main focus is not day-by-day, but almost. I focus on gathering evidence and taking care of my VA stuff, trying to get to appointments on time, and try and look at all the resources and benefits that are available for me. And talking to more people, trying to figure out, "What about this? What about that? What about this?" And not everybody knows everything, so you have to keep on staying on it, to make sure you don't miss out on anything.

...And how stuff changes, is when people start calling it out, and putting pressure on the Army. When the Army gets a spotlight on them, and they start to look bad for falling down on the job. And people are like, "Oh, you're bad-mouthing the Army!" And I'm like, "This is how you make things better. This is how you improve a situation." Honestly, this stuff is one of the few things I miss about the Army, is going to work and butting heads with NCOs every day for them falling down on the job. Like, I would speak up for other people, "Hey. Hey sergeant, this guy has a profile, what's up with that?" Or, giving them command policy. They end up getting the same one over and over again, every time they violate it. And that's how you reinforce the point you have to say.

Editor's Note: Curtis also participated in a separate interview about his participation in soldier and veteran advocacy during the Operation Recovery campaign.

I was interested in IVAW since when I came back from Iraq, in 2009. I was in Germany at the time so I couldn't really participate. When I came to Fort Hood I was interested, and then Aaron invited me to come to Under the Hood, and I showed up one day.

[That] showed me it was an active organization where people are outreaching and doing stuff. I was embarrassed that I never left my room. So it was a huge mountain to actually leave to do something that wasn't work-related.

...I'm doing what I wanted to do for a while, which is try to change the Army. Now, I know it's hard to stop a war—that's what drew me to IVAW. But Operation Recovery is just as important as stopping the war, because even once the war ends soldiers are probably not gonna get taken care of. So the goals of Operation Recovery are really important. Not just because I'm broke. I see this Army-wide: people aren't being treated.

...We don't want guys to be messed up? Let's not go to war. It's not a direct approach but ultimately it chips away at their power structure and causes them to re-evaluate what they're doing, especially when we put pressure on them. Because the public cares about their troops too to an extent, and the best way to get them to join our cause—and our antiwar cause—is to expose how soldiers are being treated. It makes the Army look bad, and they would really lose support from the public if people knew how soldiers are being treated.

Lori has gotten us a lot of interviews: news, newspapers, internet articles, which is really good. I feel like I'm directly chipping away at the Army power structure by getting my opinion out there. I'm fighting the Army by getting into the media, which makes my voice so much more powerful. We also did a Veteran's Day march that created more exposure that the Army is not a wonderful organization.

...I think it's important to talk about demographics here too. Because this whole stigma, this discrimination against broke people is serious. It's almost like race issues in the '60s, because if you're broke you get treated totally differently, and that's part of the reason I'm passionate about Operation Recovery. You get ostracized, you get treated differently. It's terrible...

...I want Fort Hood to be right here, everybody's on the same page of music. I want as many willing people to come here, make this their hangout spot, support what we do, and for us to support them. I want us to be an actual community, instead of having this big divide between on-post and off-post.

I talked to a staff sergeant today while I was doing outreach. He told me that I shouldn't tell soldiers about their rights or tell them about different resources they have available to them, because he said the soldiers are misusing what I'm saying, and they're trying to take advantage of the system through what I'm telling them. I don't think that's true at all. The problem is that soldiers' NCOs are failing them, and soldiers are having to use other resources to take care of themselves. I think one person doing outreach like this can really rock the boat, by letting soldiers know about resources they don't know about.

...They talk to us constantly about sexual assault, and suicide. If they started to talk about profile violation at the same level, that would be a success. If a soldier comes in here and says, "Hey, we just had another fucking brief about profiles," that's a success, because we put pressure on them and they reacted. Even if they just reprint the same policy and got people to talk about it, and put it up where everybody sees it, all these NCOs see it, and the main profile violators see it, that would be a victory right there. For sexual assault training, if they would actively take steps to make people take it seriously, that would be a success.

The other campaign goal is to reduce stigma. There's a policy, SURG-01, that covers stigma for mental health care, but it doesn't cover physical health care. If they would ban stigma for mental and physical care in one document, then that's a success. Or if a new command policy comes out all together that pertains to that, that would be a huge success, because the stigma for getting health care is ridiculous. If people knew about that they would be shocked. They would want to do something about it.

...By participating in Operation Recovery and being at Under the Hood, I learned about MEDCEN-01 and SURG-01, which I didn't know about before. It's a success that I can carry those policies around in my pocket now and show them to NCOs. It has helped me at work, and made my life easier. A lot of guys have copies of it now, and it's making their lives easier too.

It doesn't seem like much, but you gotta see it. When you're at work and you whip out MEDCEN-01 on some asshole who's trying to make you break your profile: you say, "Hey, this three-star general said that this is policy [not to break soldiers' profiles], so shut up, there's nothing you can do." I won that argument, and that's powerful stuff. Just that alone.



Curtis speaking at a rally in Killeen in 2012

...Soldiers don't bother to read the AR. They don't know what the rules are, they just go off what their first-line supervisor says. So if you can give them the alternatives to that, official alternatives, real information, that's powerful stuff. And that's how you impact somebody's life in the Army.

For me personally, it's really been about knowledge, learning more about how the Army works. Because as a soldier, you feel like a slave with no rights. You feel like no one's actually there to help you. And by us as people, as activists, reaching out to people to let them know that actually there is some support from the Army, that there are some avenues of support that are legitimate —plus our space and advocacy. Most soldiers don't know about those avenues. They talk to their battle-buddies, and to their peers, and people have crappy information or advice that can make their situation worse. So it ends up feeling like you're left alone...

Maggie and Aaron for example, I think they have a great impact on the people who come here. They are veterans who are professional activists here, and they bring so much knowledge to the table on how this works... It's so good to meet people like that. It makes me feel like IAW is much bigger than us in this room, or us in this space, because we have professional activists coming here specifically to help us and to help the community... They do make a difference.

...I want to show my peers, "Look, these NCOS have no power. We give them the power by

consenting to their ridiculous instructions. So you have to butt heads with them constantly, every day, all the time.” Especially when we're right, that's the biggest thing.

I try to lead by example. To show these soldiers that regulations apply to everybody and every rank. Just because he's an E-6 doesn't mean he can make me break my profile. That's why I do what I do. Because (a) I get a kick out of it, (b) I'm encouraging other people to do the same thing, and (c) that's the way it's supposed to be.

7 Cody DeSousa*

Editor's Note: *Cody* is an active duty systems specialist who did not identify his race. He has been in the Army for three years and is on profile for a knee injury.*

I'm a systems specialist, which is a communications job. I've been in for three years, and for two of those years I've been on profile for an injury that doesn't hinder me at all. I ran an 8-minute 2-mile and got a 3:46 on the PT test last time I took it. They came down and told me that I had runner's knee, which is over-exertion of the kneecap. I went in almost 60 times, being diagnosed with the same thing and getting different answers on what was wrong with me—some said runner's knee, some said patellofemoral syndrome, others said I was perfectly fine. So I didn't really know what the case was with my knee.

A few months back I got in a car crash. My knee hit the dash, and right after I had an MRI. That's what really started up the knee pain. I got put back on profile for my knee again. I was still able to do PT and still able to do work, but this time it was a “dead man” profile, just because the doctors felt that's what I needed to be on. I was supposed to deploy two days prior to that incident, and even though my knee was perfectly fine, they decided to take me off and throw me into an MEB status.

Once you're in the MEB all the doctors give you the go-around. Some said surgery, some said nothing, you're fine. So when I was able to get my hands on my MRIs and x-rays, I sent them home to my mom, who is an orthopedic surgeon. She said that I have no ligaments connecting my kneecap to my hip, I have insane amounts of fluid built up in my kneecap, and my kneecap is completely shifted off balance. None of this was told to me by any of the military doctors. Once I got that information, I passed it on to my doctors, asking for surgery.

Once again, it was denied to me, and of course they decided to put me on another permanent profile. I'm not able to do shit, and my unit is telling me that I'm malingering and that I'm fucking around and I'm a worthless piece of shit even though I did my job for three years.

They ask me to break my profile almost every day. And it's happening to other people, too. I remember one time just going down to the motor pool, and just randomly deciding to count how many times I'd break my profile. I broke my profile seven times in five minutes.

Before getting the permanent profile, I would get shit from my NCOs all the time for going to sick call. I would be told I was a shitbag for going and was told that I wasn't doing my job just because of the injury. One time I even fell on PT during a run. They made me run because I didn't

have my profile that one day and my knee just completely gave out on me. They said that I was faking it, so I had to get up and walk around and get back in the run according to the NCOs. Obviously the next day my knee was completely swollen and purple, so I had to go in to sick call again, where all they gave me was pain medication and sent me on my way, saying no it was fine and would be fixed in a couple of days.

I've been on every pain medication, from Tylenol to ibuprofen to steroids. So yeah, they denied my surgeries, but gave me narcotics. They would give me any type of pain medication, from just regular old pain medication to arthritis pain medication. But while they were giving me this pain medication, they would also tell me that I was perfectly fine and there was absolutely nothing wrong with me.

When I went to a civilian doctor, they told me otherwise.

What happened to me, where I didn't have a copy of my profile on me, so the leader ignores it, that happens all the time. The NCOs will give you crap about going to sick call—I've always just gone anyway, but other soldiers probably get deterred from going. They're afraid of the way that the NCOs look at them, afraid of being called a shitbag, of being worthless to the platoon, as an NCO would put it. Soldiers—we're pawns. That's really all we are.

Sometimes soldiers get crap from NCOs about going to mental health too. Depends on who you're talking to. A lot of the NCOs in this battalion don't really know what's going on with people, and when you try to bring an issue to them they play it off, thinking it's not a big deal or thinking that it doesn't really matter. But they don't really know what's wrong with that person.

If I had something I needed mental health for, it wouldn't deter me from talking to somebody, but from the NCO standpoint I don't know if they'd actually understand what I'd be trying to tell them. And they would almost definitely play it off like it wasn't that big of a deal or like I was just exaggerating.

Because of the draw-down, the Army is definitely trying to chapter people out for this stuff. Just a couple days ago they took me out of the MEB process without even telling me. They called me into the office one day and my commander looked at me and said, "You're out of the MEB, you're fit for duty. Are you deploying?" The next day, one of my buddies got called into a commander's office and got thrown into the MEB process without even knowing. He was scheduled to have surgery and wanted to be found fit for duty. They denied him that surgery after already verifying that he was going to have the surgery. They did that just to fill a number. With this battalion all it is is a numbers game. If they feel that they need you out, they're gonna kick you out. If they feel they can get a little bit more work into you, it doesn't matter what your case may be, it doesn't matter how injured you may be, they're going to work you until you're fully broken.

All the trainings for these issues, for PTSD, TBI, sexual assault, everybody just sees them as a joke, even the NCOs that give the classes. It's supposed to be a serious subject, but the soldiers and NCOs in this unit don't really think it's going to happen to them, so they just play it off. There are a lot of jokes going around the table as we're going through slides, a lot of off-the-wall stuff

said, and you don't really get the essence of the training.

And I haven't had any training on how to recognize the symptoms of PTSD, or TBI.

So since I'm no longer in MEB now, I'm set to deploy soon. My knee is in better shape than it has been. It's not perfect—I still can't run, I still can't jump, or anything like that but they're still trying to deploy me. I have a permanent profile that says I can't run, jump, or squat. But according to them, they can send me because I can wear gear and live in an austere environment.

But I can't move with this gear on.

8 Paul and Julie Avett*

Editor's Note: NCO Paul Avett* and his wife, Julie,* completed a joint interview. Paul enlisted in 2005, seeking financial help for college and economic stability so that he could start a family with Julie.* Both Paul and Julie are white, in their mid-twenties, and from a suburban area in the US South. Paul has deployed twice, once to Iraq and once to Afghanistan.

Although not in a combat-related MOS, Paul was in the field frequently while deployed, traveling with missions as a mechanic qualified for vehicle recovery. During his second deployment, he suffered a severe blow to the forehead when an armored truck hood fell on him, knocking him unconscious, and causing what he believes to be a TBI.

Paul and Julie have a child, and both describe the Army as a very stressful factor in their family life. As an NCO, Paul feels a profound sense of duty to help take care of the soldiers in his unit, and often goes out of his way to help advocate for them in seeking mental health care, financial support, and other concerns. He describes this as an uphill battle, as his supervisors in command frequently attempt to block or delegitimize his attempts at soldier care.

Originally, [in enlisting] I was hoping for college money, and to set myself up financially. I was planning on getting married to Julie. She was not really for me joining the military. But I didn't want to marry her without having a good job, something contracted. I knew I wasn't really gonna get fired from the Army, at that time. They weren't doing any cutbacks or anything. So I pretty much just joined to start a family.

JA: I begged him not to join. Period. I didn't want to have anything to do with the Army or the military, in any way. I begged him to go straight to college, which would've been the longer route, because he wouldn't be making money right away, the way he saw it. But I didn't have much say in that, so he joined anyways.

Both my brothers were Army, when I originally signed up for Marines, I was supposed to go to MEPS, and both my Army brothers told me they would beat me up. So I switched over to Air Force, because everyone I have ever spoken to in the military says, "Air Force is the way to go."

JA: You get higher pay, better equipment, better respect.



Paul at his home in 2014, holding his enlistment photograph.*

They say it's the same pay across all the branches, but that's for base pay. Your rank pay is the same. But your BAH and your Substance Allowance, everything like that, is higher in the Air Force. They actually make more money, per paycheck. So I signed up for the Air Force, the Air Force recruiter told me I could leave soon, so I quit my job. And we got to MEPS, and they told me at MEPS it would be like four months before I could go to Basic Training for Air Force. And I guess there was an Army recruiter with his ear to the door, and he told me, "I could have you in Basic Training in 10 days." So I walked over there with him, and 10 days after that I was in Basic Training.

...The biggest [health issue] was [my] Afghanistan deployment, in 2009. I was working on the new RG31s, and the hinges that raise the hood, the welds on them weren't that great. So when I raised up the hood and I was working on the vehicle, the hinge snapped, and the 500-pound armor hood hit me right in the forehead. It knocked me off the truck, I fell about five feet on the ground. I don't remember the hood contacting my forehead. I don't remember falling, or anything. I just remember opening my eyes, and I was on the ground. And a couple of people who saw the hood fall were running to me. My immediate leadership was pretty good, asking me if I was okay. They checked me for blood, they asked me if I knew my name, and all of that stuff. They got me up to the [medical station] on the FOB pretty quickly. They really didn't do anything for me, at all. He told me five words, and kept asking me to repeat them. And then, I was able to repeat like, four out of the five words. So he just said, "You're fine. Don't worry about it. Here's some Ibuprofen. You can go back to work."

[I was back to work] immediately after that. But my immediate supervisor told me to go home and rest. But I'm a hundred percent positive that I had a concussion and some type of brain injury from that event. They had no equipment to do a MRI or a CAT scan at the FOB. I never saw a doctor. The person I spoke to was an Army medic, who was a specialist. I don't think he had the proper training to determine whether or not I had a concussion. I haven't been through their training, I don't know. But I do not feel satisfied at all with the care I received from that.

That was about six months in. We were still there for another six months.

When we came home, we had to go through the return home process, talking to everybody. And they asked me if I had head injuries, and all the other stuff. I told them about the event. They sent me over to the TBI portion. They had me fill out a questionnaire, and still never gave me an MRI, CAT scan, nothing. They just said, "Well, it's been six months, your brain's probably healed and it won't show anything. So it'd be pointless to even look for anything." And they sent me on my merry way.

I've had memory problems. I'm not sure exactly how bad they were before, but I know after that, my memory has not been what it used to be. Long-term is not so bad, but short-term memory is definitely not good.

My anger issues got a lot worse after deployments. Headaches, and my sleep schedule's pretty messed up. I can sleep maybe three hours, and get good sleep. And if I go over three or four hours of sleep, I can't get out of bed. I'm pretty sure that's not normal. But I've sought help for anger, and depression, and all kinds of stuff. We had to go through Military One Source where we were stationed before, to see somebody pretty much weekly. Chain of command there didn't like losing me for a couple hours every week, but they didn't stop it or hassle me too much about it.

Here, Fort Hood does not have the resources to deal with it. I mean, it's the most populated Army base. And every time I seek help, they'll give me a number, they'll take down my information. A week or two later, someone will call me and try to set up an appointment. After I tell them I need help, they'll wait two weeks before they call me and try to set up an appointment. And then, when they call me, they'll say, "We have something in a month and a half," or something in two months! And then I'll say, "Fine." And then I'll go to that appointment, and they won't be able to schedule anything for another month and a half, or another two months out. And that's not going to help people, seeing somebody every 60 days.

We did marriage counseling through Military One Source, and I think they approved 10 to 12 marriage counseling sessions. And individual for me was about 20. For my wife it was something else.

We have the Brigade Medical Personnel, that's pretty much a couple of medics, and I think one nurse and one doctor, maybe. I have not been diagnosed with anything.

The ADHD wasn't a legit diagnosis. I mean, we talked to them, and they said, "Well, you could have PTSD. You could have TBI. You could be ADHD." And from what I can gather, all of those symptoms are fairly close together. So at my last base, one of the psychiatrists in the Air Force prescribed me Strattera, which has helped out a lot. But I've never had a real diagnosis.

...If you have an appointment slip, they can't tell you not to go. So they haven't really had any issues they can deal with, other than just being annoyed about losing somebody from the shop.

The only profile I have ever gotten from the Army is for what they've been telling me is runner's knee, for the last five years. Ever since jump school, my right knee has been messed up. And the first time I went somewhere, they said it's runner's knee, and I thought that could make sense. Because we were running seven to eight miles every morning for PT. All we ever did was run. So at first it kind of made sense. They put me on a no-running profile for a little while. It would seem to kind of get better, and then almost right after I'd get off the profile, it would get worse again. And I don't think runner's knee lasts five years. Six years after I'd been in the military complaining about my knee, I finally get to Fort Hood, and they gave me an x-ray. And they didn't even tell me anything about it.

...My current unit hates soldiers on profile. They look down on profiles in this unit, and I think a big part of that is in this unit we've been rear detachment, and everyone who wasn't on profile pretty much deployed. So everyone that we've had available for work for the last year is on profile. All the work we need done, we have no one to do it, because they're all broke. So the unit now really looks down on profiles.

Being in the leadership position, I see some of my soldiers who are on profile, who still show up on time, and they do everything they can. Some of them try to break their profile all the time to work, and I have to tell those people, "Stop breaking your profile. When the doc signed it, that was an order from an Army officer to not do that. So stop breaking your profile, you're gonna get all of us in trouble, and you're gonna hurt yourself." And then there's other soldiers that will just ride their profile like you wouldn't believe. They don't do anything. They have profiles that they can walk at their own pace, they can't stand up for more than 15 minutes, they can't do all kinds of stuff. The Army's pretty loose with giving out profiles, sometimes.

I haven't received any training [on dealing with profiles]. I don't really think that there is much training, as far as profiles, unless you're part of the medical field. I know we look over them to see what [soldiers] can do. We try to adjust their PT to what they're allowed to do. But that's about as far as it goes. They pretty much tell you it's common sense. If they have a no-push-up profile, have them do something other than push-ups. And that's all the instruction I've ever had on dealing with profiles.

I think that's the only job of an E-5, to take care of the E-4 and below. Because they're all the ones that are doing the work. The leadership that I am under does not allow me to take care of my soldiers' problems. I had a soldier, they were taking meal deductions out of his paycheck, two months in a row. So the soldier had lost almost \$700. I tried to take the soldier up to Finance to get it fixed, and the first sergeant in this unit told me that we had stuff going on, we needed to go out and pick grass to make the yard look pretty in front of the Motor Pool, and that that was more important than the soldier's finance issues. And to me, that's ridiculous. She won't let me take care of my soldiers at all.

He's not the only soldier that happens with. There are soldiers who are getting ready to get out, ETS or Med Board. I try to take care of their ERBs, because all their ERBs are missing awards, schools, none of their stuff is updated properly. So I get all that stuff together, I'll pencil in on a

copy of their ERB what needs to be added, and go up to Brigade to get them to fix it in the computer. And the first sergeant will tell me, "No, that's not important. You need to go pick grass." It's always picking grass. Like that's not that important, when a soldier has an issue. They're about to get out, they need their paperwork straight, for the VA, for their civilian job records. They're not gonna be able to do this when they get out. No one's gonna talk to a soldier that's already out. And there's a lot of NCOs that I've talked to, that once a soldier's out of the Army, they're not going to deal with them, at all. I had an NCO tell me that a soldier got kicked out of the Army, and since they have to escort him off base, he said, "I just dropped him off at Wal-Mart. Because he wasn't our issue anymore."

Editor's Note: Paul was asked what would happen for him as an NCO if he was ordered to do something he didn't have enough people to do.

We do that all the time. The sergeant major apparently does not like grass sticking up out of the rocks. Anywhere on base. So he passed it out to all the units, and then for a week, our whole job was a quarter-mile strip that was gravel and rock, that the grass was growing up. He wanted everyone out there picking the grass that was growing up out of the rocks.

It was me and two soldiers. They said, "We're gonna give you 20 soldiers to go do this with." And they tasked out everyone, and the last person to get soldiers was me, and then there were only two people left standing in the formation. So it was me and two soldiers picking grass out of probably a two acre spot of gravel... And then, I got in trouble because we didn't get enough done.

I think [stigma toward profiles] stems from the people who really do ride their profiles. There's one guy in our platoon that has two appointments almost every single day. And he's admitted to a couple of people that he will purposefully schedule one that's about an hour before lunch, so that can show up to formation, and then say, "I have to go to an appointment," so he'll be gone for an appointment, and then he'll have his lunch hour when his appointment is over. And then he'll schedule his second appointment for about an hour after lunch. So that he can just say, "Well, travel time, I have to be at my appointment early, so I won't make it to formation after lunch. I have to go to this appointment." And then his appointment will last the rest of the day.

[Other soldiers on profile] probably try really hard, because they hear the way NCOs talk about the other people, about them being lazy, and not being good. And they don't want to be stuck in the same category as the people who are abusing the system.

I haven't seen a whole lot of people not ask for help because they're afraid. I've seen a couple of people who were saying, "If I go up there, they're gonna put me on profile, and then everybody's gonna look at me like I'm a crappy soldier." I think most people who really need it, they will wait until it's really bad before they go ask for help.

When I got here and went through SRP, it was pretty quick. It was just an assembly line of stuff, stamping papers and pushing soldiers through. I've seen a couple of people deploy who shouldn't have deployed. Either they weren't mentally able to handle the stresses of deployment, or they were be physically incapable of doing what needs to be done, wearing that much gear, dealing with the heat, and all kinds of stuff.

I'm not sure how it affected this unit. I didn't deploy with them. My last unit, there was a couple of people who just couldn't handle deployment. We knew it before we left, and we got over there, and the soldiers ended up with suicidal or homicidal ideations. And it took a lot of time. We had to have someone watching them all the time. So not only was that soldier not available to work, but it had to be a leader who was watching that soldier, to make sure they weren't going to harm themselves or somebody else. So when each leader is responsible for four or five people, at a minimum, and then they're gone, depending on how many leaders you have, one person is not going to be handling five, they're going to be handling nine or ten soldiers now. Which is normally how it works, one other NCO will take the remaining soldiers that aren't being covered. And it's harder to deal with.

There was one that was like that, and everybody was mad. That soldier shouldn't have deployed to start with. I don't know about the other NCOs, but I didn't look down on that soldier, because I saw it coming. It's not his fault. But some of the other NCOs were saying, "That guy's crazy." And, "Something's wrong with him."

He made it home. He got out and we met him back, when we got back to home station, and he seemed to be okay. But all the suicide training and everything that we have to go through, it really doesn't help. The Army does it so much that the training we have to go through now is annoying. No one wants to be there, no one wants to pay attention. And then the Army tries to do something to make it more fun, so that we'll pay attention, and then it ends up being a joke. With the suicide prevention, the sexual harassment training, the sexual assault training, everything. I'm guilty of it too. When we have to sit there, it's the same video over and over and over. After two years, you have all the videos memorized, because you have to see it so much.

Editor's Note: Paul said what we thought needed to be done at Fort Hood to help prevent suicide.

Just have health care more readily available. That's really all they could do. It might be changing. Right now a lot of the higher leadership was brought up pre-9/11, and there weren't a whole lot of the issues we have now. Like first sergeants and all that, they just don't deal with these issues as much, and their attitude carries down, down the ranks. They think, "If you're suicidal you're crazy, and there's something wrong with you." I think that's pretty much where it all stems from.

I know some people, they don't mind deployments, they like deployments, deployments are easy. When you're a single soldier, there's danger to it, and there's some scary stuff, but overall, it's pretty easy. You just get up, go do your job, and then most people will get off at a certain time, and they'll hang out at a coffee shop or something on the FOB, and play video games and watch movies. It's an easy life, for a lot of people.

A lot of other people, they're constantly going out, and it's not the occasional fear of a rocket or a mortar attack, but constant fear of an IED or an ambush. And living like that constantly for a year is really hard to deal with. And then, when you come back and you still feel that way, when you're safe at home, after you finally adjust to feeling safe again, you get thrown right back over into it. I think the dwell time now has changed, 24 months. Which I think might help a lot, but still.

The Reverse-SRP was incredibly fast, at my last station. I don't know how it is at Fort Hood through personal experience, but I've seen my soldiers finish all that stuff in one day. It's basically

just the exact reverse of SRP. It's just an assembly line of people stamping and signing paper. It was like, quick questionnaires on paper [for PTSD and TBI], and then a two to four minute interview by somebody with an Associate's degree, probably.

We have occasional briefings on [PTSD and TBI]. They're pretty few and far between. The Army really likes to focus on suicide and sexual assault. As far as the PTSD and TBI stuff, it's pretty sporadic. There's no real focus on the subject, or letting soldiers know where to go to get help.

JA: In his last unit, I was part of the FRG, and it was the worst thing I've ever been a part of. It was all drama. It was like high school. Nobody had information, nobody cared, everybody wanted to talk about everybody else. It gave me the worst impression of the Army ever. I never wanted to be a part of another FRG ever again. It was run by the Company Commander's wife. You could go to an hour-long presentation and walk away with nothing. They threw a couple names at you like, "Okay, this is Army One Source, and this is what they do." But that was it. There were no pamphlets to take home.

We didn't go on a marriage retreat until we got down here, because before it was impossible to get on that list. If it was even put out for his unit. We actually broke up for a time, when we were about to move down here. I called his Commander, I was really worried about him. He was telling me awful things, and saying he was suicidal. I called, and they put him on watch. They didn't even watch him. They just wanted to get rid of us. We went to the Chaplain on post, and we said, "Okay, we're having so many problems, we can't stop yelling at each other. We can't stop fighting. We don't know how to fix this. And the Army doesn't seem to care." And he pretty much told us, "Wait until you go down to Texas, and they'll deal with it." We were gonna sign divorce papers. They didn't care.

The only support we got was through our family. Nobody in the Army gave two licks. They thought, "Well, these people are about to move, so let's wait until they move, and see how that goes for them there." We got orders, to move, to pack up everything, to figure out where we're going, to look up places where we're gonna live, in less than 30 days. And in Hawaii everything's more expensive. We lost so much money moving here. We couldn't afford our cars, because there, a \$500 car payment? Nothing. Here, it's ridiculous. But we bought all our stuff there because he was there for six years. They don't compensate for that. They tell you to budget better, when you were budgeting off Hawaii, and then you move here and it's not the same. It's not the same at all.

A bunch of people I know would get orders about four months before their PCS date. It was getting close to three months, so I kept asking people, "Do I have orders yet to somewhere?" And when it got down to 30 days, and I started asking people, "Do I have orders anywhere?" I called my branch manager, the person in charge of sending mechanics all over. And he told me, "No, you don't have orders in the system yet. It shows that you're supposed to PCS soon." And then my leadership told me, "Well, if you don't have orders now, it means you're gonna be in this unit again, for our next deployment."

They were getting ready to deploy. And then, I knew I was gonna be stuck in that unit again, so I went and I bought my new truck. And then, 20 days before my date that I was supposed to sign out, I called the branch manager, and then I ended up calling the branch sergeant major. I called the command sergeant major directly, to his office, and I told him the situation. I sent him an e-mail. 48 hours later, I got an e-mail from the branch manager with orders. The sergeant major asked me where I wanted to go. He said, "This is ridiculous. I can't believe the branch manager waited this long for all of this stuff." He probably saved me.

JA: Because we were at each other's throats so bad. I was blaming him, he was blaming the Army.

But at that point, we had 20 days to try to sell a house, at a time when everyone's getting ready to leave. The whole unit was getting ready to deploy again. Nobody was going to buy a house, and then deploy, because all the wives go back to their homes when their husbands deploy. So we were just stuck. We had to rent it out.

We moved here. We still had a big mortgage payment, and then my truck, which we couldn't afford now that we're making \$2000 a month less. I started telling everybody, "Look, I'm losing 2,000 a month, I'm having some financial problems." They didn't send me to a financial counselor or to Budget Planning, or anything. I just had to look at all my stuff. And even now, our bills are more than my income.

I had to adjust my paycheck with an allotment. Most of our bills are due on the first. So I had to change it so most of my stuff comes out on the first. I'll pay everything off, and I will have nothing in my bank. We have to buy groceries and fuel with the credit cards.

...And there was a program, where Army people will own a house, they'll have to PCS somewhere, and the program would help you sell it back to the bank, and close out the mortgage. But that program only existed for the bases that had been shut down, and they sent everyone somewhere.

JA: Even though we couldn't live on base. There was a seven-month waiting limit to even move on base. And there's no temporary housing. We forked out two grand for two weeks, just to hurry up and find a place to stay, because there's no living on base, no room in the hotel on base. There's nowhere to go.

And for some reason, if you move stateside to stateside, you'll get a temporary allowance for housing for ten days to find a place to live. But you have to pay ten days out of pocket, and the Army will reimburse you. If you come from overseas, you get five days, so how are you gonna set something up faster from being out of the country?

When I first got here, the entire brigade formed up together. And the acting first sergeant and sergeant major, they were fantastic about putting out information, everybody knew what was going on. And then, as soon as we started getting ready for the guys to come back, the different battalions started breaking up, and going back to how they normally would run. And the first sergeants did not put out information that well. Sergeant First Class Johns,* when I first got here, he was fantastic, putting out information, letting everybody know when marriage retreats were, and the single soldier retreats.

JA: I went through everybody [for support]. We had close friends that were Army friends, and I went and stayed at their house for a little bit. And I kept asking him, because he was in the Army, "What do I need to do? I don't know what to do." Nobody ever told me, "Okay, this is what you do if your husband goes off the deep end." Nobody ever talked about anything like that. So he said, "You just need to call his superiors." And I was afraid it was going to get him in trouble, and I called them, and they didn't care.

And then, after she called the commander, my platoon sergeant showed up at my door in Hawaii. He said, "Get some stuff, let's go. You can't stay here. You gotta go stay in the temporary barracks for 72 hours." Whether there's violence or not, the Army does a 72-hour cool-down period, where you're gonna get out of the house for three days, while you and your wife cool down. And you don't talk to your wife for three days, 'cause it would just keep the fight going. Both of you cool down, and then you can start talking again. But she was really worried about me being suicidal. All he did was pick me up, I drove my own car, he followed me over. I signed for a room, and then he said, "Alright, you're on your own for three days. Have fun."

JA: They wouldn't have known if we had contact. We lived up to that, but they wouldn't have known if we hadn't. In fact, we only had contact so he could see his child. Because they had said, "I don't want him to see his child." And I said, "I'm not gonna take away his child, that would make him more crazy." So I left her at a friend's house, and let him go over and play with his child. I couldn't imagine somebody taking away my child. And they didn't keep me informed. I kept calling them, saying "Is he okay? Is everything okay?" This is my husband, I care about him. They didn't care. And finally, at the end of it, they said, "You need to contact the Chaplain. This is what he does. This is what he deals with." It just didn't seem to matter to them at all.

And we have another soldier here at [Fort Hood], who had a fight with his wife. He's been kind of a problem soldier. But they picked him up, it was in his apartment. And he said, "Well, I can stay with my buddy, he's two doors down." So they just let him stay with his buddy for three days, two doors down from his wife. And how are you gonna make sure they don't bump into each other, or talk to each other?

JA: And nobody's working out the problems, they don't ask you any questions, they don't mediate, they don't care. All he asked me was, "Has he ever laid a hand on you and the child?" And I said, "No." And that's it. That's the only concern they have.

And then, with this soldier, the leadership here didn't understand that the policy is a 72-hour cool-down period. They told the soldier that he had a no-contact order for his wife indefinitely, until the first sergeant says otherwise. And they already had marriage counseling stuff set up. And I was like, "Well, how is he gonna go to marriage counseling with his wife if you have a no-contact order for him?" It's supposed to be three days. You are not the ultimate authority on the wife. She's a civilian, you can't control her.

I've seen a lot of leadership who do not understand policies, and then they will use some things

as punishments for soldiers. Like, their way of punishing him was to keep him away from his wife and his child.

JA: When we had marriage counseling, I didn't realize how lucky we were in Hawaii to actually get an appointment. Here we can't even get an appointment. We have not been to counseling here. Even me, as a civilian getting a counselor, there's none right here, it's all the way in Killeen. And it's still a month out. I did it over the phone because it was quicker, and even then, it's only once a month. And that's the fastest you can get it.

I didn't realize, but in Hawaii it was much more convenient, because they did have a lot of counselors. We could pick who we wanted to go to, and they were somewhat open. It was hard, because I would go to counseling sometimes, and he wouldn't know if he could come or not, because of getting off work. And I'd be sitting there in marriage counseling, and it was just me. Several times.

Yeah, which is really hard. I keep thinking it's the MOS I chose. Mechanic is a really bad job in the Army. Mechanics and cooks. Cooks get there at three in the morning to start cooking breakfast, and then they have to stay late because dinner starts when everyone gets off. And they're there for another two hours, then they have to clean up. If you have a really good system set up somewhere, it's scheduled as shift work. Sometimes they don't have it scheduled as shift work, so everyone is there all the time.

JA: And there's no over-pay in the Army.

Not for cooks. And then, with mechanics, we have to coordinate with a lot of the civilian people who do our parts ordering and our parts pick-up. We can't go pick up our parts. Someone else goes to pick them up, holds them somewhere else, and then we go pick them up from them. And our last unit, we couldn't pick up our parts until after lunch, but after lunch the one person that was on the list to pick up parts had additional duties that he had to do at 13:00, right when we get back from lunch. So he couldn't go pick up parts until two in the afternoon, and it would take him an hour or two to get the parts back to us. So we wouldn't even receive parts until an hour before close of business. So we'd be sitting around all day with no parts to put on, and then an hour before close of business, we have a bunch of trucks that are non-operational because they need parts, and the Motor Sergeant doesn't like his paperwork to say, "We have six trucks that are waiting on parts." And every day, it says this. So as soon as parts come in, we stay until all the parts are put on, every day.

Apparently, there's a lot of Motor Pools that work that way. So as a mechanic, you sit around waiting for your work to start until an hour before COB, and then you stay at work until eight or nine o'clock at night. And there's no coming to work late.

JA: You still have to be out there for PT.

The whole time I've been here has been Rear Detachment. The civilians have been holding the Motor Pool. We don't have any trucks to fix or anything right now. And the III Corps policy, I know, is everyone will be released at 17:00, unless there is a mission essential, something going on. And I don't see chain of command saying, "Okay, it's 1700, go home." I see the soldiers saying, "It's

17:00, why can't we go home?" And then the Motor Sergeant and the First Sergeant say, "Well, this is your mission, to fix trucks. This is mission essential, you're gonna stay until they're fixed."

JA: Every counselor he's seen pretty much has told me, "I can't discuss anything with you." They can't even discuss with me if he's going. So I have to take my husband's word on everything. Which, in the Army, it's not always the best policy, to take one person's word. I know my husband has lied to me several times just to protect me. Because he doesn't want to tell me, "The Army won't let me go get help." I get mad. And I understand he doesn't want to hear me get mad, when there's nothing he can do about it.

It doesn't seem like the FRG is a help at all. I have to trust him on his chain of command, who these people are. If I want any information, it has to come from him. I can't go to anybody else. And they don't seem to care about mental health, at all. We have gotten into countless fights of me saying, "When's your next counseling appointment? When's your next counseling appointment? You're going, right? You need to talk to them about your medication. You need to do this and do this and do this." There's no rush for them, they don't care. And there's so few counselors here, it's unbelievable. It's so under-staffed, for the Army, for the families. We haven't gotten to see a single counselor, and we've been here a year. And now, all they keep saying is, "Keep waiting."

When we went to marriage counseling, the number-one thing they kept telling us is, "Y'all don't need marriage counseling. Y'all need separate counseling." Because you have to fix that first, before you can have marriage counseling. It's so much easier to get marriage counseling than it is to get individual counseling. I don't know why that is. And it seems like all you can do in counseling is vent. Nothing ever gets fixed. Except when you go above somebody's head, and make a lot of noise, it seems like that's the only time somebody goes, "Okay, here." And they give you something.

I don't know if the Army could do this, but giving people more time, more information of, "Okay, you're gonna move, you need to prepare for this move"—that would've helped our marriage a lot. We didn't even know how much we were going to make when we finally got here, until we got the first check. I think having open lines of communication would help. You can't even put your name on a waiting list until you get orders. They told us we were going to Fort Hood in 20 days. We didn't get the official orders until we almost got down here. We can't sit on a waiting list. I kept calling housing saying, "Please put us on that waiting list. Please."

Yeah, the notice I got for 20 days before the move, it was an e-mail from the branch manager saying, "You're going to Fort Hood on this date." But my orders were not published and printed until four days before I left Hawaii.

JA: If it wasn't for our family, I can't imagine dealing with all the stuff we did, at all. And it's not even like our family did that much. They just listened to us, or helped put things in perspective. That's it.

A lot of the big stressors on military service members is finance. We have a decent paycheck. I make more than a lot of people. But I work 70 hours a week doing my job.

JA: There's no extra-pay. You can't get over-time if you need extra money. We couldn't even get an emergency loan for that house being unrented for a month. We did get a loan once, and we had to pay it back.

...And he doesn't even get time off. I can't tell you how many times my husband has called me, or I've called him during lunch, because that's the only time he picks up his phone. He does not pick up his phone all day, because he's always working. He does not eat lunch. He's still working through his lunch period. And I have to question sometimes, because I'm a civilian, "Why would you even work so hard for a company that doesn't even care?" He's gotten denied leave so many times, it's unbelievable. They don't care about the family, and they care even less about the soldier.

Another example of just how messed up the Army is with knowledge and help—I had a soldier who, just a couple weeks ago called me up and said, "I really need you. Like, right now." He was having some mental problems. I was in the middle of a class. I said, "Okay, well, I'm gonna take my test real quick, I'll be there as soon as I can." I rushed through my test. I take college classes during lunch. It's the only time that I can get approved to do it.



Paul pointing to his grandfather pictured amongst his fellow servicemembers.*

I drove over and met the soldier. He was having severe paranoia and an anxiety attack. His peripheral vision was blurred. He said he felt like everything was moving. He feels like there's people behind him all the time. I asked, "Are you seeing people behind you?" And he said, "No, I know they're not there. Like, logically I know they're not there. I turn around and they're not there. I just constantly feel like someone is there. I can't drive right now. I'm messed up." He broke down into tears. He was crying. It was really, really bad.

So we went up to the [medical clinic], to see the primary care provider. I said, "I think something's wrong with his medication." He said it had started when he was at the rehab clinic for alcohol. They gave him a prescription. He said about two weeks after he started taking that prescription, he felt a little bit paranoid, but it wasn't that bad. He thought maybe it was just one of those days, maybe he watched a movie or something that got him kind of paranoid. So he ignored it. And then he said it got really, really bad. So I took him in and said, "I think it's the medication they put him on. He said the paranoia started after he took the medication. He never had the problem before." And then the primary care provider said, "We don't have a psychiatrist here at the clinic, so go to the ER." We went to the ER, and the ER said, "The ER doesn't have a psychiatrist here." So the ER sent us to the R&R center. We went to the R&R center, and they said, "Well, we didn't prescribe it to you." And they sent us somewhere else. And we kept going in circles to the same people. We called the R&R to get them to check out his medication. They sent us to the primary care. Primary care sent us to the ER. The ER sent us right back to R&R.

By this time, the medication had started to wear out of his system, and he said he started feeling better. And we were at the ER when this happened, so they just said, "Well, if he's feeling better, then set up an appointment to see a psychiatrist. There's nothing we can do for you here." So I had to go back to R&R, and talk to the OIC of the R&R clinic, again. Because I had to deal with him previously for another soldier. We had to go all the way to the top, to get another soldier fixed. So we went all the way back up to this guy, and he set him up with an appointment the same day, to see a psychiatrist and go over his medication. And found out that one of his PTSD medications, when he was at the alcohol rehab, they prescribed him a medication for Schizophrenia instead. And the psychiatrist said, "That's the dumbest thing I've ever heard. Why would you prescribe Schizophrenia medication to a patient who was not Schizophrenic?" And it took us three days of him going crazy on this medication to get it fixed. All day long, he kept saying the most uncomfortable place he could be in was in a car. But we had no choice but to be in a car all day, driving from place to place, driving in circles.

...I had ten soldiers to take care of. And all of this stuff was an entire week, taking care of just one person. I'm on the phone all the time trying to talk to people, trying to get their stuff fixed, and sitting in my truck after hours, staying late to fix all their stuff.

JA: There's always little stuff, like the 24-hour duty, somebody can't pull a shift because it's conflicting with something else. The Army's not efficient at all, in any aspect. Like, somebody didn't have a locked gate, so Paul had to go and stand out there. And nobody gets in trouble. Because there's nobody you can blame. It's always somebody else's job.

There's no accountability. And with all the 24-hour duties, the Army is set up where there's a DA-6, an alphabetical list of everyone who can pull the duty. And it's just supposed to go straight

down that list, every day. Once it gets to Z, it goes right back up to A. The unit I'm in now is not doing that. They split it up by the battalions, and the battalion splits it up by which company pulls it that day, and they send the first sergeants the list. They say, "Your company has it these days." Then they just fill in the slots with whoever they want to pull duty that day.

JA: Paul had it every weekend, Friday or Saturday, which are the two worst days to pull 24-hour duty. At least during the week you would've had to work a half day anyways. But Friday or Saturday—Saturday being the worst—you don't get a next day off. Your next day off is the weekend anyway. Or, if you have a four-day—he got a couple of four-days he had to work—he never got off duty. I see everybody on this road home before him. They're like, "Your husband has to be cheating on you." I've had so many wives say that about Paul's job, because he's at work all the time, when he's on 24-hour duty. Either he's messing up at work and people hate him, or he's cheating, and I'm like, "Nope! I've gone up there, I check up on him. He's where he's supposed to be."

And I've brought it up to the command before, saying, "Why am I working longer than everyone else in the brigade? Why am I responsible for all of this stuff that's above my pay-grade?" And I've had leadership tell me, "Well, Sergeant Avett, you're dependable. So they give you the important stuff. That's why you're working harder. Because you can do it." And that's the answer I got.

...And when I asked him directly why he wouldn't promote me, he said, "Because an E-4 turns wrenches, and you're good at turning wrenches. You fix a lot of trucks. And if I make you a leader, you won't be turning as many wrenches." And I said, "You won't promote me because I'm too good at my job." And he said, "Well, it's not that. It's that I'm not promoting you because the Army needs you in the position you're in right now." And I said, "That's really the only reason?" And he said, "No, the other reason is that you've never had an Article 15. And if you have a soldier who's going through an Article 15, you won't be able to help that soldier unless you know what he's going through." Those were his legitimate reasons for not promoting me, I'm too good at my job, and I've never been in trouble.

JA: So we see tons of soldiers that have messed up, been in less time than Paul, and they're higher than him.

The favoritism is outrageous in the Army. And in the military in general. There were two other soldiers who went to the Promotion Board before I did, both of them came up hot on the urinalysis for cocaine use, twice. They were demoted twice for cocaine. Another one had been demoted for DUI twice. Two different instances. All three of those soldiers were also sent to Promotion Board before me, because every weekend they were at the Platoon Sergeant's house drinking beer and hanging out.

Editor's Note: The interview transitioned to return to Paul's experiences with various traumatic injury screening and training processes. He was first asked if he had ever taken the ANAM test.

...We took it before my second deployment. But when we got back, I didn't take another one. Or at least I don't remember taking another one. But they knew they were supposed to. That was three years ago. I remember taking a test, I just don't remember taking it once or twice. [Other

than that] no screening [for TBI] other than filling out a questionnaire that says, "What happened?" And every questionnaire, I put down that the 700-pound up-armor hood hit me in the forehead and knocked me off a truck, where I was unconscious for less than a minute. And then I do some questionnaire on how often I get headaches, and I always put, "Yes, I've had more headaches than normal since that event. My memory has been worse since that event." But nothing ever comes from that. And then, I was refused a brain scan. I requested one. And they said, "It's been too long, it wouldn't even show up from an event that happened nine months ago."

Every civilian counselor that I've ever been to tells me, "You have all these symptoms [of TBI]." But they keep saying, "From what I can tell, these are the same symptoms that are also associated with PTSD. And all these symptoms are also associated with ADHD." And they keep telling me, "Look, we can't diagnose you. You have one of these three, but we don't know which one." I've gone to a psychiatrist, and they pretty much say the same thing, "I don't know which one you have. But here's Strattera, and it will help you with all the symptoms you're having." But they don't diagnose me with anything. As far as I know, I'm just hyper and try to concentrate on eight different things at once.

Editor's Note: Paul and Julie also shared thoughts on what kinds of support Fort Hood should put in place for soldiers and families, as well as what they see happening amidst the drawdown.

JA: There need to be checks and balances. If you have a problem with somebody, there needs to be a way that that person's actually going to see some retribution. Everything that Paul's been through, there is never follow-through. Except if a soldier does something. If Paul messed up, if he was late one day, you can bet they would drag him out and take away his E-5, or something. But it seems like the higher up you go in the military, the less you can be touched, and the more you can control, the less you can be touched.

Like, Congress has to demote an E-7 to an E-6. No one in the Army can demote an E-7. And every time I have a problem with someone who's an E-7 and I go to the commander, he pretty much tells me the same thing. "Well, leadership positions change all the time. Just wait until they're gone, because there's nothing we can do."

With the drawdown, I've seen a lot of people come up for ETS, within a certain amount of time, and they'll be given the option, "Do you want to get out three months early?" A lot of people get out three or four, or six months early. I've also seen a lot of people getting chaptered out. But it's not for anything different than it normally was. Most of the people I see getting chaptered out, before the big drawdown, those people who came up hot for cocaine use, they would've been kicked out, in any other unit. They would've been kicked out immediately for cocaine use. But that unit decided to retain the soldier. They said, "Well, you know, he's learned his lesson and he'll be a good soldier from now on."

Because we were about to deploy. And our unit had the same people for almost six years. We did not get one new soldier. We started out, when I got to that unit, with 50 people in the Motor Pool. We deployed to Iraq, and then we got back, and a lot of people either ETS-ed or PCS-ed, and we were down to maybe 30 people. And then we went to Afghanistan, and we came back, and a lot of people ETS-ed and PCS-ed. When I left, we had 15 people in a Motor Pool that should've had

50. And we still never got any new soldiers.

But that unit decided, we need soldiers, so we're not gonna kick them out under any circumstance. And now with the drawdown, I'm seeing people get kicked out for spice and for marijuana, and for all the other stuff. So they're not getting kicked out because they were late one day, or something like that.

...I've had several soldiers who have been diagnosed with something, they'll be given sleep medication, and then they'll just oversleep, and they won't make it to the first formation. And then that soldier will get an Article 15, not after the first one, but after three or four times. I'll talk to them and they'll tell me, "I can't sleep, so I'll take my medication, and I can't get up in the morning." And with some soldiers, I've found out it's because they're staying up playing video games until midnight or two o'clock in the morning, and then they're taking their sleep medication at 2am, expecting to wake up in four hours.

I do things on a case-by-case basis, good leaders do that. That soldier, I gave an Article 15 to. I told him, "Look, stop staying up until 2am. You need to take your medication at eight, nine o'clock at night." And on the times I came by to check on him, and physically watched him take his medication on time, those next days he got up on time, and he was always on time for work.

And then another soldier, I've seen him take his meds on time, he just still can't wake up. I go knock on his door, I hear his alarm going off. I'll call him on the phone, his phone doesn't wake him up. I'll have someone go get me the master key, so that we can go in, because at that point we don't know if he's in there dead. So I'll tell him, "Look, I need to know if he's alive. You need to go get the key, and unlock this door now." After I fight with them, they'll open the door and we'll find him in there, asleep. His medication's just knocked him out. And then, the leadership says, "Well, you need to counsel him. He needs to be Article 15-ed." And it makes no sense to me why you would Article 15 someone for a health condition. But some leadership will still do that, and instead of saying, "Okay, take him up to health care, find out if he needs a smaller dosage, or find out what's going on." They don't want to fix the soldier, they just want to get him in trouble.

The Army has good leaders in it. Like, I consider myself to be a good leader. I'm proud of what I do, I enjoy taking care of soldiers. I feel like I make a difference in peoples' lives. There are other NCOs who do that, and I feel like the Army is just so screwed up, I am tired of having to go through what I go through. I get punished all the time, for fighting uphill battles to try and take care of them. So much that I don't want to be in the Army anymore. I'm just fed up with it. And then all these other soldiers now are stuck with the NCOs who don't care. They're here for a paycheck.

...There's no reward for taking care of soldiers.

JA: Or even bettering yourself. Him going to school is an imposition to them. They hate it. He has to beg to go to school. In four years, he's only gotten a couple credits of school.

And the Army's all about, "Join the Army, and we'll pay for your school! You get 100% tuition assistance!" And then, you get to where you're not deployed, and you're back here, there's

nothing important going on, there's no time for you to go to school.

...The Army doesn't really recognize anything more than, "Sign for three million dollars worth of stuff, and don't lose it. And if your soldier's late, write him up. And don't let anyone die." Those are the only qualifications you need for the Army to think that you're an outstanding Non-Commissioned Officer. And there are people who do that. They do the bare minimum.

And a lot of them don't even counsel their soldiers. Soldiers will show up late, and they'll just have him do push-ups, or they'll yell at him. Nobody cares about your personal life. They want you to leave that at home. I had one soldier whose grandfather died, and just because she had had maternity leave, they didn't want to let her go on leave to her grandfather's funeral... I said, "Her grandpa wasn't dead when she was on maternity leave." So I had to go above her head, and talk to the commander. I got her leave approved, and she went on leave, and then I got in trouble.

JA: I know this sounds bad, but I've begged him just to take the easy way. I've said, "Just don't care about your soldiers. Don't go in. Don't pick up that phone call. Please don't do that." We have no family time. Extra stuff around the house is done by me. There is no husband in this house 90% of the time. It probably is really easy to go, "Okay, I don't care anymore." We've met a lot of his first sergeants, and they're mean people. They're just mean, nasty people. It's almost like they're purposefully wanting to hurt you. And I can see why. I can see how climbing up through the Army will make you mad, all the time.

Editor's Note: In closing out the interview, Paul and Julie spoke about what their plans are for after Paul's ETS.

We plan to stay here, because we like the house we're at, we like the school that our daughter's in. I have an application in right now for State Troopers. I don't know why I wouldn't, but if I don't make it into the State Troopers, then I might try to apply to work on an oil rig.

Spouse: We've talked about him going officer. They make that information unbelievably unattainable. Besides the fact that he hates the Army now. He absolutely hates it. But we've talked about going Officer, because it's a different side of the Army, and we've heard it's better, and enlisted is just crap. And he has his Associate's now, and he can go green to gold. But there is literally nobody to talk to about that. Nobody wants you to be promoted. Nobody wants you to change sides. Everybody wants you to stay on the enlisted side, because you're so much cheaper.

...There is a surprising amount of Officers that were prior enlisted, but I did not know that until my brother went from an E-5 to an O-1. He tells me Officer life is so much better, so much easier. And you make SO much more money. It's ridiculous how much more money Officers make, for the little amount that most of them do. Some put in a lot of work, just like NCOs. I think my brother is a good Officer.

I think that's probably him used to being an NCO. That's how he learned the Army, was taking care of soldiers. But as a part of that, though, if they were prior enlisted, all of their retirement time from the enlisted side carries over.

Editor's Note: In January 2014, we met back up with Paul and Julie. Paul had recently gotten out of the Army and was living in Killeen and taking classes. He described feeling somewhat better since having left the environment in his unit.

During his last months in the Army, Paul had sought care, but described being shuttled back and forth between a primary care provider and mental health specialist before finally being referred to a sleep specialist off post. Eventually, he just decided to wait until he was out of the Army and set up care through the VA.

Paul had applied for VA benefits and had been granted 30% disability for a series of issues, but was denied for his head injury because no CAT scan had ever been conducted and the concussion had been poorly documented. Between the unemployment benefits recently-discharged veterans are entitled to, and school benefits with the GI bill, the family was making more than Paul had made while active duty. Later on, he planned to pick up work doing auto and home repairs. Paul had decided not to appeal his disability rating at the VA and instead focus on finishing school in order to rejoin the Army as a commissioned officer. Paul and Julie were confident he would no longer encounter the many of the issues with "incompetent leadership" Paul had experienced in his previous unit as an enlisted soldier, and that he would finally be able to act as the kind of positive leader he had always tried to be while a NCO.

9

Eve and Sean Morgan*

Editor's Note: *Eve Morgan* is an Asian Fort Hood veteran who, at the time of her interview, was an NCO in the process of transitioning out of the Army through the Warrior Transition Unit and had recently had brain surgery. She and her husband, Sean,* also a veteran, offered insights from her experience with care for her TBI.*

I decided to join the military to get medical benefits, because I had three kids back then, and also for money for college, which I did get. Then I wound up liking what I was doing, and I re-enlisted...until I got sick.

I was always the type to put myself last. It was always mission first, and myself last. But when I would make appointments and the MTOE¹⁵⁶ for a mission was high, they would always ask me to change my appointment. And if you don't change it, there's repercussions, but the kind of repercussion you just don't see. Where you're a great NCO and then, all of a sudden, you tell them you can't change your mission for this. And they say, "Oh okay, well, since you can't change your mission for this, you're going to go ahead and grab three soldiers and go dumpster diving for aluminum cans." They told me to do that, but I couldn't jump in there, because I'd just had foot surgery.

Before I went into the WTU,¹⁵⁷ it was very hard for me to go in to see a doctor. As an NCO, they always made me mission commander, so I had to go off and do those missions, and I couldn't always make the appointment that I want to make or keep the appointment that I wanted to keep.

Since I got to the WTU, it's been wonderful. I have a wonderful Nurse Case Manager, I have a wonderful commander and first sergeant squad leader. I never have to ask for anything, they stay in contact with me pretty much everyday.

I didn't have a long wait to get in necessarily, but at my old unit, prior to going to WTU, they lost my paperwork for WTU four times. I had my brain surgery April 6th, and I got discharged from the hospital April 12th. Then they put me into a rehabilitation hospital. I had to learn how to walk, I had to learn how to talk and eat again, after my brain surgery. So we submitted the paperwork, the WTU matrix, on April 13th, 2011. I got into the WTU in September of 2011, because my old unit kept missing or losing my paperwork.

The Ill corps surgeon general had to get involved with my WTU matrix. He did all the legwork, all the paperwork, and everything to get me transferred. And mind you, this was several months

before I got in. And then, the ombudsmen got involved with the III corps surgeon general, and he said, "Alright, I'll do the footwork myself." He stayed in contact with my husband every single day until the paper was signed, went to the board, and then once it got signed by the board, he called my husband and said, "She'll get her orders within ten days." And I got my orders within ten days.

My husband talked to everybody that was important. He knew that would help us. We had to extend my leave after my brain surgery. My company only approved 90 days for me, while my doctor had said I needed 120 days to recover, if not more. They were trying to get me back to work, but I couldn't even walk. I still can't walk now, barely. Not without getting dizzy and getting sick, and that's the whole reason why I've been in and out of the hospital since the surgery.

The care that I've received off-post is wonderful. The care that I receive on-post was just from my primary care provider, my PA. They don't know the extent of my brain surgery. They just know, "Okay, she had brain surgery. Her convalescent leave is over, let's send her back to her unit. She's fine." And it doesn't work that way.

I think part of the problem is that they don't listen. The PA says, "They said you only need 90 days." No, my doctor said I need 120 days. "Well, those are all just recommendations. It's not written in stone." That's the kind of attitude I get. And my husband just says, "Are you serious? She's still in a wheelchair. She's a truck driver, it's not like she will benefit you at all if she goes back to work."

But because I have certain experience, as an NCO, they said, "Well, she can come back up here and do that." At that time, I still had blurry vision, memory problems, lots of things. I'm still having problems remembering, and I'm still in speech therapy.

When I did go back, when the surgeon general got contacted, he personally called my commander and said, "She is not going back to work." The surgeon general extended my leave by himself, without my PCM or anything. He personally wrote me a profile to extend me, until I returned back to work September 28th. That's when my orders came in to go to the WTU.

This all started when I came back from deployment, and started complaining about headaches. I'm an easy-going person, if I get a headache I'm gonna pop a Tylenol or two, or a Motrin, and I'm fine, let's get back to work. But then it got to the point where I was getting migraines, and I was actually throwing up. And while I was in the truck, as my soldier was driving, I was seeing double. So I made an appointment to go see the doctor, and the doctor just tells me, "Hey, you know what, you're dehydrated, drink some water. Here's a bottle of Motrin. Carry on."

That went on for six months. And then, I found out I had the TBI, because through our PDHRA¹⁵⁸ we had to get screened for TBI. I told them I had headaches, so they referred me to Dr. Thompkins for my headaches. He started treating me for minor TBI, gave me medication. But by the time I got to see him, I was already so depressed, and I had really bad anxiety. Everything that I'd see on the side of the road was a threat to me. It just got really bad. My dreams were very vivid, about guns and my family and stuff like that.

But back to how it got discovered. That was when, in October of 2010, my eyes were getting red and irritated, and all bloodshot. And my first sergeant said, "What's wrong with your eyes?" I said, "I don't know, first sergeant." He said, "Does it itch?" I said, "No, first sergeant." He said, "Then it must not be pink eye. It's probably something else, you're probably irritated or have allergies. But I don't care," he said, "You're going to sick call."

Sick call treated me for pink eye. And then after a week and a half of being treated for pink eye, it still didn't go away. That weekend we happened to have a four-day weekend. On Sunday, my blinds were closed in my room, and my room was dark anyways, but even just the light coming through the blinds was killing me. It felt like it was literally burning my eyes. I had taken four washcloths, folded them in half, and covered my eyes with them. And out of the corner of them, I could still see light, and it was killing me. So my husband took me to the emergency room at Darnall. The emergency room told me that I had iritis,¹⁵⁹ not pink eye. And then they checked the pressure in my eyes, and they realized I had a lot of pressure in the back of my eyes. That's when they decided to do a CAT scan.

From the CAT scan, they saw a blockage in my brain, where my brain stem had fallen into my C1 and gotten stuck. That was blocking the spinal fluid from traveling into my brain and back down. So I was pretty much stroking my spinal cord out. And then, a month leading up to my surgery, I was actually walking around like I'd had a stroke. Everything was sagging on my right side. My arms turned in, my legs turned in.

When I had seen the TBI specialist before that, they didn't schedule a CAT scan or anything. He just thought I had a minor TBI, and it could be treated with just medication. But going back, once he saw the CAT scan images, he said, "We're going to send you to a spinal cord specialist to have spinal cord surgery." And we don't have a spinal cord specialist on post, so he had to send me all the way to Austin. We went there for the appointment, and the spinal cord specialist said, "I'm not worried about your spinal cord. What I'm worried about is your brain, the way it's sitting. You're going to need brain surgery, so I'm going to refer you to a brain surgeon." So he referred me to the brain surgeon, and then it took three, four weeks for Tracker¹⁶⁰ to approve my brain surgery. So here I am sitting in pain.

I was on leave at the time. Dr. Thompson had written my profile before he found out that I needed brain surgery. But he knew I needed to take it easy, so he gave me a profile from nine to five, and no driving, not even my personal vehicle. And he gave me medication for pain. And I was taking a lot of other medication, because I started getting really depressed, and I was taking medication for anxiety. But my supervisors were upset about that, and my platoon sergeant told me that my profile was BS. He told me, if my doctor can account for me at 6:30pm, then I can stay out until 9pm. But if my doctor can't call him and say that he's accounted for me at 6:30pm, then I can't be out.

And that happened to be the day that I needed to go see my brain surgeon. I had an appointment with him at 9:00am. They called me in at 5:45am to come in for 6am formation. I told them I had a nine to five profile. Now, I can understand if it was a different soldier, but I'm the kind of soldier where you have to make to go to sick call. I'm the kind of soldier where you have

to tell me, "Hey, you know, Sarge Morgan, stop, there's still tomorrow." I'm the kind of soldier where when I want to get things done, I want to get things done. And I'm not just gonna tell my soldiers to get it done by themselves, and not watch over to make sure things are done right. I'm hands-on with my soldiers. I feel like they treated me bad after they found out that I had a nine to five profile. They weren't happy with it.

So, that morning we went to go see my brain surgeon, and I told my husband what my platoon sergeant had said, that my profile was BS. My husband is a pretty calm guy. He said, "Let's go see what this brain surgeon says. But I'm going to come back and talk to your platoon sergeant myself." He's prior service, he was an NCO. He knows how it works. We went to the brain surgeon, and he only saw me one time. All he needed was to see me once and look at the image once. He set a date for my surgery. Originally, it was late November. But TriCare didn't come back in time, so they had to re-submit my referral to get permission to operate.

So I was working all the way up to when I was referred to have brain surgery. And that day my platoon sergeant told me that my profile was BS, that morning when I saw the brain surgeon, he said, "Oh my god, you need to have brain surgery. And you need to have it fast, because you're pretty much stroking your right side out." I was walking weird, talking weird, I had lost a lot of range of motion on my right side. So he said, "We'll set a date up for your surgery as soon as possible."

That appointment was a month before my surgery. We came back from the doctor's office, and my husband took me straight to the office at work. We walked into the room together, and luckily my platoon sergeant, my platoon leader, my first sergeant, my commander, and my XO were all there. They knew not to talk to me, because I was already crying. I was crying when they told me that I needed to have brain surgery. My husband knew where the first line's office was, and he walked into the first sergeant's office and said,

"I need to see you, you, you, and you... You all need to come into this office, we need to talk." And then he said, "I'll tell you what, my wife will take leave, 30 days leave. And if she has to take more until her brain surgery date, she will. I'm not debating with you, I'm not asking you, I'm telling you. And if I have to go further up to do this, or write Congress or whoever, I will. And the fact that you said that my wife's profile was bullshit is wrong. The fact that you treated my wife like she was the best NCO, and now that she needs your support, you treat her like a shitbag, is wrong."

That's exactly what my husband said.

"When everything was good, you could count on her morning, noon, or night. You got her in a platoon sergeant's slot as an E-5, you got her doing an E-7's job. And she was good to you. She was awesome. Now that she's hurt, she needs your help, and all of a sudden you're treating her like just another soldier that's riding their

profile.”

I've never ever had a profile before that, never. I had been home from Afghanistan from October 2010 to December 2011 when the surgery happened, so I was dealing with these issues for almost a year before they were taken seriously.

The first time you deploy and the first time you come back, you get screened within the first two weeks of getting home. So no soldier is going to know if they've got any of these symptoms yet. I didn't experience my issues until after my first deployment and into my second deployment, when realized that I had chronic PTSD. Because I'm not a short tempered person, it takes me a whole lot to get me upset. But then, I was going off on lieutenants, going off on E-7's, on an E-6, even going off on soldiers, and that's not my character. That's not me.

And I was having nightmares that keep me up all night. I'm to the point where I get afraid to go to sleep. My husband can tell you, I won't sleep for 32 to 42 hours, because I'm afraid to go to sleep. And I was afraid to tell anyone that I had PTSD, until I got to see my PA, and I told him what was going on.

At SRP, they just ask you the common questions. They don't ask you, “Do you have nightmares? Do you have this?” They ask, “How are you doing? How's your family? How's this and how's that?” So if you don't want them to know your business, you don't say anything.

After my second deployment, they asked me why it was affecting me now. To be honest with you, my second deployment didn't affect me as much as my first deployment. Everything that I remembered from my first deployment caught up with me on my second deployment.

I had never gotten any briefings on PTSD. Not until I was diagnosed with it.

At first I was afraid to tell them that I had nightmares, and that I was going off on my husband, going off on the kids, because I didn't want to be labeled as a nutcase, or weak. Because I've seen it all. I've heard it all. “Oh, she's claiming she has this,” or, “He's claiming he has this.” Even though I'm in a truck driver company, I didn't get to see a whole lot my second deployment. But my first deployment, I did. And all of that comes back to me. Everything that happened the second time, even though it wasn't as bad, it just brings me flashbacks of the first time. And in my sleep, my nightmares have to do with getting my kids out of the house, where my house is sitting in the middle of nowhere, like it's in Afghanistan, and I know the bad guys are coming, but I can't run there fast enough. Things like that.

I never received a briefing about TBI. I never took a pre-screening for TBI before I deployed. I did go through explosions on deployment. I never received any screening afterward. I have symptoms of TBI.

I wouldn't say it's the TBI that's bothering me now, it's the surgery that's bothering me. But before that, it was the headaches, the migraines, and I couldn't stop throwing up when I had migraines.

A few other soldiers I know have been affected by TBI and not been tested, but they're not doing anything about it. If you try to tell them to go see somebody, they say, "No sergeant, I ain't weak." And that's what I said before, too.

With me being hurt so much, always in pain, I was really depressed. I was really depressed and stressed out. Dr. Thompkins knew that I was depressed. I told him. He wrote me a prescription, for my depression. Prior to us knowing that I needed brain surgery, he wrote me a profile for depression and insomnia, because I couldn't sleep. And that's when they started really treating me like I was a shitbag. I couldn't drive trucks anymore, so I was no longer good. I was on every shitty detail you can think of.

Against my profile, I was pressured to go on mission—not necessarily to drive a truck, but to go on the mission. And what good am I, if I'm a truck commander, and say something happens to my soldier, he doesn't feel good. What am I supposed to do then, jump into the driver seat and just drive? With me taking the medications that I'm taking? But that's their way of doing it. They say, "Oh, you're just a TC.¹⁶¹ We just need this mission done, it's only going to be two hours. If not, everybody's going to be staying late tonight." So I don't want to be the one who says no, because then people are going to say, "Oh, you're the reason why we're staying late, because all we needed was one body to finish the mission."

I wouldn't say that my commanders don't care that there's policy against violating profiles. I would say that there are so many soldiers that rode their profiles, that it makes it as if one profile is no different than the other. That's how they treat it. But asking us or telling us to violate our profile, I think that's wrong.

The Primary Care Manager, my PA, gave me my profiles. They were issued for every six months, until they put me on permanent. I was never re-evaluated before the temporary profiles expired. When they expired, I had to go back to sick call, tell them the same story, and then they made me wait to go see Dr. Thompkins, to write my profile due to the medication he was giving me.

Some soldiers get turned down from sick call. And they are not supposed to get turned down. Say if it's time for them to renew their profile, and they can't get in to see their primary care provider. If my profile ends in a week, I know to make an appointment in a week to see my primary care provider, to update my profile. But because there are so many soldiers, you're not going to be able to see your primary care provider in one week. So the next thing to do is to go to sick call, and hopefully get in, so you can extend your profile. But you need to wait to see your primary care provider to get into sick call, so in the meantime, whatever condition that you have, whatever issues you have, because you don't have a profile to support that, they make you do what you're supposed to do, like PT.

So if you don't do PT, because you're telling them, "Hey sergeant, my ankle is still swollen or my foot is still swollen, and I can't get in to see my primary care provider," he's going to yell, "That's not my problem, where's your profile?" And then you get counseling for being disrespectful to a non-commissioned officer.

As an NCO, I have been asked if I thought that a soldier's profile was legitimate. And I said I'm not here to determine that. If a soldier has a profile, they have a profile. And I'm not going to ask them to break their profile.

But if you're on profile, people frown on you. They treat you like shit. For example, if you're on profile and you can't do your mission or your job, instead you are cleaning toilets, you're going around to everybody's office picking up trash. You're going around the motor pool, just doing unnecessary work. Every platoon has a team everyday that's going to clean this area, and the other platoon, that area. Soldiers clean up after ourselves. And the soldier who's on profile that cannot lift more than 10 pounds or five pounds, then here he is having to lift a mop bucket to mop the division's whole hallway. Just because he can't go on mission. And then he doesn't get to go to lunch, because he's on profile. He's going to sit and wait by the phone, until everybody has lunch, and then he goes to lunch. It makes sense, but leave somebody with him. Why make them stay there by themselves?

I had always been a support to my soldiers. I still have soldiers calling me. I'm not even in the unit. They ask me, "Sarge, can you help me write counseling?" Or, "Hey Sarge, can you help me do this?"

Sean Morgan*

Editor's Note: *Sean Morgan,* Eve's husband, joined the interview and offered his insights from both his own military service and his process of supporting Eve. He testified as follows.*

I've been an NCO as well, so I've seen both sides of it. You do have a lot of soldiers that try to milk the system, and don't want to deploy. Or for whatever reason, they don't want to do their jobs. But then, when my wife and I have legitimate problems, the chain of command has had so many people that abuse the system that they don't know what to believe. So what they do is treat everybody like they're full of it. It's not fair. They need to treat the actual problem, case by case, with each soldier.

So soldiers who have real problems tend to get abused under that mind-frame. They have a lack of respect for you. They put you on the worst details. They totally treat you as if you're not a soldier. When I was a squared away NCO, I would never get in trouble, I had never been late, any of that. I was deployed to Iraq and got injured. And then they would say, "You suck, you're a piece of crap."

I ran around with eight pounds of gear on, outside my sector, and I have a banged up knee. So,

I'm sorry, I can't jump from building to building, kicking down doors, because I can barely walk. I went instantly from a squared away guy to a piece of shit. And I'd much rather be out in sector, because I have four guys who're 18, 19 years old, never been off, never been nowhere. I'm responsible for these guys, so I don't want to sit in the hooch¹⁶² all day and do nothing. That's not what you're paid for. I'm responsible for these four guys. That's a thing I have to deal with, that's a letter I have to write to those parents, because I can't explain to them what happened, because I don't know, because I wasn't there. Because I pushed myself to the limit, and I didn't want to be labeled as a shitbag. So I hurt myself even more.

You can go to sick call. They'll ask, "What you going to sick call for?" The soldier says, "Oh, I got this." "Drink water." That's basically what they tell you. My body right now is broken down. I'm in my late thirties. When I wake up, it takes me 15 minutes to get out of bed. I can't walk like I used to.

Especially with mental issues, with PTSD, it can be from a car wreck, anything. I fell out of a tree when I was two years old, and I'm scared of heights now. You can get it from having a bad situation in Basic. Or you can be out in sector, and just that environment itself can be traumatic to you. Because of the things you have to do, or the things you have to ignore.

I have children, I have six of them. And it broke my heart every time I walked sector, I see a little kid that's begging for food, or fighting for candy, or struggling for water. That kills me. So all those things can play a factor. We're people. Yes, we're soldiers. But we're people. When you're at the firing range, you're shooting at targets, and when you go out in battle, in combat, they still try to make you think that you're shooting at targets. We're supposed to turn off the physical fact that you're no longer a human, you're a target. And you can get brainwashed into all that. But then when you step back, when you step away from it, you realize that those are not targets. Those are people.

You agreed to do this job, so you should be expected to do these things, but as people, as conscious thinkers, the reality of it is, it sucks. It hurts. You can't look at somebody and say, "This is not a person." And if you do that, then you end up having these relapses where—for me, I can only do my job, I get sweats at night, and nightmares, and all that stuff. Those mental things become physical.

The process is a whole lot better now than in 2007. When I got out in 2007, it was crazy. The chain of command says, "Oh, here we go again, we've got another guy, another soldier gone crazy because this or that." We're not machines, it's not like you can throw WD-40 on us and send us back out there.

Multiple deployments have made this stuff worse. I was at Benning, and I was in the military for five years, from 2002 to 2007. And in that period of time, I had three deployments. In five years, I spent over 21 months in Iraq. And this is during the time when my wife is in the military, and she's deployed twice. Our family life was nothing, it didn't exist. The multiple deployments definitely make things worse. If you deploy, you're gone for around twelve months. Then they give you a six-month block, where you take 30 days leave, and then you train up for the next deployment for

the next four or five months. It's hard on the family. It's hard on the person. You don't have a chance to recover. Six months is not long enough, and actually, 30 days is not long enough, to come down from a deployment.

It took my wife a whole year before she could even drive.

We've been together since we met in the military. We've grown together up through the ranks. At Benning I had a great lieutenant command, and it was good learning. They took care of soldiers. And so, from that experience, when we had people taking care of us, that's how we were as leaders. Anything one of our soldiers needed, even if they were not even a soldier anymore—if he needed a babysitter right now, if he's going through something, we say, “C'mon, bring the kids, we'll keep them as long as you need them.”

10 Cynthia Thomas

Editor's Note: Cynthia is a long-time community leader in the Killeen-Fort Hood area. Though she had ended her long-term marriage to a career soldier, she had not stopped her advocacy on behalf of injured soldiers and military families. At the time of the interview, Cynthia was living in San Antonio with her two daughters. In her interview, she speaks about her own experiences advocating for her husband-at-the-time's well being amidst repeated deployments, as well as her work to support and advocate for the rights of all soldiers at Fort Hood and beyond.

I met Chris* in August of 1991. He had just gotten back from Desert Storm.

We met in California, and I knew him four months, and then I married him. I came back to Texas, and he was getting stationed in Germany at the time. He came down to Texas, we got married, and four days later he was in Germany.

I stayed here in Texas, and had my first child. I wanted to be close to the family. He got out in December of '91. That's when Clinton was doing all the cut-backs and stuff, and he got an early retirement, but he stayed Reservist, and worked civil service for five years. And then in '98, I think it was, he decided to go back active duty. And we lived here in Texas that time. So, we went back.

After that, he was stationed in Germany, and it was ridiculous. He got there September 4th, I think, of 2001, and then 9/11 happened. And I was pregnant with my second child, ten years later! So he was in Germany again. And at that time, that was really hard. Because he was stationed, and then of course, all the security happened, and everything. And I'm here in Texas going to school, and have my first child already, and pregnant with my second. And we were apart. I think we saw each other 10 days of 14 months. And then I had my second child. And I told him, 'That's it. I need to go with you. I need to be there with you.' Because I knew they were gonna deploy. And so, after the 14 months, I went to Germany and spent four months with him there. And then he was gone for his first deployment after re-enlisting, to Iraq.

So basically, we saw each other four months in a span of probably two years.

We were stationed in Fort Hood in 2004. And then, he deployed again, about two years after the previous one in Iraq. He got wounded there in 2005. He was a truck driver, but they were security in the humvees, convoys, and all that. And I don't know what happened—it was a roll-over. He

was on life support. It took them seven days to bring him back to Walter Reed. And then he was there, and he was...you know, PTSD, TBI. They actually didn't think he was gonna make it. He died on the table three times. And they had him on life support, and he had fractures in his back, his pelvis, face, everything. He was really messed up.

That was in 2005. And then they redeployed him again in 2007. After the doctors told them, "He's non-deployable. If you send him out there and there's enemy fire, he won't be able to save himself." Because his body was so messed up. And so was his mind. He had Traumatic Brain Injury. And what people don't understand, which they were explaining to me at Walter Reed, is that it's actually 'permanent brain injury.' Because it is permanent. By the time I got back to Fort Hood they had changed it to Traumatic Brain Injury.



Cynthia and her two daughters in Austin, Texas, in 2014.

That third time is even harder to remember. It was August of 2007, and he was supposed to be gone for 15 months. And I had told him, "You don't have to go. I can—I'll fight for you." And this was of course before I was an activist, or knew anything about it. I was just a spouse. And I was like, "Don't go. Don't go. You should not be going." Because mentally, he was just not there. He had a lot of memory loss. And considering the injuries he had, he was only at Walter Reed one month, and I brought him home.

I had enough courses in nursing that I was able to do it. He was like, I don't want to be here anymore. Take me home, take me home." And so I told them, "Do whatever you have to do. Hospital bed, everything." We were in a townhouse, and so I said, I'll take care of him at home." And they said, "Okay." He was in a wheelchair, and had a back brace and everything. He got wounded on September 25th and he was back at work by February.

And he had lost 30 pounds in 30 days, and was in the wheelchair, and wasn't supposed to be really doing much. But they didn't give him any physical therapy when he got back. They would send him to the pool with the older women who were doing their little water exercises or whatever. He did have some cognitive therapy. They did some biofeedback, you know. But I think it was maybe six month's worth, and that was it. They were like, "Okay, we're good." And it was like, "No, you're not good." And they didn't even know how bad it was unless I spoke up. I was like, "He needs therapy. This is what's happening." Because he didn't even realize he had memory loss. I would observe him, and I would talk to the doctors and everything. But I think it was really hard for him, because every time they would see the paperwork, they were like, "How did you survive?" And that would mess with his head. But they knew, and they still deployed him.

They gave me no support, as his spouse. None. Even at the time they came and notified me. But one of the good things was the commander from over there with the rear detachment. The commander from over there wanted them to take the Chaplain with them to notify me because they thought he was gonna die. And the acting commander was like, "Ah, no. Unless he has passed, we're not doing that, because that is a trauma in itself." And so, when they came and notified me they didn't have the Chaplain. But of course, that didn't matter because I didn't notice that he was there or not. At that time I had to prepare to go to Walter Reed. I had a three year-old and a 13 year-old at home.

So that's one of the things the military needs to start understanding. When this happens, there is no support for the family members. I think somebody from the Family Readiness Group called me over the phone. She had five kids of her own. I could hear all the kids in the background, and she's like, with no expression, "Oh, well, you know, what happened? Do you need any...."—and I was just like, "Mmm, no. No." That's not support; that's not what we need.

I had prepared myself if something like this had happened, so I was lucky enough that since I had prepared, I kind of had my head on a little bit straight. I called my family. I had my mother and my sister come up. I went to Housing, and I told them, "My sister's coming here with her three kids. They need to be allowed in Housing. They need permission that they're going to live here." I gave my sister power of attorney to all my accounts and all my bills. I enrolled her three kids in the base school. I was lucky that my sister could do that for me. But the unit support and Family Readiness Group didn't do anything. I asked them, "How do I get an ID for my sister?" So that she could use the commissary, come in and off post, and stuff like that. It took them two days to get back with me. By then, I had already had the answer myself. I just went in to the ID place, and they gave me the paperwork.

There is nothing in place to help the family members through any of this stuff. I think it would be a huge help for family members if they would make support available. But until this day, I don't think anything's in place like that. Because the last thing that our kids need is to be uprooted and sent off to another place. I think if we could have something within the base to help our kids while we're off taking care of our husband, or if you have a family member that can come on post and take care of our kids then that would be great. That was a huge relief for me.

His third deployment was supposed to be 15 months. And we talked all the time. And I was

always asking, "How are you doing? How are you doing?" For one, his body was not in shape enough. He was pulling 16-hour days. But he couldn't really do much. The doctors told him, "You're never even gonna run again, much less drive trucks." So of course they left him on the FOB. But they were making him sit at the FOB doing dispatch or whatever for 16-hour days.

He was an E-7 at that point. And he was just in so much pain. They were giving him medication. For one, one of the medications they gave him specifically said, "If this person has Traumatic Brain Injury, do not give them this medication, because it could cause seizures and kill them." And they prescribed him this medication. The good thing was that he had told me, "I took this medication, and it made me sick." And I was like, "What's the name?" And of course I google it, and I just said, "Do not take this medication." So he didn't anymore. Also, they knew that he was already wounded and they would not let him go to the doctors. The base doctor would see him. But they were just like, "Oh, no." And he was saying, "I have a lot of headaches. I have a lot of headaches." "Oh, it's because you need glasses." My husband has always had 20-10 vision and never ever has wavered from that. And then they're saying, "Oh, because of your age." He's having dizzy spells, he's having headaches and they just didn't care. They just really didn't care.

After 12 months, he calls me and he's like, "That's it, I can't do it anymore." He's on the verge of tears he's so emotional and stressed. And that's when I started fighting for him. I went and talked to the battalion sergeant major and it was the worst experience of my life up to this day. They were so callous. You know, they're just like, "Oh, well, I think he's fine." And it got to the point where I showed up and they're like, "Well, no, we don't know. We ask them if they'd had any prior injuries or anything like that. And he must've put no, because if he'd put yes, we wouldn't have deployed him." And I said, "He would not." He said, "A lot of soldiers hide this from us because they really want to be with their brothers." I said, "No. Mine wouldn't have. You don't understand how badly wounded he was."

My husband had copies, because he keeps everything. So he sends them to me, and I show up, and I said, "Here's your paperwork. He told y'all, over and over." And I remember the month prior to him deploying, where they were asking him, "How are you doing? What's the doctor saying? You ready to go?" And he's like, "No. The doctor says I'm non-deployable." I remember. He had permanent profiles.

And I'm like, "Don't tell me you guys didn't know!" And he said, "Well, I don't know." I showed up with a stack, two, three inches thick, of his paperwork from Walter Reed. I said, "There you go. Bring him home"

And they said, "Well, this and that." And so we fought, and I said, "Look, all I want you to do is send him to see a doctor. Not just the local doctor, but an orthopedic doctor or somebody that had specialized in his body and everything." And they had to fly him there. I told them, "Just send him there. If they say he's okay, then I'm good. But if they need to send him to Germany to get checked, then you need to send him to Germany. And if they okay it, and send him back, I'll be good with that. Someone just needs to check him." And I knew, that as soon as they saw his chart, there was no way they'd have him stay. He was not supposed to be there.

And that's exactly what happened. They sent him, and as soon as the doctor saw his chart, they said, "What the hell are you doing here? There is no way you should be here. You're on the next medevac out." And his doctor told him, "Well, no, because he's not emergency, we're gonna take him back so he can get his stuff. And we'll medevac him from there." And they kept him. Even though the other doctor had said, "He's outta here now." They kept him for another month. I was over here just fighting. It got to the point where I was having screaming matches with them, and I almost physically got in an altercation with the sergeant major. Because he was just horrible.

And that's when I realized that, my husband being in his 40s, he had already served over 20 years. I was in my 30s. We had already done three deployments. He had done Desert Storm. I was like, "If they're treating us like this..." He had a little bit of rank. "If they're treating us like this, what chance do these young couples have, that have been in the military one, two, three years? They don't have a chance at all." And that's when I decided to fight and become an advocate for soldiers.

Before his third deployment, I had been pretty ignorant. You always think something could happen but you don't really think about it that much. But then, when you get that knock on the door, it all changes. So the third deployment was really hard. I went into depression. The majority of the wives here are on medications and depressed.

I started reading on the internet—I didn't agree with the wars anymore. My step-son joined the Marines, and then I thought, "We're gonna be fighting these wars—our kids are gonna be fighting these wars." And so I started looking for a group, and I couldn't find one in Killeen. I had seen a picture of Desiree from Code Pink when she was at Congress, and she had the blood on her hands. She was telling Condoleeza Rice, "You have blood on your hands." That image stayed with me. So when I found out who the group was, I looked up the website and found out that there was an Austin chapter. That's when I reached out to them. I just showed up at one of their meetings, and never left.

I was in Austin at least three times a week with them. And of course, meeting other activists. Actually, the first day I was at Code Pink, they were doing an interview with the Austin Statesman. I ended up doing an interview that day. If it wasn't for Code Pink, I don't know what would've happened that year with that deployment. Because I was with them a lot. They were a huge support. So when all this happened, that's when I decided to take active steps.

We had already talked about the old coffeehouses, and people wanted to do something in Killeen. The peace community cares so much about soldiers and family members. But we're always so guarded, families in the military, and we stay away. We're pretty much brainwashed. When Chris came back in August of 2008, we had already started the concept of the coffeehouse. But a lot of it starting had to do with when my son just called me and said, "I have something to tell you." And I knew immediately, as soon as he said that. And it was devastating.

He told me, "I'm joining the Marines." And one of my biggest regrets was not taking him to see his father at Walter Reed, because I think that would've changed his mind. And he joined. He got

lucky and he never deployed. He was in four years. He knew immediately that, “Oh, this is bullshit.” He figured that out in Boot Camp. Boot Camp's eight weeks, and he's like, “Damn, what was I thinking!” And then he had to stay in for another four years. But he's out now, thank goodness. And he's good. I'm still trying to get him to move down here.

So Under the Hood opened in 2009. My ex-husband was a big part of that. I wanted to create a space for soldiers, but I tell people I had also selfish reasons too, because I wanted him to have a space. Little did I know that he just wanted to block everything out. He just didn't want to think about it. But he was supportive. I mean, he helped clean it up, and with our first barbecues he would barbecue for us, and it was great. It just took up a lot of my time. And they always told me “You gotta find a balance. You need to take care of your family first.” But how do you tell a 20-something-year-old soldier that you're not there for them? It was hard on him too, you know. But it was something I had to do. And I knew that, with him, I had given him all the support I could give him, and now he had to take that next step, go to counseling. Because he wouldn't. He just didn't want to. He didn't want to think about it. It was difficult. But he just kind of separated himself from it.

The coffeehouse became a place for organizations to come and collaborate, which is what I wanted. I didn't want an organization, because we have a lot of great organizations. But I didn't want one organization, with their agenda, or what their views were about it. And when I was working with our active duty soldiers at the time, we had a lot of Vietnam vets that see things differently. Fort Hood is a world of its own. What works in one base does not work at ours. What works at ours does not work at another base.

We had to make sure that it was community-run. When we created our board and we made our organization, the first thing was that the Fort Hood people are gonna call the shots, because we know our community. It would be real difficult for someone from the outside to understand how it is for us there, and what we have to deal with on a daily basis. One of the biggest things I wanted to do was bring our military community and our peace community together. Because the peace community has this misconception that they'd be used, or that the military brainwashed us. I wanted to bring them together. I also wanted other organizations to be able to come together. Since it wasn't one organization's space they could all use it, whether it was ISO, or whether it was Veterans for Peace or whether it was Iraq Veterans Against the War.

For the most part, we created the space for IVAW, you know, but we welcomed everybody. So, and that's why we had the Communist Manifesto, the Koran, we had everything there. And some people did not like that. Our more conservatives or moderates, were kind of like, “Mmm, what's...” —But it was like, “No, it's open to everybody.” I loved that.

The biggest issue we were facing, from the beginning, was of course the PTSD, the self-medicating. But with prescription drugs, from the base. They would just give them all this medication. They would take extra, or whatever, and it would get them high. They were just a mess. With some of the medication, they weren't even coherent. They were zombied out. And so they would decide to stop taking the medication, or we would try to help them out in whichever way we could. A lot of cases we had, I took them to the fifth floor.¹⁶³ I would sit with them in the

ER. I was lucky enough that even though I wasn't a spouse, I would just tell them, "I'm a family friend, and their mom just wants me to make sure they're okay," and they would let me go in the back with them in the ER. And because they were freaking out at the time, at least they weren't by themselves.

And then of course, the ER calls whatever NCO to come and sit with the soldier. And some of them were real jerks. Having someone else there present made them back off and stuff. But I did that with several of them, and we had one that was there for a couple hours. It was a black-out. I mean, he doesn't remember anything of it. And we ended up asking, "Where's he at? Is he in the restroom?" We started looking, and he was hiding behind a tree in the front. He was there and he was freaking out because he was seeing images of a child he had shot. He just freaked out. We ended up having to take him to the ER, and they admitted him. He was there for probably a week or two and came out.

Then, there's always that stigma and shame. They make you feel like you're crazy because you go to the fifth floor. But these guys found a way to say, "You know what? We're human. We are human, and we have break-downs, and we're fucked." And so, towards the end, they were saying, "Well, I was there five weeks! I beat your ass!" You know, it kind of became okay. When we had other new soldiers come in that needed help, it made it okay to go get the help.

We had a lot of people come in to the coffeeshop that were just needing advice, or saying "Okay, this is what's going on. What do I need to do?" And we would say, "Okay, well, this is what we found helpful." And we would tell them the process: you can do the walk-in, and just ask for an appointment to get an evaluation. And we would tell them, "This is what you do. Just go sign in." And I would tell them, "Be prepared, because your ass is gonna be there all day." It's almost like they do it on purpose just to see how many of them walk out. Also, the paperwork you have to fill out. I went several times with a couple soldiers that had panic attacks. They had to sit against the wall, because they didn't want anyone walking behind them. And I would sit there with them. I had gone through the process with mine, so that's why I knew. A questionnaire of 300 questions! I'm like, "You cannot give a soldier with issues these questions! That's ridiculous!" There would be almost the same question but re-worded, and that would frustrate them so much. And I would say, "It's okay." And just give that support, being there with them where it's like, "Okay, why don't we take a break. Let's go outside and smoke a cigarette." Come back in, finish the paperwork. We would be there hours, five, six hours. It was ridiculous.

And so people would come in and we would give them the step-by-steps, what they could do, what options they had. Later on we would hear that they made it into the Warrior Transition Unit or that they got their 5-17¹⁶⁴ and they were out. But people that came to the coffeehouse didn't always stay at the coffeehouse. Now I wish I would've collected the data. Because at the time I didn't, but now it would've been...Even just, "John Doe," and what they came in for, what kind of information were they seeking, and what would we give them? We never did that. Now it would've been kind of nice to say "Okay, this is who we helped."

But I know that all those soldiers that came through our doors...our regulars, none of them redeployed. I didn't realize that until one of my soldiers told me that at the end, when I was

leaving. That's good. We did our job. That's what our goal was, to make sure they were okay. So that was cool.

I was there at the coffeehouse about two years. We had our soft opening in February, and we had our grand opening by the first of March of 2009. And I left April, 2011.

I've heard it blamed on spouses, when guys get PTSD. The most the command did was say, "They've been at war"—and this is later on, it wasn't at the beginning. "They're gonna come back a little different," or, "They're gonna be a little stressed, and you guys just kind of need to take it easy on them." It was just bullshit talk at one of the meetings right before they came home. It was nothing like where you could sit and hear testimony from another spouse, like how bad it can get, what are the issues. You are not prepared when they come back, for any of it. Because you have no idea. You have no idea what they went through. And some of them talk about it, some of them don't. A lot of them come back and they're just violent, they're angry. They leave the war, but they bring it home with them.

Our war starts at home. My husband was always passive, very laid-back. With every deployment, he was different, and definitely more aggressive. So if you're already aggressive and hyped before, then you come back that much worse. The stories some of the wives would tell me, it was unreal. It was unreal. That's where all the abuse comes in, and we're talking bad. Breaking arms and putting their heads through walls, out of pure rage and anger that they just don't know how to control.

The soldiers need counseling, and anger management. With a deployment, you have to be able to find ways to cope, and they don't know how. And not only that, it's almost like they're discouraged to do it. If they're already having issues at home, and then you send them for another deployment, it's not gonna get any better. I used to think of when, at the beginning in 2005, mine was wounded. And I was watching some TV show. It was a soldier speaking, about how his wife had left him. He had PTSD. And I was so angry. I was angry at her. Like, how could you leave your soldier? How could you do that? No matter what, I would never leave mine. I loved my husband, and no matter what issues he had. But I was dumb, I was ignorant. I didn't know what she was dealing with. And then when you walk a mile in those shoes, then you're like, "Oh, okay. This is what she was dealing with." And then of course you understand. But those issues are never addressed by the military.

And we got divorced. He chose to leave, in September of 2009. We were separated by October first. That's when I moved out. We had our issues before, you have to understand. After he was wounded and we reconnected, we were just completely inseparable. And then, the issues started. He got a little bit physical. I packed up my stuff and I left with the clothes on my back. I got my kids and I said, "You know what? I'm not even sticking around for it to get any worse. This was enough for me." And I left.

Before that I had already started going out of town, just to get away, because he was so detached and then when he would interact with me, it was usually fights. Not provoked. He could be sitting down, watching TV, and I would walk by, and he would turn and look at me, and I knew

the moment he would look at me that that was it. It was pure rage. And it was on. My kids saw a lot of that because we were always home. We never went out, we never drank, we never did any of that. He would drink at home. It just got to the point where I started leaving the house, going out of town for a week at a time and then go back home. Since he had separated himself, I started keeping myself busy doing other things.

So then, I ended up leaving. He was really, really angry, and hunting me down, and threatening me. And I was calling his command. I was calling his first sergeant, because he was good friends with him. And I said, "Look, I don't want to get him in trouble. I don't want it against him, or anything like that." Because I knew he was not getting help. And I was like, "You need to talk to him. He's calling my family and my friends, and threatening them. You need to go check on him, please. Somebody go check on him." So they would and everything. But it took him a while. We filed for divorce. And he calmed down, and we started talking again. And we were trying to figure out, "Okay, we're gonna sell the house." He was going to buy me a house in Houston. We were on good terms again. And then we find out he's deploying again. And I was not gonna leave him like that. I came home. We were only separated a couple of months. And I came back. I was there again a few months, and then he deployed, to that last one.

This was on his third deployment to Iraq. The issues started with when we was wounded. When he came back from this last deployment, I knew he was gone. Completely gone. He was already different with each deployment, but I knew I'd lost him with the last one. And so that's why I kept myself busy, and I threw myself into my work. Of course, he wasn't used to that because my life was him and the kids since I was 18. I was always at home and taking care of the family. He wouldn't get help. And it just got worse and worse. He finally just one day said, "I don't want to be married anymore." And by that time he was already running around. I could've tried to convince him, but I was like, "He's gone."

The real sad part is that he didn't get the help, and it's already been—what? Two years now? His anger is a lot worse, than even when I was around. I've talked to him, and he drinks a lot, a lot, and gets angry. He was never like that. And I'm like, "Are you kidding?! You cannot expect for me to let my kids go to see you." I'm not sending my 10 year-old, because I don't know what's happening. That's my fear, that he's explosive. And he's a good father. But when he explodes... He said, "No, no. I'm getting help." And whether he has or hasn't, I don't know. But it just gets worse.

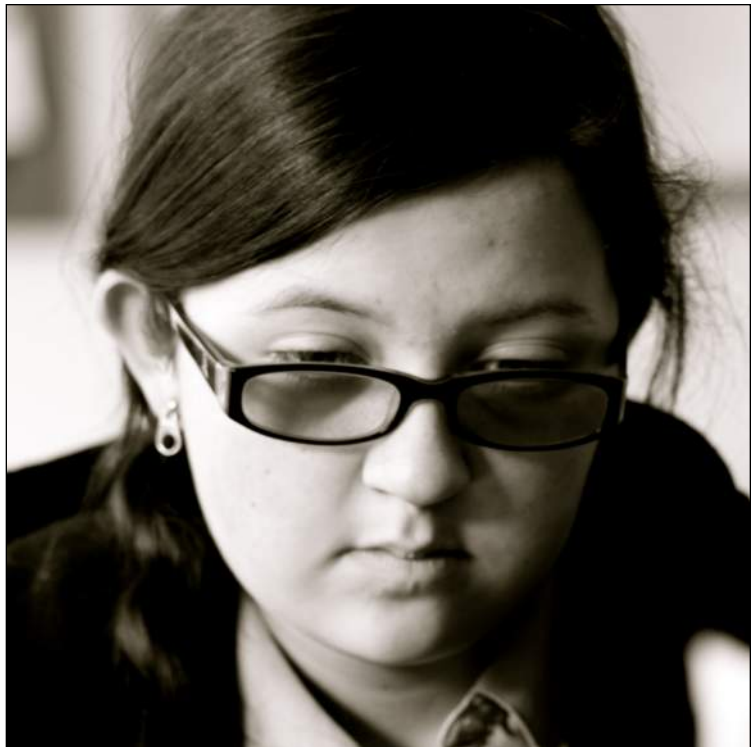
My younger daughter, the 10 year-old, she doesn't know anything else. But she has attachment issues. She does not like to be left alone. She gets scared if one of us goes, like we're not coming back. I'm thinking that all has to do with when she was little and we disappeared on her, because I went to Walter Reed, and then dad comes back and he's in a wheelchair. She was only three at the time, but she remembers. She will tell me, "Yeah, I remember, when I would sit with dad on the bed and watch TV, and he was in his back brace." She remembers all that, and she was three. So she does have separation anxiety, things like that.

With the older one, she's got more shit. She hides things very well, but she also has commitment issues, separation anxiety, everything... She even says, "I need counseling." You know, I say,

"That's good that you realize that, now just go get it." But she hides it all. She doesn't talk about it, because she starts immediately crying, because it's very hard for her. She says, "I have daddy issues." "That's not my father." She does not consider her dad her dad anymore. And she hasn't since she was 13, 14. By his second deployment, she was like, "That's not my dad." And she's said that since.

I just got lucky with my kids, because they're good kids. They didn't turn to drugs or just acting out. That's because I was hard on them. But a lot of their friends are base kids and are very, very messed up. They're lost, just lost. Because the parents are having their own issues, or the kids are unsupervised. When my daughter was in junior high, they were sneaking out of the house and drinking, doing drugs. They were having orgies.

Supposedly they have services for the kids. But we never hear about them. I think it was sixth, seventh and eighth grade talking to the principal and the counselor, and they were talking about the kids: "We don't just have kids that have one parent deployed. We have kids that have both parents deployed or the single parent deployed." They gave me examples. One girl, it was both parents deployed for the last six years and mind you, she was in seventh grade. For six years, one would go, and one would be home, and then this one would go, and the other one would go. That's how they were doing it. Another one, her mom was deployed, and she was a single parent, so the girl went with the grandmother, but the grandmother died. So she's the only one at home, and her mother's in Iraq.



Cynthia's younger daughter, in 2014

I knew about my daughter's friend, whose mother was involved with the rear commander, and the daughter was seeing this while her dad was deployed. These kids just don't have the support. They don't have enough counselors for our soldiers, much less for the family members.

One woman I knew had a 15 year-old at the time and he was having issues. They sent him to behavioral health, the psych ward, whatever, off-post. This was at midnight or something. I drove them over there, and we were admitting him and so she was doing the paperwork. I'm sitting there and I'm watching the night shift. They're all standing around there and they're talking and all the kids are asleep, listening to them, and they're like, "Oh, yeah, so and so was running around! And he ran around me, and I had to catch him!" I'm listening to them, and I asked them, "Do you mind if I ask how old he was?" The little boy was six. And I was like, "What?!" Because the way



Cynthia's older daughter, in 2014.

he made it sound, he was a big orderly. So, but I'm thinking, he was bigger and so I asked him how young, and he was like, "Six."

He was one of their inpatients already. We were admitting my friend's son but the orderlies were talking about another patient that was already there. And so, I found out the patient was six. So I asked him, "How young do they come?" "Four." I was like, "Wow!"

Then I said, "Do you have military kids in here?" And he said "The majority are military kids." And I was like, "Really?!" And he said "Yeah. The majority of our patients are military brats." And that was when I started becoming aware of what's happening.

But those are extreme cases. And that's when the parents decide to send them, but a lot of times they don't. I had Criminal Investigation Command come to my door, and ask about a neighbor. And there was abuse there. I don't know if it was physical, sexual, or what, but it was abuse of a child. And these are our neighborhoods. This is what we deal with on a constant basis. Kids running around, and people just don't talk about it.

11 James Cleary*

Editor's Note: *James* is a white, single soldier in his late twenties who works as a Chaplain's Assistant and had been on two previous deployments at the time of his interview.*

I'm kind of from all over. I was born in the Southwest. Mainly raised in the Southeast. But I've got three years in the Northwest, and another two or three in the Northeast as well.

My dad was in the Army. He went to Korea after we left the Southwest, and my mom went to the Southeast, so that's why we ended up there. He was ready to deploy to Desert Storm the entire time. But never did. He got out in the early '90s, and then he ended up moving up and down the East coast. Then we ended up hitting hard times, and going back and forth between the Northeast and Southeast, and then the Northwest and Northeast. Lots of moving.

My dad's a government contractor now, and he was deployed to Afghanistan for a year. When I came back from Iraq, he went over. It was in between my deployments that he was gone. But my dad and I don't really talk.

I enlisted out of the Northeast. It was a last resort. I never was really the military type, per se. But it worked, it was a means to an end.

I couldn't afford school, and I wanted to get away from the life situation I was in beforehand. I had gotten turned down for any sort of support for school because I wasn't a resident of the state. And I just had to get away from where I was at, and that was the only way to do it. I was 18.

I actually wanted to go Navy first. And the Navy recruiter blew me off, and I got offered as a job to come in as a diver by the Army recruiter while I was waiting and getting blown off by the Navy recruiter. So I took the job as the diver, and then I got sick in the middle of the training, and they re-classed me to a mechanic.

The diver MOS was in my contract. I Drop on Request-ed, DOR-ed, because I got sick. It's the only training you can drop on request. I was sick through all of Basic, up into AIT.¹⁶⁵ Upper respiratory infections, everything else, I could hardly do anything. I was fine in the water with the training, 'cause you can't breathe anyways, but when it came to land stuff I couldn't do anything, I was just useless.

My first deployment was 15 months. We all knew, essentially, that it was gonna be that long. I didn't do any ride-along missions or the vehicle recoveries. I just never got tasked out for it. Originally I was on the reactive team, reactive to anything that broke. You would go out and fix it,

on command. And then they switched me over to routine service maintenance. So I ended up doing the regular services on the vehicles.

We had the biggest motor pool in Baghdad. By the end of it we had 45 HETs,¹⁶⁶ 75 PLSs,¹⁶⁷ five or six different 5-tons, and a few other random vehicles. We had a 10 to 12 man team. And we ended up getting people that supported us coming out of Fort Hood, attached to us to help us out. But it was ridiculous. And then, when we were there, it was time for all the HET trailers to have their five-year services. It was general recognition that we got it all knocked out, to the point where people were sending their HET trailers to us, after we finished ours, to have us work on them. And then they attached a bunch of civilians to work with us.

Our chief got to look good for that. We were still shitbags, and got yelled at every night for it, because of how terrible we were. Meanwhile, he was at a luncheon getting an award for our actions.

But I've been in now for six and a half years. Your first idea of health care is Basic Training. You're just pushed aside and ignored. Anything you have to say, they tell you to drink some water or take Ibuprofen, like everyone else. I still have damage on my knee that I haven't had looked at because of the stuff that went on at Basic Training.

We were going directly from a grenade ranch to FTX,¹⁶⁸ so we did our 8k ruck march in between the two spaces. We had everything for both the field as well as the grenade range in our bags. So we had 80, 90 pounds on our backs. We were almost at the field site and, walking on the gravel, I rolled my ankle and I came down—I want to say it was my left knee, but I can't remember 'cause it's so long ago now—where a rock jammed underneath my knee cap and my body weight came down on top, and then the rucksack came down on top. At first I was okay. And then I was walking funny for at least a week. But I was so close to being done with Basic Training, and on top of the hassle that they would give you, and the ignorance and attitudes that you would get for going to sick call, and the chance of being recycled,¹⁶⁹ I just suffered through it.

My major health issues happened on my first deployment. We were at a meeting in the summer of 2008, and we were getting yelled at for something. It was 11, 11:30 at night. I had this gut-wrenching pain, and I didn't know what it was. I was digging my fingers into the wood. I ended up having a hard time breathing, and I leaned over and grabbed a hold of one of the NCOs next to me. And he said, "Are you okay?" I thought I said no and shook my head, but I don't know. At that point I lost consciousness, fell forward, and him and the guy next to me caught me, stopped me from falling on my face. They said that I was shaking in their hands, slight tremors.

Then I sat up, and I was looking around at everybody, and everybody's looking at me like I was crazy, or thought I was faking it or something. And then my eyes rolled to the back of my head, my body flew backwards, my back bowed, and I continued to tremor. Shortly after that, I woke up with my head shaking and them holding me up in that position, stiff as a board. I felt worse coming out of it than when I went under. There were about 14 people there for witnesses.

And then the automatic first question, "Is he drinking water?" This, that, and blah blah blah. And

one of the other NCOs said, “No. He's one of the only people I always see with a bottle of water. He's always drinking water.” So they took me to the sick call place. It was after-hours. I got in there and they asked—with their normal attitudes because it's after-hours and they don't want to work. They asked, “What's going on?” And I said, “I think I had a seizure.” And they said, “You ‘think’ you had a seizure?” And I said, “Well, I don't know, I lost consciousness. My back bowed, my entire body tremmored, 14 witnesses, what do you think?” And he asked, “Well, did you have a bowel movement?” And I said, “No, I didn't have a bowel movement! I know it's common, but is it mandatory? No.” I knew something had happened. They gave me more attitude. And then they hooked me up, checked me with an EKG, took my temperature, checked my heart rate.

They said they couldn't find anything, and they flat-out said, “We're gonna write it down as an isolated loss of consciousness. If it happens again, we'll probably send you to Germany, but other than that, there's nothing we can do. Or nothing that we want to do.” They didn't write it down as a seizure, just an isolated loss of consciousness. I said, “Okay, fine.” About a week later I lost consciousness. I didn't go back, though. I didn't want to get mistreated and have more hassle. So I lost consciousness, and reported the losses of consciousness over the years that I'd been in, and from that point on nothing's been done of it, to this day. And that first one didn't even make it to my medical record. I found that out after my second deployment, when I came back and was getting looked at for Traumatic Brain Injury. The loss of consciousness wasn't in my record, and I said, “Make sure that it is in there, because it did happen.”

The same deployment, I had this crazy abscess that a lot of people were getting in different spots. I got mine on my thigh. It got to the point where the red area was about the size of a softball on my thigh—with a giant red infected area right in the center. I went in, and they told me that I should have gone in earlier. And I said, “Well, I thought it was an ingrown hair. I thought it would have gotten better, but it didn't.” They said, “Well, there's nothing we can do, as far as numbing goes, because it's too inflamed.” So they proceed to bring over someone to learn and see what they're supposed to do in this situation.

I think it was a full colonel that was taking care of me at that point. He grabbed a scalpel, stabbed my thigh, and squeezed the hell out of it. Then he proceeded to grab a pair of clamps, and just started ripping the flesh out of my thigh. Again, with no numbing. And then he squeezed it some more. Eventually it just went numb on it's own, because he went into my thigh about an inch deep and about as big around as the size of a dime. Then, he was going to use a Q-tip to stuff it with gauze. And he said, “I'm supposed to use the soft end, but it's more precise with the wooden part.” I said, “Okay.” And he started grinding the wood against the side of my leg on the inside, and naturally I jerk in pain. And the nurse looks at me and says, “Are you sure you don't want any numbing?” I said, “Really? Now you tell me I can have it?” So they finished stuffing it and put an ace wrap around it. They ended up giving me four days of quarters, but when I got up to walk off the table and I naturally started limping, the colonel looks at me and—with attitude—says, “You can walk normal now.” I said, “Really? I'm gonna walk normal with a hole in my leg? Thanks.”

They never knew what it was. I went in every day for a week and got the gauze changed out. And I went in once a week after that for a month, continuing the gauze change-out, and that was it.

They didn't even give me any pain meds when I came in for the change-outs. They found out later that I wasn't getting any sort of medication for pain, and they decided to give me some. But that was it. They still don't know to this day what caused it. But there were five or six other people that were getting it too, in different areas. And a lot of them were worse than me.

I'm just going to stick with mainly describing the stuff that's been documented. The next big issue would've been the care that I got when I had the suicide attempt. I'm not racist, and I don't care if someone's Arab or Muslim. I know what a real Muslim is and I know what a radical is, but a lot of the people in the military don't and they stereotype immediately. There are people going into the Darnall facility dealing with PTSD and all this other stuff, and I thought it was rather alarming that one of the main doctors up there looked like a straight up Hajji,¹⁷⁰ and he happened to be my doctor when I went into the hospital. And I just thought that was off. Plus, he didn't listen to anything I had to say. As a matter of fact, I caught him not listening to anything I had to say in the middle of one of my meetings, and called him out on it. I had given him all my medical history the day before, explaining that I know what I'm talking about, I've been on medications before, this, that, and the other.

But when we had our command meeting, he was trying to talk to me about getting help. And I said, "Do I want help? No. But I'm not gonna have a choice. I understand that my actions have repercussions. It's fine. I'll walk the path. I'll go forward with your quote-unquote help. But do I really want it and do I expect it to work? No." He said, "You want help but you don't think it'll work?" And I said, "No. I don't want it, either." And he just repeated himself. And I said, "Fine, whatever, sure. You're right. Whatever. Just shut up." And then he says, "Have you ever had any major therapy?" And I looked at him straight-faced, and I thought, "He's really asking me this?" I said, "Since I was nine. Like I told you yesterday."

He did a double-take. He said, "What?" And I said, "Yeah, remember? All the medications I've been on, and everything?" And he said, "Oh, well, I'm not trying to put you on any medications, blah blah blah."

That was a fifth floor¹⁷¹ doctor. As far as I know, he's still there. He tried to say everything that I was going through was because of my childhood and it had nothing to do with my first deployment, the hours that we worked, the military demand on us, the getting blown up while we were there, numerous rockets coming in. Not even two weeks before we left, we were staying in a tent city and got rocketed left and right. And then, on my second deployment, I had the rocket come and land probably 50, 60 feet from the car that I was driving on base. And it wasn't an armored car, it was a Chevy Tahoe.

I was driving back to the FOB and we were all there, Julie* and Major Jacks,* retired now. The rocket ended up cracking my windshield, and stuff was scuffed across the top. I've been diagnosed with a grade two TBI from it. And then the stress, and the fact that I buried about 18 people over my second deployment. And everything I'm going through is obviously from my childhood, according to this man.

But it didn't end there. I had another doctor who just sat in on the weekends and he looked like

he was high as a kite, and he looked at me flat-faced when I told him my story, and he said, “Well, honestly, I don't think that the best psychologist would be able to help you. You're essentially a hopeless case.”

And then I had another one—a Major that was an RN—tell me that I needed to get electro-shock therapy, that I'd been through too much, that I needed to just erase everything that I was and start new. I said, “Wow. Great. Thanks. That's fantastic.” It was funny, because the military and civilian nurses that were working at the hospital, they were more help than anybody else. The hospital gave me a break from life, to where I was able to analyze on my own and re-evaluate myself, and talk to the nurses and voice my thoughts there. The nurses were more helpful than the doctor ever was. But they were saying, “Why the fuck are you still here? It's obvious we're out of your limits, that we aren't able to help you. Why are you still here?” And I said, “Talk to the doctor. It's whatever. I don't care right now. I really just don't fucking care.” I was there for 20 days. Normal stay is usually a week, to a week and a half, maybe. So I went through three different cycles of people. When I got out, I saw quite a few doctors off-post. Just normal therapists. The main bad one was when I tried to get re-evaluated and they sent me over to Metroplex, and I saw a doctor there.

Metroplex is the civilian side. If you don't go to Darnall, sometimes they send you to Metroplex for their medical facilities off of Clear Creek. They have psychologists there. Because I refused to see any psychologists on post. I was using the nurse advocate's center for off-post case managers. I went to go talk to a doctor there, and I don't know how they stay in business. The doctor was rude and late. I sat there for 45 minutes after my appointment was due. I saw him for a total of 15 minutes. He asked me three questions and then tried to tell me that I was Borderline Personality Disorder. Number one, for a full evaluation you need at least an hour. There's no way you can make that assumption over three questions, either. He asked me about my home life, whether I talked to my family still, and one other random question. And I said, “Okay. You want to know why I don't talk to my family? Do you want to know why my home life is the way it is? If you're gonna ask these questions and you just want a blunt answer, I'm gonna give you the blunt answer. But if you're gonna make an assumption, when there's obviously more to it than the obvious one-word answer, then at least give me a chance to explain it. And don't make a rash decision.”

It was rather funny, because I went back and talked to my regular therapist the next week about it, and I said, “No, I'm not going back. That guy was a quack. And I'm actually offended that he told me that I was Borderline Personality Disorder. I knew something about the personality disorder to begin with, and then I did some more research when I got home. I was offended when I found out about it.” I thought, “Wow. That's nothing like me.” But when I explained that to my regular therapist, he said, “Yeah, normally I don't take much weight in a lot of people and what they say, coming here with complaints about this, that, and the other. But when you have consistently, person after person after person, saying the same thing about this one doctor, it's kind of undeniable.” And yet, the Army still sends all of its soldiers there.

The fifth floor diagnosed me as Adjustment Disorder with Mixed Emotions. But according to that doctor, everything derived from my childhood. So even if I tried to get VA benefits because of that, unless I got re-evaluated by a VA doctor who validated that it was from military service, the

military wouldn't have to pay for any sort of benefits, because he put in on my childhood.

I wish I could remember that doctor's name. He's a civilian. I actually put in a complaint about him when I left the hospital. He was terrible.

There were so many people that had bad experiences on the fifth floor. And there were cases while I was in there. Obviously patients talk and we're open about our cases. I saw the movie *Silver Linings Playbook* last night and it's about this, a crazy-people kind of thing where we're open. A lot of people that have been on medications or have been through some stuff, they're a lot more blunt and open, and they see things differently than most people. It was kind of obvious to us what our different cases were, and we knew what was going on with different people. The command had so much power over people's medical care while they were in there, and command would make promises to get them out, to get their hands back on them, to manipulate their cases—it's just ridiculous.

For example, your command could say to the doctors, "We want this person out. Is he borderline, yes or no?"

And command even influenced the over-seeing doctor's decision on one point. A lot of times the commander would just play the game and say what the doctor wanted to hear. And then they would fail to follow through, on every basis of what they said they were going to do to support the soldier, and attack the soldier for it. It was just ridiculous.

A really good example was this one female I was with, her case was unique. She had a suicide attempt and it was because she was raped. When she told her boyfriend about the rape, he no longer wanted to be with her. So she felt like she had nothing left, and she attempted suicide. This all came out while she was in the hospital, and the command was extremely supportive at that point. Then, she got out of the hospital and was going through the process of dealing with what had happened. But all the rape charges toward the man who raped her were all eventually dropped, and he maintained all his rank. And I think—to keep her quiet—they ended up PCSing her somewhere else so she wouldn't have to be around him. From the beginning of that situation, too, the unit was attacking her for what had happened.

There were cases like that, and then there were other ones where the command would take and switch a person back and forth in between two units, when they knew she had had issues in the past where she was assaulted or something. And they would just go back and forth, saying, "Oh, we're gonna help you. We're gonna PCS you. We're gonna switch you over to this unit." Well, it'd be back to the unit that she started out with. And then they'd send her back to the other one that was where she had the other issue. It was just a constant, continuous thing. It was to the point where staff at the hospital were saying, "You hear so many stories coming through here, that are so much alike, there's obviously something wrong." I have such a distaste for psychology and therapy, and anything to do with the psychological field from everything that I saw and went through myself.

Most people in my unit were shocked when I got hospitalized. They didn't expect it. There was

overwhelming support from people that knew me and talked to me on a regular basis. Other ones looked down on me, but they didn't ever really say anything, because the sergeant major and the colonel—I was working directly for them essentially—had my back. But more than anything, they wanted to keep everything silent, as quiet as possible so that the unit, the lower ones, wouldn't be impacted by the fact that the chaplain's assistant attempted suicide. So they tried to keep it as hush-hush as possible.

And here's where my issue with III Corps is right now. I've gone up the chain the proper way to try to get PCSed¹⁷² to somewhere where I have more of a safety net or a network of people that I can go to for support. And they said no.

I started contesting their answer at least a year ago. And they ended up saying no again. I've only got two years left—it was two and a half at the time. The military has PCSed people to Hawaii for a year left in their contract, but they refuse to move me, because they don't want to. My colonel said that he is perfectly fine with letting me go. I've had other people working avenues to try and help me, but the higher-ups won't. The best they're gonna do right now is move me elsewhere on Fort Hood, and that doesn't change the fact that I don't have someone I can go and talk to, or deal with the issues that I have, or that I can trust, without driving a minimum of three or four hours. And for them to get proper use out of me, to where I'm actually helpful to the military, you can PCS me anywhere on the East or West coast, and I'll be okay. But here in the midlands, I don't have anybody hardly. It's just complete disregard in that respect.

My first tour was mainly during the Surge, taking Sadr City, and everything else. We took IDF¹⁷³ randomly. But everything was pretty calm for the majority of the deployment, until the very end. That's when we were in the tents, and we got rocketed and everything else left and right.

My second deployment was kind of varied with IDFs, it was a back-washed area. Once a month or so we would get rocketed. And when they did, they'd shoot five or six in. There were quite a few of them that came in and hit stuff. Luckily a bunch of them didn't fully detonate or detonate at all. The one that I was involved in was a partial detonation. If it had been a full detonation, I would've been dead, because I was driving into it. Those were the main ones. Then when I would travel, we'd hit the ones at Kalsu,¹⁷⁴ also known as KILLSU, where they got to the point where they were shooting flares in the air to try and deter people from rocketing them. People would drive up to Tampa¹⁷⁵ and just fire right down into it, because it was a terrible location. The other base I was at, same thing—we were rocketed left and right. The night before I got there, they had a rocket hit the basketball courts right next to the chapel, and blow the basketball court up. And there were vehicle-borne IEDs that were used against the politicians at the gate.

One VBIED¹⁷⁶ attack woke me up. They were trying to kill a politician. Automatically we were thinking rockets were coming in 'cause it shook every CHU.¹⁷⁷ Everyone ran to the bunkers, and then we found out it was a VBIED. A lot of the combat was on the outside of things, when we would drive through some really bad areas. In one spot we set up a training camp, and people were getting attacked left and right, just driving through the city. We had two different incidents where people passed away from RPGs¹⁷⁸ being fired at them.

And RPGs were fired at the gunner's hatch. Sometimes it would hit the gunner and a lot of times it would hit outside the gunner. It jerked one of our gunner's body back and slammed him forward and almost severed his torso. It was all shredded. Other times the blast would come up and it would fry their lungs from the inside out and the doctors would literally make an incision and try and pump their heart for them, and they couldn't come back. There was Patterson,* Evans,* Clark*. Clark was a passenger, he was with Evans, and shrapnel came in, hit him in the back of his head by the brainstem, and killed him. I had to clean his body. Just one after another, people rolling in from different vehicle attacks, from being out on convoys.

At that point I was a Chaplain's Assistant. If I needed to talk to anyone for my own care, I would talk to the Chaplain if I needed to, or I could talk to Major Jacks, at the time, just 'cause we had that kind of relationship. But I just kind of shut down on it. I just closed my heart off.

The first experience I had with it really was with Levi.* He was the first one to go, and he got hit by a sniper. I had to tell one of my friends in the unit and I had to be there to try and help him. He found out and he was possibly gonna go on the mission, he was blaming himself for what was happening, and he shut down. I was trying to just be there for him when I could. And then later that night, when we had the hero flight, they had people that weren't even trained to do it. It was supposed to be us four, and we were supposed to work with the morgue and the body and everything else. And the guys refused to do it—they had our regular clerks for the S1 shop¹⁷⁹ down in the troop level for dealing with it.

The guy was just really superstitious, and he didn't want to go in there alone so I went with him to help. The RCO¹⁸⁰ came into the morgue while we were in there grabbing his belongings. And we got stuck there when they unzipped the body. My first thought was it looked like a wax figure, to the point where his eyes were still open. I thought that was disrespectful that they didn't even close his eyes.

But that was my first experience, and it was awkward, in the sense that I was not bothered by it. I felt like I should be, but I wasn't. And then the second one was dealing with Evans and Clark. I was literally cleaning the body and I thought, "Whatever. I'm not just gonna sit in the room with a dead body, I'm gonna help out the medics how I can." But it just didn't bother me, it was just like another day to me at this point. And it was awkward because it always seemed it was a Friday or a Saturday that someone would get hit. We just kind of held our breath every Friday and watched for choppers or any sort of signs for anything to happen. Nine times out of ten I'd be down in the morgue, trying to help out in there, and then the Chaplain would be in the OR,¹⁸¹ dancing around the physicians and trying to do his thing. He had to not only take care of praying for the soldier on the operating board, but be there for the doctors and the nurses that are dealing with it too.

So it was like we were the fall-back. We were everyone's support, for Major Jacks and for all them too. And Julie the NCO, she would come to me with her issues, and kind of feed back to me. And then Major Jacks and Chaplain Bancroft* did it back and forth for each other. That's one of the reasons that this deployment was so hard for me, because I didn't have anybody like that, that I could fully confide in. I didn't have that one person I could latch on to. So I really disconnected in a lot of ways. That was a bit of a challenge. I just shut down and a lot of that

feeling's still gone.

We've had people die here and it doesn't bother me. I just think, "Okay, another one. Another senseless death." The only time it somewhat bothers me is when the memorial ceremony that I conduct doesn't go like it should, especially when it's for someone that has a legit innocent death, which has happened. And there's more of an anger factor than anything else that I don't feel like we've paid the tribute that he deserved, by having the proper memorial.

Since the attack with the rocket, I've had trouble sleeping. I've only been on sleeping pills. They refused to put me on anything at first. I would get Benadryl. Benadryl just made me more groggy than I was the day before. It worked for about three days, to get me to sleep, and then it stopped working. I've been on Ambien. I'm supposed to be on Atarax right now. I take it off and on, but it still makes me groggy until eight o'clock at night the next day. So I limit taking that. I've also been on Trazodone. And none of the above worked.

When I went through Reverse-SRP they told me to address it, said for me to try Lunesta because I started having addiction problems where I would get migraines and withdrawals from the Ambien. So they told me try Lunesta. I brought it up to my medics and they just brushed me off and ignored it. That was because the main physician that I was dealing with was that one who said, "Everything's because of your childhood. You don't need medications." I said, "I don't want to be on medications, but I also realize that I need help right now. And I know that a lot of the medication is what makes a person completely utterly numb, and that's speaking from experience." So it's a hard thing for me to say that I'm willing to try medication. That's a definite sign. But again, he disregarded everything I had to say.

As far as the TBI itself, I took that ANAM memory test before I deployed the second time, not the first time. But I haven't taken it since I've been back.

I haven't gotten any treatment for the TBI really. I have headaches, it's random. I used to never get headaches beforehand. So I have a dissolvable tablet that's supposedly the fastest reacting headache medication they've got. But most time they're gone before that even takes effect. So I just kind of deal with that.

It's kind of a lozenge. I wish I could remember the name of it. Honestly, I use TBI and the process of getting looked at for TBI to get looked at for the other issues I was having that are more serious in my mind. Like the fact that I lose feeling in three of the fingers in my hand, and that I get severe pains in my hand to where I can't even turn a doorknob. So I had MRIs and CAT scans and shock treatments done to try and figure out what's wrong. And they can't find anything wrong with me. I was already looked at by a physical therapist while I was overseas, who then told me to go talk to the nerve people. The nerve people can't find anything either, so they basically told me to go back and see the physical therapist, who already told me they can't help me. So if my hand hurts, I just don't do anything that day. If it's numb, I type with one hand because I can't type with the other.

That's how I started getting the sleep medication, from going to the TBI clinic. And that's how I

ended up in biofeedback to try and get my levels to where they needed to be. That was the only place I could really go to as an avenue for actual help. Which is sad to say, that I couldn't go to a legit, regular aid station to get that. I had to go through a Traumatic Brain Injury place to get the care I needed.

I wasn't on profile for the sleeping meds. I was on a profile for when I came out of the hospital, which is the mandatory six-month profile—not allowed to carry a weapon, non-deployable. At that point I had six doctors appointments or so a week. It was ridiculous. They had me going to biofeedback, they had me seeing the R&R Center therapy on Wednesdays, or whenever it was. Then they had me seeing the regular therapist off-post, and they also had me seeing the ASAP¹⁸² guy on top of it. And there was something else going on too, I forgot what. It was just appointment, appointment, appointment, to the point where even the doctor was saying, “You have too many appointments, and this is too much therapy.” One of the other chaplains I worked with was laughing, because I was so frustrated about the whole situation. They said, “You're gonna take this boy and change him from being suicidal into homicidal.”

It's so enraging, because most of them don't listen to what you have to say, and they're contorting it, because it's such a manipulated area. So many of the doctors are doing what the military wants just so they continue to get a paycheck rather than doing what's truly right and helping a person. Or they're manipulating TriCare and just trying to milk whatever money they can get out of a person without actually helping them.

I know about people that have overridden and deployed people that shouldn't be deployed, or tried to do so. I don't know about any specific policies about profile violation, never had any briefings. I just know whenever someone starts to violate profiles, when people get really, truly fed up with it, and they go to the patient advocacy center and they work it out there. Or they go to IG.¹⁸³

My position is unique. There are certain people that truly want to help, and I try and point people in need to them as much as I can. I also know where the bullshit areas are. And I have to be an avenue for help for people at the same time. In my position, more than anything, I sit there and act as a sounding board for people that are dealing with frustrations. And I've been there, I understand.

Honestly, the system needs a bit of an overhaul. They need to stop looking at us as numbers. As much as they say they don't, they do. And while they may say that we're not, their actions say otherwise. There are numerous medics and doctors that I've seen that have such a distaste for what is going on in the system. We had a doctor overseas, Dr. Solomon,* that the command couldn't stand, but he was a soldier's doctor, he took care of the soldiers. The soldiers loved him. But because he was taking care of them and giving them profiles they needed in order to heal, he was given a hard time, ridiculed the entire time, and knocked down left and right.

And then there are the other doctors who just ignore people's pain. There was a female my first deployment, Brandt,* who had huge amounts of back pain because she had a small, slender body type, but a really big chest. She was wearing 28 pounds of extra weight on her chest as a

small-statured woman. Immense back pain, and spasms. And the doctors said, "Oh, well, you just have back spasms, here's some Ibuprofen, do this stretch," and that's the end of it. They wouldn't do anything to help her. They just ignore others with spinal pain. It's just constant stories like that. You don't even have to experience it yourself, because so many other people have experienced it for you. People you know are not lying, and you see them in pain. It's just one thing after another.

SRP just feels like it's checking a box. It takes more time than it needs to, it's really disorganized. And even if you go through the SRP section and you start filing for stuff to start happening, nine times out of ten it still doesn't happen.

I've seen people who were not fit to deploy go through SRP and deploy anyway, oh yeah. We had that my first deployment. I wish I could remember her name, but she was crazy and she didn't even make it two months into the deployment. She got sent home 'cause she went to the sick call center and while she was waiting to see the doc, she started sucking her thumb and slamming her head against the wall.

While I was deployed, we had Mercer* and Sergeant Wolff both commit suicide. Mercer did it while he was overseas and Sergeant Wolff did it when he was on emergency leave. It was a huge effect on the unit. Our colonel was told by our regimental commander that if we had another one, he was going to be relieved of command. We had an emergency safety stand-down week, where it was a three-day process. The chaplain and Major Jacks had to create a curriculum while coordinating across the board with other medical centers in the region, and come up with a four-day plan of suicide and resiliency training, where people were stuck in the training for six to eight hours a day over two days. The first two days was all the higher-ups, and the second two days was the lower enlisted.

It wasn't effective. It was entirely too rushed. The plan didn't give people time to prepare, and it was just a quick, fast reaction to appease the higher-ups rather than look at the situation for the soldier. And the commander didn't address the issue that quite possibly and most likely it all had to do with the way he was using his command. He tried to live his command in consistency with Machiavelli. Lead by fear. The fact that people were committing suicide isn't much of a shock when that's the case. But he didn't want to see that, and he wanted to push the blame on someone else.

The process afterward was done way too fast, and it didn't even give people a chance to fully process the suicide, the second one anyway. The second one was Sergeant Wolff, and that was the one that hit everybody pretty hard, because it was so unexpected. And then we've had one suicide since we've been back. But that didn't really affect the unit because the guy was fairly new to the unit and his was in reaction to marital issues. And we have a new command now.

In my position, I'm responsible for battalion size. It boils down differently in size depending on which squadron you're part of. My squadron, we have right about a thousand people. After the suicides started, they just started sending everyone home. They were scared while we were deployed. The command got nervous and so anybody they had an inkling of a suicidal factor,

they were trying to get medically sent home. And then other people that just wanted to go home started to playing it that way. They sent people back to the States from the deployment. Some people were milking it, and other people were just trying to go for help to be better and didn't need to be home, but got sent home anyways.

Also, there's so much discrimination. A lot of it depends on the unit. Every unit has a different atmosphere, a different environment. So you're gonna see some units that are very open-minded and then you're gonna see other ones that aren't.

I'm in combat arms right now, so anybody that's considered weaker in any way, shape or form, is automatically looked down on. It's ridiculous as far as that goes. There's always the huge masculinity factor there. And then, of course, being in the military and then being in combat arms too, there's the whole gay thing going on as well.

People tell terrible gay jokes and straight people are acting gayer than the gay people are. And heaven forbid someone finds out that someone's actually gay, because then the harassment starts. That kind of thing is just stupid shit.

I've seen that stuff from the sidelines. My first unit was a little bit more open-minded, but there was discrimination against a few of the gay people at the same time. But there were so many of them, there was 16 gay people out of 200 people at one point, which was kind of a high number.

There was one case where a guy ended up getting out of the Army for being gay. It was just 'cause he pushed the issue, because he couldn't take it anymore.

He was getting discriminated on by one person in particular, and thought, "I'm done with it." Then there was a sexual assault of one of our lesbians in the unit. They ended up turning it to where it was all her fault, and that was the attitude of most of the unit, too. Eventually she got out for being gay. And she struggled with that really hard. It was really because of what had happened to her and the way that the unit turned against her that she wanted out, more than anything. But it wasn't easy for her to get out. She ended up having to send an 8x10 photo of herself in committed sexual acts to the post general in order for her to get out, on DADT.

My first boyfriend was at Fort Hood. He went as far as to get "Faggot" tattooed in rainbow across his forearm and attempted to get out with that. Waving it like a flag. He got out years ago though, before I was here, and he ended up getting out on depression.

They ended up letting him out for depression. I think the turning point for him was when a female in his unit tried to commit suicide. She had overdosed, and later on it came out that he knew that she had and he didn't report it. And command said, "Oh, we could come after you! Why didn't you come to us?" And he explained, "She's depressed because she hates you. And she has to deal with you every day. Therefore, you're the cause of her issues. Why would I go to the cause of her issues to try and get her help? Are you retarded?" And he added, "Besides, it's her life. If she wants to take it, let her fucking take it. What's your right to say that she can't?" But that's coming from a person who's naturally depressed. "It's her life, let her do what she wants."

On MST, I've just had the regular safety stand-down stuff. The only other thing I've had to do with sexual assault training was at a chaplain training, and it was more to address the issue of sexual assault in the military as a chaplain corps and what they need to do with it. So we sat down and watched 'The Invisible War.'

I was glad that they showed it. It needed to be seen. It was hard to watch. I think they could have made clearer reasoning behind showing it and where they were going with it, rather than leaving so much to interpretation, like chaplains like to do. It turned into a free-fall discussion about "What's the real point of this?"

Someone in a sister unit of mine dealt with MST, so I know her story. And there were people that tried to help her. But in my unit, not so much. It's mainly an all-male unit, so not much is gonna come out there. I know who my SHARP is, but we just see them to check the box.

In terms of being gay, lot of people say, "Okay, I'm gay. I can't show any sign of weakness because I am gay. I'm in a macho man kind of position." There's some people still hiding it and then there's others with the mentality of, "Okay, I'm gay, I already have something against me, I don't need to give them any more ammunition. So I'm gonna do everything at the top of my game." And then there's the other kind, "I'm gay, I'm gonna make the best of what I can." And then you have the ongoing jokes and harassments—that was kind of me. I just secluded myself from other people.

And I knew where there was a line for joking and I walked around that. I started out in my first unit saying that straight people are gayer than the gay people, 'good game'-ing each other left and right. And they had the nut-tap wars too. Numerous times with the good-game-ing somebody would smack my ass and hit it so hard and grab ahold of it to the point where they would lift me off the ground. Then there was another time where somebody came up behind me, ran their hand across my chest and squeezed me tightly. They said, "Oh, sorry, I thought that was mine." I looked at them and I said, "I have nothing I can say to that," and I just walked away. I wasn't even out. And I wasn't super-obvious either, about being gay. But they saw me as a target and thought, "Oh, let's fuck with him."

Sometimes it makes people fall apart because of that. When the repeal of DADT was first starting to be talked about during my first deployment, I had an E-7 come up to me and say, "I don't know what's gonna happen with that! I don't know if DADT, blah blah blah. I don't need no girl trying to rape me in the shower or looking at me!" And I said, "You think they're not there now? Do you think they're not in now? And that aside, that's why we have sexual assault prevention. Isn't that what that is for? It covers everyone, gay, straight, bi, whatever. It doesn't matter." And he said, "Oh, well, I never thought of that." So a lot of it is just people's overall ignorance and close-mindedness.

In terms of medical providers, there're so many medics that I know that are gay. They refuse to come out too because being a medic, they have to deal with genitalia. So many people are close-minded and paranoid. Just knowing the person's gay, even if they're ugly and there is absolutely

no attraction, they will try and claim sexual assault. So medical providers refuse to come out.

When I was in 5-East, they knew I was gay. Because the providers there were mainly civilians, they were like, "Oh, okay, whatever. It makes sense, makes this part fall more into place, to where I can understand this." But other than that, as far as my command, they don't know. But at the same time, for me, my orientation is my personal life, and it shouldn't matter. It doesn't affect my work life. It's not like I'm using that in my work life to do my job.

And the other thing is, on top of everything else, it irritates me that people make orientation such a big deal, to where it has to influence your work and what you can and can't do. Having to keep that part of myself protected, it's like I'm still a second-class citizen.

You have heterosexual people get married and their spouses are able to get medical benefits. They're able to get GI benefits if their spouse passes away in combat. If I was to marry a man, there's no nothing. He would get absolutely nothing, unless I had allotted part of my SGLI¹⁸⁴ to him or said my paycheck is gonna go to him. He would get no medical coverage, nothing. He would get no help, no health insurance, no housing allowance. It would be just like I was a single bachelor. And I wouldn't even be able to truly live with him because they would say, "No, you're gonna live in the barracks as a single man."

I don't live in the barracks right now. I have a contract marriage and I'm not ashamed of it. Because I am a 25 year-old man who refuses to live in a dorm lifestyle with a bunch of 18 year-old high-school-mindset children, being treated as though I don't know what the hell I'm doing. And I'm able to still show up to work on time and everything else. I think the Army needs to address that as well.

I'm only out to certain people in my unit, even. Again, I consider it a personal life factor, and I don't let a lot of people in my unit into my personal life. If they want to build a relationship with me, as a friend, I'll let them in on it, sure. But most of them I don't really care for and it's none of their business. 'Cause it doesn't affect my work. It doesn't affect my capability to do my job or anything else. And as long as I'm not coming on to them, why the hell does it matter? But a lot of people don't view it that way. They are afraid that "you're gonna catch the gay," or that if you're gay, automatically every man is attractive and that you have no idea how to control yourself.

Last I heard, my squadron is slotted to deploy for January of '14, to Afghanistan. But I won't be going, 'cause of my ETS.¹⁸⁵ I have to be back a minimum of three months before my ETS date. This interferes with the timeline. Plus the fact that my colonel and sergeant major wouldn't let me go at that point anyways. And I'm supposed to be getting transferred out of that squadron anyways, to be on rear detachment.

The latest medical issue I had was when I went in to sick call. It was on a Saturday while I was on leave. I had gotten a phone call that someone I had slept with had gotten a phone call that they had gotten something, but over the phone they couldn't tell me what it was. So I said, "Well, I need to make sure that I'm good to go. I need to be checked for everything." The first thing they told me at sick call was, "Oh, we're not even sure we'll be able to do this for you today. You might

have to come back, blah blah blah,” trying to just disregard me.

Then I went back into the hospital, and the doctor asked me if I'd had any symptoms. I said no, but that I didn't even know what the other person had. He said, “I'm gonna check you for two things: chlamydia and maybe syphilis.” And everything else I would have to do through a regular provider, but at this point, my aid stations¹⁸⁶ were really weird and I was between providers. I was not even sure where I was supposed to go, to be honest. But that doctor could have easily just done everything right there at the hospital. He was just lazy about it. I got tested for those two things there, and I still haven't gotten the results back.

Out of frustration and distaste after everything else that I've been through and seen, I just said, “Fuck it,” and I dished \$750 out of my own pocket to get a full test on my own through a civilian. I had my results less than a week later. And then, while I was on leave, I got really sick, and I had had a sore throat for a week before that. I went to clear my throat in the morning, and blood started coming out. And I thought, “Oh, great.” Someone I was staying with had a doctor's appointment the next day and the place they were going took TriCare. So I went there and I got looked at. My blood test came back and said that I had Epstein Barr in my system, so I found out I had mono. And I also had a viral and a bacterial infection in my sinuses that was dripping down into my throat, causing inflammation and pain. So they gave me a Z-Pak.¹⁸⁷

That bill was \$250 and TriCare refused it. Right now I'm waiting to find out whether I'm gonna have to pay that doctor bill, on my own, even though I went through the proper channels and put it through TriCare. It was so messed up with TriCare that they sent me a letter back saying that they refused to pay the bill, and the letter showed they were processing the bill to my father as my sponsor for medical care coverage instead of me, even though, even though I'm active duty and I have been for six and a half years now. So within the last month, I'm definitely \$750 out of my own pocket, potentially a thousand. And then they want us to go outside and run in the rain in 30-degree weather. And at this point I'm refusing to, because right now I'm paying for my own medical care.

By now, I've spent about half of my time in the Army as a mechanic, and half as a chaplain's assistant. I hated being a mechanic. I wrote out a list of everything I was eligible for and I thought, “I could be the guy to push the big red button.” And then I thought, “Wait, I could be the guy who tells the guy to push the big red button.” And I was trying to look at what I could realistically do on the outside, as far as a continuing career. So it was in between being a chaplain's assistant and a paralegal. And I asked the career NCO at the time to look into being a chaplain's assistant. The woman then proceeded to just sign me up for it even though you have to sign up for six years. And you don't get a school date for another year.

I thought, “Are you serious?” At that point I had no choice—it's either I stuck with being a mechanic or I had to through with this. That first deployment had me dealing with faith issues anyway, and I so I thought, “Okay. I can't go wrong with going with God.” So I just put faith in it, and in the fact that I hated being a mechanic more than I hated being in the Army.

I don't regret my time in the military, but I'm definitely over it. I definitely have a distaste for the

military at this point. But I don't hold a lot against the military other than the specific situations. The military is a great institution with a lot of possibilities for people. It's just a matter of knowing how to work the system to get those possibilities to work for you. And knowing what you're doing going into it is important. A lot of people go into it blind, and get manipulated left and right, and they get screwed over. I'm very aware of that.

But I'm also aware that it's given me a lot of opportunities, and the fact is that 90% of the stuff that has happened in my life since joining would not have happened otherwise. The people I've met, the relationships I've fostered, and even me moving out of state. It just wouldn't have happened, I would've been trapped at home. It would suck. It would, and that's the truth of the matter. So that's where I have a distaste for the military in certain respects, but I definitely give credit where credit is due.

I also know that it's time for me to move on. I have a year and a half left.

Becoming a chaplain's assistant was partly because of spirituality for me, and partly a career choice. I wanted to get back into spirituality because I'd lost a lot of the Christianity, the faith that I used to have. No surprisingly though, I've kind of been driven further away from my Christianity beliefs since being in a chaplain's assistant role, and seeing more behind the veil of how different pastors in the military are, and seeing how so many of them should not be what they are. My spirituality is more of a personal factor for me than anything else now. I still don't go to church unless it's for work. I work at a church, and I want nothing to do with it outside of work. I'm just done. I wash my hands of it.

Originally I wanted to go into social work, and wanted to go for accreditations and continue my career in that once I got out. And then everything happened with my suicide attempt, and the crash, and the windfall that I had last year. The distaste that I got for that whole field of social work and psychology just washed that idea out of the water. At this point, honestly, do I know what I want to do or what I have a passion for? No. No idea whatsoever. But I'm gonna go to our West, and I'm gonna do cosmetology, because it's something I can possibly do, that I can see myself doing and not actually hating. But is it a passion, it is something I truly, truly want? No. I'm still trying to figure out a way to live and not simply survive. 'Cause there's a huge difference, and the truth of the matter is that for 90% of my life I've been surviving.

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Rebekah Lampman

Editor's Note: *Rebekah is Fort Hood veteran who recently got out of the Army. She is an NCO who has been on two deployments. She is white and in her mid-twenties.*

I'm fourth generation military. And so, I joined because of a mix between family history, and then I needed money for college, so kind of both. I was 18 years old.

I hit my six years back in July. I've been an NCO for about three years now.

It's pretty easy to go to the facilities, but as far as once you get there, getting care, sometimes it's not exactly to the standard that it needs to be. For example, I'll go to the ER, and they'll just write it off as something not important, and send me back on my way.

The mental health side I think is pretty good. I think the problem is there's not enough providers, so you have to wait. Or, they'll send you off-post, which is good, because you're talking to a civilian, and it's a lot more comfortable. But they don't talk with on-post doctors, so if it comes to the point where I'm at, where they're looking at, "Maybe this soldier needs to be Med-Boarded for PTSD." Well, they don't take my off-post records. I have to go see somebody on-post. But on-post, I have to wait two or three months to get an appointment. The communication between the providers could be better.

I started out seeing an off-post talk therapist last year. I still see her now. And then, a few months later, she suggested that maybe I should try some medication for anti-anxiety. But she can't prescribe anything, because she's a therapist. So I had to make an appointment with my primary care doctor, who's actually really cool about it. He hooked me up pretty well. We tried a couple different medications, and we finally found one that worked. So it was alright.

And then my Nurse Case Manager sent me to an off-post psychiatrist, who sat down with me for about five minutes, and then wanted to throw a bunch of pills in my face. He wanted to put me on three additional medications to help me with everything. And I tried that, and it didn't help. It didn't work. So ultimately, I just stopped going. I dropped off two of my medications, and now I take the rest of them, because those actually do work.

So I've just cut out that middle-man. He was a doctor in the clinic where I'm supposed to be seen, because it's really hard to get appointments, so they're just like, "Well, we'll just throw you at whoever's available in the clinic." So you could go to the clinic, and see a doctor that's not your PCM.¹⁸⁸ I've been switched around between like, three or four doctors.



Rebekah at Under the Hood in Killeen, Texas, a few days before her discharge from Fort Hood

I've been on one pill, the same pill, since November of last year. It's Paxil. It's for anxiety. And then, they have me on two different sleep medications. The sleep pills, I tried back in June. The one medication, it was either not enough, or it's too much. I could never find that right dosage. The first one was Restoril. They took me off of that, and then they prescribed me Remeron and Minipress, for being able to get to sleep, and then my nightmares. The one that was for nightmares, that one actually did work. What it does is it switches things in your dreams to where you can manage it. I had a lot of dreams about being shot at. Well, instead of being shot at with bullets, I was being shot at with water balloons, or paintball pellets. It's so your mind can handle it, and sleep through it. And it worked for a little bit, but I ran out of the prescription, because I had to cancel my last appointment with that psychiatrist. I called, nobody answered, I left a voicemail, I kept trying to call and nobody would answer. So I didn't go to my appointment, because I had to do something at work. Then they slapped me with a \$45 no-show fee, because they said, "You didn't show up to your appointment." And I said, "Well, I left you guys a voicemail. I kept calling, nobody was answering." And they're like, "Well, you still have to pay." So I stopped going to that psychiatrist. I just saw him that once. I was going in for my second follow-up appointment when that happened, a little over a month later.

And I was at the VA for seven weeks, mostly for inpatient. So I haven't had time to really go and get my prescriptions fixed.

I get the other stuff through my PCM. He'll give me like three refills, and then once I'm about to

put in for my last refill is when I'll call and make an appointment, so he can re-do the prescription for it. So I see the PCM about every three months, just for medications.

When I went to see the psychiatrist off post, I was just on the Paxil. But the Paxil wasn't helping my sleep, and my PCM didn't feel comfortable with prescribing me sleep stuff, because he wasn't quite sure, so I had to talk to my Nurse Case Manager and get the appointment for the psychiatrist. So when I went there, I told him I was already on Paxil. That's when he prescribed me the extra sleep stuff.

I have diagnoses, from the talk therapy, and then from the PCM, who also put it in my medical records. I have severe PTSD, I have an Anxiety Disorder, I have Insomnia. And the talk therapist isn't licensed to diagnose, but she feels like, based on her experience, that I have Borderline Personality Disorder. But she can't officially diagnose it. I'd have to go to a psychologist, and get tested for it. Which, being in the military, you are not allowed to be in with Borderline Personality Disorder. I just haven't had it diagnosed yet.

I love her. After the first meeting, I was like, this is the one. And she was actually the first person I'd gone to. So I was kind of worried I'd have to jump through a couple therapists, and have to say my story all over again. But I got really lucky, and I've been with her a little over a year now.

I feel lucky to have her, because on top of my PTSD from combat, I was sexually assaulted. So I've had to deal with that as well, and having to talk to so many different people is draining, it really is.

I'm currently enrolled in ASAP¹⁸⁹ as well. Because of the sexual assault, I started drinking a lot, so my command referred me to ASAP, and so I had to tell my ASAP counselor. And then I'm in group, so I had to tell group. And then, the Court Martial's coming up, so I have to tell lawyers and police officers, and CID,¹⁹⁰ and it's just...It's been a big ball of stress.

I've told my commanders about the diagnosis. I recently got a new command. We got a new company commander a few months back. I've known her since I got to III Corps in a few years ago. She was my old XO,¹⁹¹ and now she's a company commander for our unit. She's very much aware of my entire situation. She knows my diagnosis. Our new first sergeant's really cool. He cares about the soldiers. I haven't had a command like that in a really long time. So I've sat down and talked with him. I've explained with him everything that I'm going through, and my diagnosis and my treatment, and the medication I'm taking. So they're fully aware, and they support me in anything that I need. So they've been really awesome.

I came to this command last July. I was in Rear-D, because I got sent home early from deployment. I was going through a lot of stuff. I was dealing with my PTSD, which at the time I didn't know it was my PTSD. And then, I had dealt with two people since January who had killed themselves. And then, I had just had a recent break-up. So I was going through a lot of stuff.

And one night—I hadn't even planned on driving drunk. I gave my keys to somebody else, and they ended up getting mad at me for something during the night, and threw my keys back at me.

I don't remember leaving the club, I don't remember driving. I just remember waking up on post, and my car was totaled in a field. So when I tried to get care, I went through ASAP. My commander was supportive. And then, I got out of ASAP, and then that was when I thought, "I need to go see somebody." So I went to go get my therapist. And they were still supportive then. It was when I had a different first sergeant. I've gone through three first sergeant's in the past year. The first two were both very supportive of my situation.

And then, we got a new first sergeant. And he did not like me, for some reason. He was very religious, and I think I kind of clashed with him and his values and morals. And then, when my sexual assault happened, alcohol was involved, and they really didn't seem to be on my side at all. They didn't seem to care at all. So I started drinking really heavily. And then, a couple months later, because my assailant wasn't moved out of the barracks, I still had to see him every day. And it just so happens, that one day, I had to see him, and he came up to me and he said, "I think you're lying about the whole thing. It never happened, blah blah blah." And then, I also had a conversation with my first sergeant, because after the rape, obviously my work performance dropped drastically. Because I still had to see this guy every day. He worked down the hallway from me. He wasn't in my company, but he's in my battalion, and our two companies are in the same building, down the hall from each other. So I had to see him at work. And so, I didn't want to go to work, I didn't want to do anything. And my first sergeant pulled me in his office. He called me an incompetent NCO, threatened to take my stripes. And I asked him, I'm like, "Look, I'm not asking for special treatment, I'm just asking for you to kind of be a little...sympathetic of my situation. This is what I'm going through." And he said, "I'm not gonna be sympathetic or empathetic for you. You're an NCO and a soldier, you need to get up and move on." And that really did a number on me.

So I had to deal with those two things. And then my girlfriend at the time was fighting with me because our relationship went downhill after the sexual assault as well. It was too much for me, so I drank a lot, and that night I threatened to kill myself. I burned myself with cigarettes, and I was like, "I'm done. I can't do this anymore." And so, they sent me to the VA for a week, on suicide watch. And when I came back, my commander didn't ask if I was okay, didn't ask me anything. All he said was, "You're getting enrolled in ASAP." I was like, "Okay. Well, I understand, I've been drinking, it's an alcohol incident."

So at our ASAP meeting, where you meet with the counselor and the commander to go through your treatment plan, he said, in front of my ASAP counselor, with me in the room, "If you had not been drinking that night, you would never have been raped. It is your fault, because you were drinking. You could've stopped it, if you had not had alcohol." He's like, "I don't understand why you can't just stop drinking. Why is alcohol such a problem? Just stop drinking. It's not really that hard." I was absolutely speechless. He left the room and I broke down. I broke down crying. That in itself caused so much built-up stuff with me dealing with the sexual assault, that I blamed myself for a really long time. A very long time. I went through four weeks of outpatient later, in the intensive outpatient program on post.

And then, I had been sober, I hadn't been drinking. The day I graduated, I was in the day room. I again saw my assailant, because they still had not moved him, even though I asked multiple

times. And they were like, “Yeah, no, we're gonna move him, we're gonna move him.” Still had not moved him. He came into the day room, even though we had a no-contact order in place, he came into the day room where I was—he was supposed to walk out, he didn't. He stayed there, drinking beers. And I was just sitting in the corner, afraid to move because he was in there, and he was drinking. And he was really intoxicated when he assaulted me. So I was freaking out, and then he finally left.

And then, I relaxed a little bit, and somebody started asking where he was, they kept repeating his name over and over and over again. And I lost it, and I went outside on the balcony and just started crying. And then, my friends came outside, and they were like, “It's okay, he'll be gone soon.” And I'm like, “Well, what do you mean, they're finally moving him out of the barracks?” And they're like, “No, they're chaptering him. They're giving him a general discharge.” And I was like, “Are you serious?” And they're like, “Yeah. They're just gonna kick him out.” And so, I got pissed, and drank a whole bottle of vodka to myself in an hour, if that. And then, I blacked out, and when I woke up I was in the MP station. It turns out, what had happened was, I went to my friend's room, got a knife, went upstairs to his room, and tried to stab him.

They took me to the ER first. I had a blood-alcohol content of 0.27, and after that they took me to the MP station. I didn't even know what I had done. They released me to my first sergeant, and I was like, “What am I—I don't even know.” He took me to my commander, who's at the company. He's like, “Don't say anything to me, don't say anything to anybody. You're going back in the afternoon to give your statement.” I was still kind of drunk, so I slept a few more hours, my NCO came and got me, and went back down there. And the MP took me in the room, and he's like, “Alright, I need you to make a sworn statement.” And I looked at him and said, “What did I do? Seriously, what is going on?”

And he's like, “You really don't know? You really don't remember anything from last night?” And I'm like, “No! I remember being in the day room playing pool, and then I woke up here.” And they're like, “Well, we're charging you with aggravated assault.” And I was like, “What? What did I—what?!” And they're like, “It's on the assailant.” And I looked at him, and I was like, “Did I kill and murder him last night?” And they were like, “No, but you tried to.” And I was like, “Oh, okay. Well.” And my sworn statement was about two sentences long. It was, “I was in the day room. I woke up in the MP station.” And then there were a few questions. He ended up not pressing charges, obviously. And after that, they still did not move either one of us.

We were in the same barracks, but we were on different floors and on different sides. Like, according to the no-contact order, he couldn't use my side of the stairs, I couldn't use this side of the stairs. But that was a custom agreement made by the commander. According to regulation, either the victim or the assailant has to be moved within 72 hours of reporting the assault.

After it happened, I left his room, went downstairs to CQ desk, told them that I needed to go to the hospital because I had just been raped. So automatically it was unrestricted, from the get-go. I went and got a rape kit done, and everything. The court martial, which is getting pushed back and pushed back because of the Hasan case,¹⁹² is supposed to be the end of next month.

Like I said, he didn't press charges for what happened with me later. So I had gone through all that, was still in ASAP, and now my commander was talking about chaptering me out as an ASAP failure, because I had relapsed. So I went and talked to the social worker, because she had mentioned that there was a Women's Trauma Recovery Center at the VA. It's a seven-week inpatient program. So I went through that. And it just so happened, while we were there, we had a visit from Secretary Shinseki, who is the head of all of the Departments of Veterans Affairs, the guy that works under Obama. He came to talk to us about the program and see how it was. And it was there that he looked at me and was like, "Well, how is it on the active duty side?" He looked right at me and asked. I didn't even have a second to stop myself. I just blurted everything out. I told him everything that I had gone through, my entire story. And he looked at me and he was like, "You're telling me that you were assaulted eight months ago, and you still to this day see him every single day?" Like, "Yes, sir."

That afternoon he had a meeting with General Campbell already planned. During the meeting, he had General Campbell in there, he had another general, and then he had the general who's in charge of Darnall, over all the medical. And he told them my story. And there was another active duty soldier there, who was also dealing with the same situation with hers. Her assailant got moved to a unit that was attached to the same unit she was in, so she still worked with him. And they didn't pursue any kind of action against him.

So he was basically like, "Why is this going on? What is the deal? Why is Fort Hood treating their victims like this?" And General Campbell, from what I heard, was just shocked. He didn't know. So he called the lieutenant colonel that's in charge of all the SHARPs on Fort Hood, he called her and ordered her to have a meeting with all the SHARPs, so they could start looking at, "Why are these victims being treated like this?" From there, she got a hold of the social worker that I was working with. And they sat down and talked with me about stuff. And by the time I graduated the course, that day when I graduated, I went back to the barracks, he was gone. Because when he came and saw us, we were about less than a week away from graduation. So in less than a week, this guy was moved. I have not seen him since.

It's just, if you talk to the right person, I guess. That's the only way stuff gets done. So since that, it's been a lot easier for me. But like I said, we got our new first sergeant a few months ago. When I got back, we had the new first sergeant. And then, we got a new commander the month after. And actually before that first sergeant left, I guess his last little kick in my face, he put in a packet to send me to the NCO Reduction Board, which was supposed to be in two days. But my first sergeant now pulled some strings and talked to the battalion sergeant major, and got me removed from the list. Because he said, 'This is everything that happened from her sexual assault 'til now. You can't punish her for having to deal with everything that she's had to deal with.'

Nothing was done according to regulation. And then my commander, before he left, he tried to get me chaptered out for patterned misconduct, for everything from the car accident on. But once he left, my new commander started to go through everything, and he didn't put the packet together how it's supposed to be. He didn't do it by the book. So that got nixed. She said, "I'm throwing that out." And then, he had flagged me for some administrative action. And she was like, "No, I removed that flag, and got it taken care of."

So it's been a really long road of not being treated the way that I'm supposed to be. They bring sexual assault up in safety briefings, and say, "Look, if you report it this is what's gonna happen. We're gonna make sure we take care of you. And blah blah blah." Are you sure? That makes me really doubt the system. Honestly, it makes me realize why so many victims do not report.

My SHARP, actually, was the last person to find out. She didn't find out about it until about a week after I reported it. The next day, after I'd gotten out of the hospital and was at the company waiting, I had to go turn in some paperwork from the hospital to my commander. I was sitting there in the Orderly Room, and we had our E-7, who's the head of the DFAC.¹⁹³ NCO, male type. He comes in and closes the door, so I'm alone with him. And he's standing in front of the door. And he's like, "Hey, I heard about what happened, are you alright?" And I just looked at him. First of all, I'm freaking out because I just went through what I just went through, and now there's a guy, who has me in a room by myself, between me and the door. I was about to have a panic attack. I was so scared. And then, how did you even find out? I looked at him and I asked him, "How do you know about that?" And he was like, "Oh, I overheard CQ¹⁹⁴ talking about it." So within two hours, I had people texting me, "Are you okay?" I had people coming in my room, "Hey, are you alright?" There's MPs outside investigating the assailant's room. And within two hours everybody knew. They put it together. They knew I had been sexually assaulted and, "Oh, there's MPs at that guy's room. It was him that did it." So I had to deal with the rumors and people coming up to me every five seconds.

I think if the SHARP would've been called ahead of time, then things would've been handled a lot better. And I just wish that confidentiality would've been played a lot more. I think yeah, it's an unrestricted report, but it still needs to be on need-to-know basis. Because that is a very sensitive subject.

When the SHARP finally came out to me, she said, "Um, well, for some reason, I just now heard about what happened," I was like, "Oh, hey, how's it going? I didn't even know you were my SHARP. But hi." Both her, and I had a Victim Advocate that met me at the hospital, when I went in there that night, and she both recommended to the first sergeant and commander that I get a few days off to heal, and just kind of wear off a little bit. But no, it happened on a Friday, and I was back at work on Monday.

The Advocate suggested, "Give her a couple days off, to just chill out in her room, to just be by herself. She needs this right now." And they said, "No. I'm gonna have her come back to work." Because it was right before Christmas exodus, my SHARP recommended they just add on a week of leave to my exodus, and just let me go on exodus early. And they're like, "No. We can't do that." No reasons why.

I was very happy with the VA program I went to. I think the biggest thing that it helped me with is not blaming myself, and not looking at myself as a victim anymore. I don't have a lot of the guilt that I used to have. A lot of it being from hearing that it was my fault, and that alcohol was involved. For the longest time, I thought, "Well, what if I had done this? Well, I should've done this." I was doing all that kind of stuff. But the program really helped with recognizing those

statements, and making you realize that there really wasn't anything that you could've done. You can't control what somebody else thinks or does. And you can't put somebody else's actions on yourself and take the blame for that, so to speak.

They do set you up, once you leave, with a psychologist, somewhere. We had one-on-one time. Most of it's group. You're with eight other ladies. For seven weeks. It was great, I still talk to some of them now. Just to check in and see how they're doing. Honestly, you do become almost like sisters, because you're growing. And it's really awesome, the animal mascot for the program is the butterfly. And it's like you come in and you're in this big shelter of all of your stuff, and slowly during the seven weeks, you just blossom, come out of your shell. And it really does change you. Honestly, I don't know how I'd be now if I didn't go through that program. Especially with the court martial coming up. It helped me a lot with not feeling like I was responsible. So now, when I go there, I'm ready to get justice.



The courthouse on Fort Hood, in which Rebekah's assailant's court martial was held.

That was the only thing done for my treatment, I didn't get any profiles. I was on profile once, after that accident. I was on the eight-hour work profile for a little bit, because I did suffer a TBI from it. I had a pretty bad concussion, when I wrecked the car. So I've been on profile for that, but it was a temporary one. But as far as a psychological profile...no.

I think having limited work would've helped. Because after the accident last year, I was put in a new position. So for a while I was doing sergeant major detail every day. Raking leaves, doing all

the detail stuff. It was just they needed an NCO to be in charge of that detail. I didn't have a job, because I'd just gotten kicked out of my real position, so I wasn't doing my MOS. So they said, "Well, we'll just have her do it." So for seven months straight, every single day, I was on that detail. And then, finally I'd just had enough, and I said, "Look, I'm not gonna be on this detail anymore."

So then, it was switched from that detail to I'd get put on random different tasks. So now, most days, I sit around and I don't do anything. I wait to get put on something. This past weekend I did a different detail. And then I've done set up for ceremonies, and random stuff. When they need an NCO to do something, it's like, "Oh, hey, Sergeant Lampman is available. Let's have her do it." It sucks. I haven't done my job in over a year.

I left my last deployment early because of the draw-down. I had waived my dwell time to deploy with that unit. I'd been back for six months. And then, once the draw-down started to happen, they needed somebody from our unit to go home early, to help bring the percentage down. And I was the lowest ranking, and because I had waived my dwell time, the sergeant major in my section was like, "You're gonna go ahead and go." So it wasn't anything disciplinary. It was just one of us had to go.

When I got back from my first deployment, and we had to do the Reverse-SRP, and then the PDHR.¹⁹⁵ Looking back on it now, I think I had some warning signs that probably should've been addressed, that they might have missed. But that was three years ago, and a lot has changed since then. I think it might be addressed now, if I went through now. I don't really have any complaints about it. Except that I'm just like every other soldier: when you get to the drinking part, you lie. Because soldiers don't want to go into ASAP. Because we've had guys that are in there, and they say, "The only reason why I'm in here is because I told the truth on the SRP sheet." It just seems like they have one standard for everybody, and if you go above that standard, "Oh, you're an alcoholic." I think they're really quick to label people as alcoholics. It really deters people from getting the help that a lot of people need.

You do want to answer them untruthfully, just because you want to get out of there. It's like, if I put no, and I don't put yes, then I get out of here half an hour early, and then I don't have to answer and go into these follow-up questions, and I really don't have time for that. They always want to schedule the SRP and you have stuff to do, and there's a lot of people there, and you're just like, "Alright, well, let me just check no, no, no, no, no, no, no, no," so I'll just get pushed right through, and then I'll be done. I think a lot of soldiers have that mentality. So they just rush in, check the block, and then leave.

And I was never screened for PTSD or TBI when I returned, from any deployment. They asked me questions, but at the time I didn't think I had them. None of the red flags went up to get the screening—except for my drinking.

We got the general briefings on PTSD: "These are the symptoms," like if you have flashbacks, if you have nightmares, if you're jumpy, if you're this, this, and this. And then, we did that one test that's down over near the TBI clinic, near the NCO Academy. It's a computer test.¹⁹⁶

We did that when we got back. I don't remember whether we did it before we left.

When I was deployed, they put two soldiers under me, one was an E-3 and one was an E-4. I mentored them and everything, during the deployment. And then, in my first unit, we had an E-4, and then there was me, and then there was another soldier, and our NCO decided to make me Team Leader, so I had those two under me.

The only one that really needed any kind of care was one of the last soldiers underneath me. She has really bad asthma, and then she's allergic to a mold here in the air in Texas. So hers was a little bit more intense, because she had to use a nebulizer, and do breathing treatments.

Generally, my unit now is okay to people on profile, they don't look down on it. There's a lot of soldiers in my unit that are on profile. But this is our new command. Our old command, it was, "Oh, you're on profile again? Oh, you're still on profile?" That kind of thing. But our command now, they're really good at honoring the profile. We have one guy in our section now who has a eight-hour work profile. And they're really good about. He doesn't go to 6:30 formation, because that cuts into the eight hours. So he comes in at nine, every single day, and he works until three, and then they let him go. They're really good about keeping his schedule.

Under our last command though, I don't know if they were serious or joking, but I know our first sergeant used to joke about, "Oh, this guy's going to sick call again, I'm not gonna sign his sick call slip." But then he'd sign it. But I think that's generally across the board how the Army is.

I think it should be that if you legitimately have an injury or an illness, that you need to sit out and let it heal, because if not it's just gonna get worse. And then, you've gone from a soldier who has, say, a two-week profile, to now you're on permanent profile. So you just give them that time, and then if it looks like they keep going back, but it looks like they're kind of faking it, that's when you step in. But ultimately, you're not a doctor, so it's really not your call.

I think commanders overriding medical opinion is ridiculous. Like I was saying, about the one soldier who had the asthma and had to do the breathing treatments. It was a big machine that she's got to have at her house when she does her breathing treatments in the morning. Our commander said, "Well, you could just bring it to the unit and do it here." And she's trying to explain to him, "No, it's really complicated." And then our platoon sergeant was like, "I have a sister who has asthma, and she doesn't have to go through all this, and blah blah blah." They kept saying that she was faking, that it wasn't as bad as what it was. And our commander brought up that point with the profile. She said it's commander's discretion. I can follow this if I want to or not. And so, they gave her a really hard time about it. And they expected her to come in and do her breathing treatment.

Well, she'd call me at five, 5:30 in the morning, and I could barely understand her, because her chest was so tight. I'd end up saying, "Yo, just text me." And she'd have to text me, "Hey, my chest is really tight. I might have to do a breathing treatment." And those breathing treatments take anywhere from two to four hours. So she wouldn't be at formation, and they'd ask, "Where

is she?" And I'd say, "She's doing her breathing treatment." "She can come in and do her breathing treatment!" And I'd say, "Look, I'm not gonna have my soldier drive when her chest is tightening and she can barely breathe, and put other people in danger. Because she could end up being to where she dies, or passes out, and then you've got a car with nobody in control of it hitting a family in a van, or a soldier, and then you've got an injured soldier, or a dead soldier.

And they'd give me flack for it. They would say, "You need to be on top of your soldier. She's running all over you. You're letting her get away with everything." And I'm like, "What?!" And I looked at my first sergeant and I said, "Look, I'm just trying to take care of my soldier, like I'm supposed to do." And my first sergeant looked at me and said, "That's a sixth grade answer, sergeant." That's not a sixth grade answer, it's in the NCO Creed. "I will take care of my soldier," it says that, in black and white. I think they pick and choose who they want to give a hard time to, as far as that goes. Because they didn't really like her. But then, you've got other soldiers who, generally speaking, are very top-notch soldiers, they get a profile and it's like, "Oh, it's okay, you know, you'll be alright, you'll bounce back." And they'll honor it and not give them a big deal.

But what I didn't understand with them giving her a hard time is, that's the whole reason why she got Med-Boarded, because of her asthma and her allergies. Obviously, it's not her faking it if she's almost to the very end of her Med Board process. She's gotten this far, through several doctors, maybe it's legit, and maybe you guys just need to stop trying to be a doctor, and start looking and paying attention to your soldier and taking care of her.

Honestly, I think this is a big reason why the suicide rate is so high. They don't take the time to take care of soldiers, and they put combat readiness as a priority, and you get these soldiers that, for lack of better words, they slip through the cracks. And then, they want to sit back and wonder why it happened. They need to take a look at what their priorities are.

Around the time of my accident, two people I knew killed themselves. One was a civilian and one was a service-member that I knew. It just hits you. The civilian, I was the last person to talk to her alive. I was trying to get her to go get help, and she ended up taking her own life. So that hit me really hard. And then, the military guy, he was going through a really bad divorce. He was an older guy, E-7. He had been going through a divorce, so he was hanging out with myself and my roommate, because he lived off-post at the time. That's how I met him, through my roommate. He'd come over, and we'd cook him dinner, we'd hang out with him. He'd sleep on our couch, a couple nights. We were just trying to do everything we could for him. We didn't think he was as bad as he was. He never really hinted at wanting to take his own life. We just figured he was depressed, like any person would be, 'cause he didn't want the divorce. They had kids together.

We were just trying to cheer him up as much as possible. And then, we found out he had pretty much drank himself to death in a hotel room. So when we found out, we were just like, '...Wow.' My roommate was a Medic, so he took it especially hard, because he had known him obviously better than I did. And he felt like he kind of failed at his job. Like he should have known, there's more that he could have done.

I kind of felt that way about the E-7. But I felt more about that towards the civilian that I knew,

because I literally was the last person to speak to her. I just had so much guilt about it. Maybe I could have said something differently, or done something. It hits you really hard. Whenever you hear about a soldier who commits suicide, you're affected by it. But if it's somebody that you actually know and spend time with, all you can do is sit there and wonder what you could have done differently. So from those experiences, I've learned to reach out a lot more to other people. I know that I'm going through a lot right now, but I know that what I'm going through, I can handle.

Now, I go out of my way to talk to soldiers. I live in the barracks, so I see a lot of the soldiers, a lot of the single soldiers. I make it a point to go and talk to a lot of the soldiers that live in the barracks. If I see them around, I'll say hi to them, even if they're not in my company. I try to do my best to branch out. And a lot of the soldiers, they'll come up to me all the time, and they're like, "You know, I wish I had a NCO like you in my unit. Because you actually care. You sit down and listen to us." And if it's a problem that I think that I can solve, or help them with, I do it. And I'm not the type of person that's just all talk. I guess they have a lot of NCOs in our unit that are like that. They're like, "Oh yeah, I'll help you, I'll help you." And they don't come back with answers. Whereas, if I have a soldier who's going through something, I'll go on the internet and I'll research for hours, trying to figure out a solution for them, and I'll come back and say, "Hey, this is what I found. This might work for you. This might help."

Sometimes I feel I'm like the female version of Dr. Phil in my barracks. We don't have a whole lot of females there, and being a lesbian, I have relationships with girls as well. So soldiers will come knocking on my door and whisper, "Sergeant Lampman, I need help. This is the situation I'm in. This girl is da-da da da da." And it's cool. The soldiers are younger than me, so I almost feel like a bigger sister to them, in a way. And when they're drinking and causing a ruckus, I'm like, "Look guys, I've been there, done that. You don't want to do it. You do not want to do it."

I'm out at work. And it's really not a problem. I mean, before Don't Ask Don't Tell got repealed, people kind of figured out that I was. It's kind of obvious. But I think the repeal of Don't Ask Don't Tell lifted a lot of stress. The last girlfriend I had when I was dating, she came over to the barracks. And after the sexual assault, she came down to be there for me. And a month or so later, when she came to visit, I was able to come up to my NCO and say, "Hey sergeant, this is my girlfriend." I was able to introduce her to everybody. And everybody was like, "Hey! How you doing? She talks about you all the time at work!" And it's just really cool. I felt normal. Like, it was no big deal at all, which was really, really cool. I haven't had anybody that's really been negative about it, except that one first sergeant that I had that was really religious, and I think that might have been why he didn't really like me. I don't know for sure, he never said anything. But that's the only reason why I can think of for him to right off the bat act like, "I don't like you."

I was out in my own when I was in Cav too, for the most part, with the junior enlisted. Everybody knew. And then, during the deployment I came out to my NCO. And he was like, "I already knew." I had a fiancée at the time, and he was really cool about it. I gave him her CHU¹⁹⁷ number, and where she lived, because we deployed together. And I'd be like, "Hey, I'm staying over there tonight," so if he needed me for anything, he'd come there and he'd knock on the door. It was the same thing when we got back. We got back from deployment before I got my BAH¹⁹⁸ and was able to live off-post. I gave him her barracks room number, and where she lived. And if he needed

me, he'd come to the barracks room. He was really cool about it. I think I've been blessed and really lucky that I haven't had to deal with any negativity towards my sexual orientation.

The only way that my sexual orientation has really been an issue or come up, has been during this court martial. The defense is trying to say that there have been times when I've been intoxicated, and I've made out with a couple of my really close friends. They're trying to say that because of that, when intoxicated, I am not really a lesbian, and that I pursue sexual things with dudes, so therefore I was the aggressor that night. Because he doesn't remember it. And it's funny, because he says he doesn't remember it, and in his sworn statement, he stated, "I never touched her. She's a lesbian. I would never touch her. Nothing happened." And then, once the DNA came back, he changed to, "I don't remember anything." And then, a few weeks before we were supposed to go to trial, it came out that he wanted to make a report on me for sexually assaulting him. So his story's gradually changed, and now my sexual orientation is being questioned and brought up in this court martial. I feel like I have to defend my sexuality. Which I don't think is right. You can't use that as an argument for sexual assault.

This way that women are made to feel like they're to blame, it's very blatant. And I hope that when it does go to court martial, there's going to be senior leaders in the jury. There's gonna be sergeant majors, lieutenant colonels, majors. I'm hoping that they can see how blatant this case is. It's just so much stuff, in this trial. I just want it to be over with.

My attorney that I have now, he's been absolutely wonderful. He's a Special Victims lawyer. That's all he does. And he hasn't lost a case in six years, so I'm really confident in him. He genuinely cares about the case. He's not just checking a block. Him and his paralegal. She's another NCO. She's absolutely wonderful too. I have two lawyers and a paralegal. One of them is a lieutenant colonel, and one of them is a captain. My whole team has been nothing but supportive. Everything that my commanders try to do, every step of the way, I get right on the phone with my lawyer, and I'm like, "Hey, this is what they're trying to do." And they'll go right to the battalion commander, and be like, "Hey, this is what's going on." I think, honestly, that's why I got pulled from the Reduction Board. I called the captain and told him. And he called the lieutenant colonel. The lieutenant colonel called me and said, "Look, I'm about to be up at Battalion for a legal briefing. I will talk to the battalion commander and battalion sergeant major, because this is ridiculous. You should not be there."

A week later, that's when the first sergeant said, "Hey, yeah, don't worry about the Board." Them, my therapist, and my first line supervisor, he's an E-6, all three of them have just been on my team the whole way. And now that I have my new first sergeant and commander, who both back me up, and a new platoon sergeant who's backing me up, it's like a whole lot of stress has been taken off of my shoulders.

My commander, the day before Thanksgiving, took me into her office, and I was like, "Yeah, what's up, Ma'am?" And she said, "Go ahead and have a seat." And I sat down and asked, "What's this about?" And she asks me, "How are you doing?" And I was like, "What's this about? I didn't do anything." She said, "I know you didn't do anything. I'm just asking you how you're doing, because since I took command I haven't had a chance to talk to you, and sit down with

you and stuff.” And I’m like, “What do you want?” I was really stand-offish. And she asks me, “Why are you doing this?” And I said, “Because you are legitimately the first person in almost a year to pull me into an office and sit me down and ask me how I’m doing, without having ulterior motives.” And she said, “Are you serious?!” Because she didn’t know anything about what happened with my other commander. And I said, “Ma’am, let me just tell you a story.”

The stereotypes around sexual assault are bad. The last safety brief that I went to, half the time the guys were joking around in there. They were like, “Oh, you got a pretty mouth, boy. Oh, blah blah blah.” Even the instructor, before it started, he just said, “Alright, we’re just gonna go ahead and skip through these slides.” It was a sexual assault class. And there’s a master sergeant in there. And he said, “Whoa, this is a pretty serious subject. You shouldn’t just skip through these.” And it was an E-6 that was giving the class, so he set the tone of, “Yeah, this class isn’t important at all.”

I think that’s why all the other people were joking. Who were also NCOs. So you’ve got NCOs joking about a serious topic with other soldiers in the room. Soldiers aren’t gonna take it seriously, because the NCOs aren’t taking it seriously. There’s a lot of safety briefings that go on every single week. They always talk about drunk driving. They always talk about domestic abuse. They never really talk about sexual assault.

And not even just sexual assault. My first sergeant now, every safety briefing, he says, “If you’re gonna have sex this weekend, don’t do it while you’re drunk. Wait until you both are sober, and then talk about it and see what you guys want to do, after that. Do not have sex while you’re drunk. Because you’re gonna wake up, and they’re gonna wake up, and you might not both have the same point of view when you’re both sober. So why even risk it?” I commend him for that. Because a lot of soldiers, they go out and get drunk, and think, “I’m gettin’ laid!” And the next thing you know, they get slapped with a rape charge, because they didn’t ask for consent. Or they misconstrued what was going on, because they were drunk or the other person was drunk. And it’s not just in the Army. It’s society, culture. We’ve been ingrained in our minds, with so much, “Weekends are for going out to the club, getting drunk, bringing a girl home.” The drunker, the better. They’re the easiest. You see it in movies, you see it in music, you see it on commercials, you see it on TV shows, it’s everywhere. And I think until us as a society takes this seriously, it’s not gonna change. And they need to stop putting so much blame on the victim, and start putting the blame where it needs to be, and that’s in the assailant.

I think that rape is the most serious crime out there. When you are raped or sexually assaulted, you are violated on the most vulnerable of levels. It takes away every single aspect of your life. It’s physical, it’s emotional, it’s spiritual. It’s psychological. It breaks you down so much as a person, to where you don’t even feel like a person anymore. And I think until people realize that, it’s never gonna change.

And it’s staying the way it is in the Army because these leaders at the lower levels aren’t pushing it up as an issue in the chain of command. They’re stopping it right where it’s at. And it’s not only that, the soldier that gets treated like that, they don’t do what I had the opportunity to do, and that’s to go higher and advocate for themselves. They stop at the lower level, because they feel

like their voice isn't gonna be heard. That's one of the major symptoms of dealing with a sexual assault, is you don't feel like you have a voice. You don't advocate for yourself. You think you're less than nothing. So, honestly, if we're gonna produce change, we have to talk to these victims and let them know that they're not victims, they're survivors. And that they do have a voice, and if we all come together with the same voice, we're gonna get heard and things are gonna change. Because until we have victims and stories and examples to back up what we're trying to change, it's not gonna change.

I have a diagnosis of PTSD now. I have meds and the talk therapy for it. That's actually what is being decided on right now, whether or not I get medically retired, for the PTSD. They just recently changed the Med Board process for that. It used to be that a soldier took all their documentation from the Nurse Case Manager, and everything about what treatment they've been doing, they walk it over to the R&R Center to triage, and get an appointment with the psychologist. And then they have to sit down and talk with them, and then they tell them right then and there either, "Yes, I think you could be a candidate," or "No, you're not." If it's yes, then they schedule another appointment for the next part.

They changed it to where now, the Nurse Case Manager will write up an e-mail to their boss, explaining, "This is the soldier, this is her situation, this is the treatment they've gone through, this is what I recommend." Their boss looks at it, they say yes or no. Then, if they say yes, then it goes up to their Head of Psychiatry, which I believe is a major lieutenant colonel. They look at all the stuff, and they are the one who decides, "Yes, I'm gonna make an appointment so we can talk about it. They'll come in and we'll discuss it." Or, "No, they're not a candidate." So right now, I'm just waiting. My Nurse Case Manager sent the e-mail, so I'm waiting to hear back from what her boss, and then higher-up says, if it goes that far. I should be hearing something back hopefully within a week or so.

If not, then my company commander said, "If you really want out, we can do an ASAP failure." Which is an honorable discharge. She's like, "It all depends on if you want to stay in or not. I'm willing to give you another chance. I removed the flags, if you want to try to go somewhere, or get promoted, or whatever you want to do, just let me know." I'm hoping it'll come back a yes. I'm ready to just get out and move on with my life. I'm over this chapter of my life.

13 Nicolas Addison*

Editor's Note: *Nicolas* is a white active duty soldier in his late-twenties. At the time of his interview in late 2012, he was living on Fort Hood with his wife their two children. As a Warrant Officer, he was in a position of leadership with other soldiers, and reflected on the changes he saw needed as a leader, as well as his own experiences with issues of physical and mental well-being in the military.*

I'm a military brat. But I was born in Nevada, and I grew up overseas, and a couple different states of the United States.

I decided at a very young age...I'd say six or seven. I always wanted to be a pilot. And the best way to do that is the military.

I was hoping to get fully qualified as an aviator. I was hoping to get deployed. I was hoping to go to combat. I kind of wanted what my dad had. I wanted to go see the world, live in interesting, exotic places, kind of have that Band of Brothers, you know, dine-ins, dine-outs, barbecues. I wanted the family and I wanted the exotic locations. I wanted to see what I was made of.

It was personal challenge, camaraderie, and also a matter of convenience. I wanted to be a pilot, the best way to do that was the Army. Army or Air Force, they pay for everything. They've got the most powerful, interesting aircraft, and they pay you good money to do it.

...Aviation is kind of an odd bird, in the fact that it's very small, and there is almost no recourse. There is essentially unlimited power and discretion given to battalion and brigade commanders. And the fact that everybody wants to fly, and all it takes is one word from them to ground you. They can ground you at their discretion, based on any number of factors. If you're having issues at home, if you're having any issues dealing with the tour, then they can just say, "You're sitting for x-number of days." And that's gonna hurt you, because you're not gonna get the flight hours, you're not gonna get the combat time, it's gonna be a write-up in your Airman IECF—I'm can't remember the exact acronym, but it's the file that has all the paperwork on how many hours you've flown, what kind of tests you've taken, what kind of training you have. Basically it's a black mark on your record. So the accessibility is there, the clinics are there, there's staff, there's Chaplains, but if you go to them, you're gonna get penalized. And especially if there's anything that you seriously need help with, for example, medication. Medication has to go through the Flight Surgeon. The Flight Surgeon either has to approve or deny.

There were a few times when I was having difficulty with some of the things that had gone on, and what I did was I kind of went around the system. I found out who the mental health care providers were and just approached them offline. I would just go up to them, “Hey, I’m so-and-so. I was hoping I could buy you a cup of coffee. I’d like to talk to you, but the problem is, I can’t officially talk to you, ‘cause I’ll get in trouble.” And they were very receptive to that. It was all counseling, no paperwork, all confidential. And that’s kind of how I went around the system.

Editor’s Note: Nicolas clarified that he does not know if others have dealt with their health care needs in the same way.

Because there’s no way that we would talk about it to each other. Because everybody could potentially dime you out. And there’s not a whole lot of trust among the pilots. It’s a very, very dog-eat-dog environment.

It’s exceptionally competitive, and everybody wants a few slots. Everybody wants to be an instructor pilot, everybody wants to be a maintenance test pilot, everybody wants to be a stands guy. But there’s probably one slot for every five guys who wants it, so if you can potentially black ball someone in some way, it increases your chances of getting what you want.

In a related subject, there’s a wait time for certain medications. In aviation, if you take such and such a medication, you have to be around for x-number of days to see if you’re going to have an adverse reaction to the medication. That’s perfectly normal, ‘cause you don’t want somebody to have an adverse reaction like drowsiness or allergic reactions when they’re flying. But here’s the flipside of that coin: your chain of command can at any time decide that they’re not going to allow you to accept the medication because they can’t spare you.

An example for me was: under the auspice of smoking cessation they can prescribe you Wellbutrin. Wellbutrin is an antidepressant. There was a doctor that was at Shindand¹⁹⁹ that I was speaking to about the difficulties I was having and things of that nature. PTSD is what he called it. I call it just a normal reaction to combat. I’m not trying to get weird on you, but when you are sent to go kill people and they’re trying to kill you and you’re trying to protect people on the ground and they’re getting killed under your protection, it’s a lot to think about and deal with. And you’re separated from your family, you’re living out of a tent. It’s a lot.

...Where he was saying, “Hey, you know, this is pretty clear-cut PTSD, combat stress reaction, whatever you want to call it.” He said, “What helps a lot of people is Wellbutrin.” He said, “I notice you smoke. I can sign you up for smoking cessation and I can get you Wellbutrin that way, and that way it never has to go down in your file as depression.”

If you come up on the Flight Surgeon’s book for depression, forget it. You are done. If you ever fly again—which you might not—you’re definitely not gonna be in the running for any of those good jobs. Depression holds such a negative stigma in aviation that you’re a whiner, you’re a cry-baby, there’s something wrong with you, you can’t be trusted, you can’t hang, et cetera. Which is total nonsense. I’m no medical professional, but trust me, walking around and dealing with some of

these people, there's plenty of depression going on in the aviation field. It's just no one says anything.

The care I received I would say was good overall, because they really went out of their way and kind of risked their necks a little bit to help me out. For example, he ended up prescribing me Wellbutrin, but I wasn't allowed to take it for five months because they said, "Sorry, I need dual-seat-rated aviators, who are MVS and MTB qualified"—those are ratings, certificates, that I hold, and they needed those for the mission. "So sorry, we can't spare you for five days." 'Cause there's a mandatory five-day down period for this medication. So basically they told me just to tough it out—sorry, tough luck. And at the end of the deployment, if they feel like it, they can hook me up with five days of down-time to get me on this medication. Meanwhile, I'm sitting back just hating every day and really resenting the fact that you hear, every day, "Go get help! Go get help! No stigma! We'll help you out. Your chain of command is receptive to this." But in reality, they're absolutely not. They're quite the opposite, whatever the opposite of supportive is.

The propaganda out there on AFM, which is Armed Forces Network—you see all these vignettes and shows and every poster you see in the hallway, in the hangar, says, "Go get help. It takes strength and courage to go seek help." But if you do, you're done for. If you're trying to complete the mission and deal with some of the issues you're having, the command is 100% unsupportive of that. In addition to the fact that you couldn't possibly find the time. And if they did find out about it, you'd be in trouble. And if they find out that you're talking to somebody off the books, you're gonna be in trouble for that too because you're supposed to go through your Flight Surgeon for everything. So you can't win.

...I'm taking Wellbutrin under the pretense that it's for smoking cessation. I've specifically avoided a diagnosis...[and] I do not have a profile.

There's been a couple times when I probably really should have been allowed to sit [and not fly], but wasn't. That's another thing with profiles, that's in your permanent record, that's nothing you want.

Editor's Note: Nicolas was asked if this stigma results in a more dangerous work environment.

Absolutely. And let me give you an example. This was my very first engagement and I'm gonna give you the declassified version of it. It was down on a place called Shewan Garrison, South of Shindand. We went down there because two platoons were trapped, completely pinned down under heavy fire from three directions by RPG, PKM, grenades and AKs. PKM is a belted machine gun. AKs are small arms or whatever kind of AKs they were, there's multiple variants. They were in knife fights and I'm having difficulty trying to sort out civilian versus Afghan police, versus insurgents because, as you can imagine, there's no insurgent uniform. And the ANA²⁰⁰ sometimes just completely disregard uniform standards. And it is very, very difficult to see at four thousand feet, going 120 knots.

So, long story short, we go in there, end up putting a bunch of fire down. We pacify the threat, we get them taken care of, and the QRF, the Quick Reaction Force, came in, scooped up their guys,

and started to ground evac them out. We did a BHO, battle hand-over, with another ship. And later on after we'd already departed, our two-ship formation had what we call a bad shoot. They misidentified ANA for insurgents—which, to be perfectly honest, they could have been insurgents and Afghan National Army. You've heard of green on blue? They ended up servicing this target that ended up being Afghan National Army. This is the first time I'd ever taken life. And no one ever wanted to talk about it, it completely did not happen. You're supposed to get a thing called Combat Action Badge. If you ever go forth and get shot at and shoot at people, you're supposed to get a Combat Action Badge. I wasn't awarded one of those.

Nobody wanted to talk about it. We were not permitted to talk about it in the pilot's office. The battalion commander never recognized that me and my crews had done anything down there. They didn't want word getting out that this bad shoot had happened. They didn't want the negative publicity of their superiors coming down and getting them in trouble, I was just left out to hang. It's very difficult to explain, when you come back, and it's like nothing happened. How should I feel? Am I a hero? Did I do something right? Did I do something wrong? Tell me something, just don't ignore it. It's so confusing. That probably messed me up worse than anything. There was no reaction. You need that affirmation from somebody.

Especially when it's like it never happened. This was a very, very big deal—it's my very first engagement, first time I've been shot at, first time I shot anybody. And we come home, and it's as if, "That, forget that. Never happened. Don't talk about it. I don't want to hear about it." There's no paperwork on it. Freakin' —that never happened.

I talked to some of my platoon leaders, and they said, "Hey, total BS. Don't worry. Next time around we'll take care of you." This is gonna sound maybe conceited or like self-aggrandizement, but we did a really, really good job down there. We put a lot of very heavy, accurate fires, we put a lot of danger close. Danger close is when you're shooting in very close proximity to American or friendly forces. It's a difficult shot, there's a lot of stress involved, because the potential is good that you could hit your own guy. We did a great job down there. Air Medals and Distinguished Flying Crosses have been handed out to other crews for considerably less than we did. If anybody says they deserve a medal, they probably don't. But at the same time, I have seen where other crews who have done less than we did were rewarded with at least an Air Medal. We didn't even get a Combat Action Badge. There was no—forget about it. Never happened.

[The medal] is something to point to. This is more of a cultural environment, but if you don't have anything to point to...it's like the phrase, "Pictures or it didn't happen." That's kind of how it is in aviation. It's Air Medals or it didn't happen. Another unit will say, "Hey, we got in a total knife fight, and we were putting down all this danger close, blah blah" —"Oh yeah? So what'd you get for it?" "Oh, we didn't get anything for it." "Uh huh."

I do not know any pilots that have a profile for any sort of TBI, PTSD, et cetera. For physical injuries, yeah. There's an individual in my unit, he was a prior Tanker, drove tanks. And he has a no-running profile for some of the injuries that he sustained on Haifa Street in Iraq. It was an IED, rocket, and RPG.

Editor's Note: Nicolas was asked if soldiers are under pressure to violate their profiles.

Every day. He has a walking profile. Every time he walks, people are giving him crap for it. Like, "Oh, a shammer. You can fly, but you can't run?"

He gets stigmatized for it. They can't make him run. They can't say, "Hey you, run." But the problem with that is, then you're placed in a position to disobey your commander. And you can imagine how that works out for you. Even if you're right, they won't forgive you. You'll never be forgiven for that.

We're familiar that profiles are not supposed to be violated. I don't think that anybody would know what regulation it is. But everybody knows you're not supposed to violate a profile. I personally have violated profiles. I was on a no-fly profile [after] I sprang the heck out of my ankle in Iraq. I was supposed to be down for two weeks and I went down for four days. I had to get helped in and out of the aircraft by my Crew Chief. But because that pressure is so strong of, "You need to be up and flying," I was willing to fly injured, as opposed to take the rest that my ankle was supposed to get. Now that was a personal choice. I take responsibility for that. I succumbed to the pressure. But at the same time, especially with the new guys—I was the new guy in the unit at that time—it's, "You gonna be a team player or are you not?" If you're a team player, you get back up.

...And by repercussions I mean, you'd be considered a non-team player, and non-team players don't get ahead. If it's between me and somebody else, and let's say I wanted to go to the Maintenance Test Pilot course. Let's say I've got 700 hours and this guy's got 700 hours, and both fly about the same, we got very similar records. But if this guy's viewed as a team player, and I have gone and set myself apart by saying, "No, I've got a profile, sorry. Can't do this." Guess who's gonna get the school.

I was re-evaluated by the doctor [before it expired]. I just basically lied my way through the interview. "How's your ankle?" "Perfectly good." "Any swelling?" "Nope." "Hurt to walk on?" "Sure doesn't."

The Flight Surgeon [issued the profile], about October of 2009. It was DNF, "Duties not to include flying," for 10 days.

The pressure [to violate it] came from mainly the instructor pilots, specifically the guy called the Standardization Pilot. He's the head instructor pilot. They make the flight schedule. And basically they have a list of men and a list of missions, and they have to match enough bodies and aircraft to support all the missions. You take one body away from them and that makes their life much more difficult.

So they just come at me every day and said, "Hey, when you getting up? When you getting up, Shammer?" Instead of being on bed-rest like I was supposed to be, they're saying, "No no no no. You're going into the Pilot's Office, buddy. You need to be studying." So basically I had to sit at a table for eight hours a day. And sitting there was a bad place for my ankle, because they wanted

to make it uncomfortable for me. I wasn't allowed to stay in my room and lay in bed and read. They said, "You're gonna walk yourself up and you're gonna hang out here until the day's over."

At least when I was flying...[it was] pretty comfortable... It wasn't mind-numbingly boring. You didn't have people kicking you in the teeth all day and hassling you about spraining your ankle. It's not like I wanted a sprained ankle. Like I went out and hit my ankle with a sledgehammer or something? I said, "You think I want this?"

I'm a Chief Warrant Officer. It's above enlisted, but below Officer. The Army and the Marine Corps have them. It's a silver bar with square dots... I'm a CW-2, Chief Warrant Officer II. I'm in charge of three lower enlisted, but just for additional duties. I'm not their first line supervisor.

I think that [care for trauma] is available, but no one's taking it. I don't think that the Army is failing in the fact that there are tons of resources available. But no one's willing to reach up and dig into that cookie jar. That's the problem. It's not that there isn't high-quality care available, it's not that there's not enough providers available. It's that access to it is restricted by chain of command and culture.

Editor's Note: As someone in a leadership position with other soldiers, Nicolas reflected on what kinds of programs or policies would help leadership support soldier well-being.

...I mean, it's just as easy as, let them go. I don't think that there needs to be any new programs. You just have to remove that stigma, and actually remove it. They can stand up in front of the group all day long and say, "No pressure, no stigma, you know, you get help and you'll be just as good as before." But you know, until somebody actually goes, gets help, comes back, and really does not suffer for it, then you're just gonna have the same problem. No one's gonna go. I mean, it's one thing to say it, but it's not true.

For a great example, there's a staff sergeant, who was in charge of a shop. And he was having a hard time with his wife, he was battling depression. So, you know, he came to me and he said, "I'm thinking about going to a counselor, blah blah blah." And I was like, "Hey, you know, they said no repercussions, you know. You're not taking time off work. I think you should, man. Go talk to somebody." Like, "Well, I don't want to be a weakling." That's not the word he used. But I was like, "Look, man, counseling's counseling. You know, what's the difference between talking to me and talking to some counselor? You know, at least they're professional. You want to talk about helicopters? You come talk to me. You want to talk about marriage problems? Go talk to someone who knows about it."

So he goes, seeks counseling, gets a referral. One of the doctors says, "Oh, I believe that you're Bipolar," and puts him on medication for that. The second he got put on meds, they took his squad away, he was supposed to get a job—he was up for a promotion, he was supposed to get the Brigade retention position, which is a great job, great resume, it gets you in a position to meet people who can help get you ahead. And he didn't get that, he got his squad taken away, they put him on the do-not-deploy list, and then they tried to Med Board him out, because he wasn't deploying. He said, "Hey, I'm willing to deploy." They're like, "Nope, sorry. On that medication

you're not deployable, and since you're not deployable, you are no longer of any use to us, we're going to Med Board you out."

Fortunately, he went to—I don't remember if it was the inspector general or if it was the brigade commander, but he basically went to one of those two individuals and said, "Hey, this is nonsense, you can't do this to me. I'm willing to deploy, I'll stop taking this medication right now. This is—you can't do this." But the problem is, he had not gone through the unit commander, which by the way, that's another scary proposition, because he's either gonna help you out, or you're going to be screwed forever. So...

Editor's Note: Nicolas was asked to reflect on the general perception soldiers on profile.

They're dirtbags...they're shamming, they're faking... Two days ago, the people who weren't going on a division run—you know, people on profile fall out. The entire formation is [yelling], "Hackers! This is bullshit! Ugh!" "You can run! Fatty!" et cetera. And that's, you know, in front of God and everybody. Commander's standing right there, doesn't say a word about it. I didn't say a word about it either, 'cause you know, it's that bully talk. I hate to say it, but it's just not worth it. 'Cause for a while I was trying to improve the climate and the culture. One person isn't gonna do it, and you're just making your life harder. You know, it's not gonna change anything, and then you're gonna be on the outs too. So it's just not worth it.

...[For it to change] it would need to be at least the battalion commander. And not just, you know, lip service. It would have to be a battalion commander with an ingrained, intrinsic belief that this is a temporary problem that can be fixed, by counseling, medication, whatever. Whatever it is that soldier needs, they need to stop viewing it as, "Once you're depressed, you're gonna be depressed forever." Or, "If you've got PTSD, you're broken forever, you're gonna be having flashbacks 'til you're 60 or something."

And the reason I say the battalion commander is that he has the authority and the ability to push things through. Like, let's use me as an example. If I came up, and you know, I said, "Hey, I'm having trouble getting to sleep, you know, I'm having auditory flashbacks every now and again, that's sort of thing. You know, I'm getting angry all the time, for no reason, you know, all these things. I need a week off, I need some counseling, I need to go on a trip with my wife, we need to reconnect. You know, I need some time and I need some help." And if I got the time and the help, and then when I came back, I still got the things that I need for my career, then I think other people would do it.

Because if I went and did that now, the battalion commander would probably say, "Yep, no problem. Go for it." And right now I'm up for what's called pilot in command. I'm starting my pilot in command progression, so that if I go take this help, and then come back, as of right now I guarantee you I wouldn't be up for my pilot in command, and there's no way in hell they'd be sending me to Tac Op school in March, like I'm supposed to be going. So I mean, that's now. Now, if the Battalion commander said, "Yep, go get that time, go get that help," and when I came back, I immediately re-started my pilot in command progression, and I still got my school in March, that would send the message right there. "Hey, you can take this help and still get what

you want.” But the only person who could make that happen is gonna be the battalion commander, because anything lower than that, there's just too many chiefs, there's too many people that can mess it up for you.

[SRP] is a long, painful series of stations. It gets the job done, but it's so inefficient, as to just boggle the mind... I haven't heard of anybody [being pushed through]...not to my knowledge. If you're broken, and you make a big deal of it in SRP, you're probably gonna get Rear D. But if you get Rear D, get ready for that Med Board... The unofficial name for Rear D is 'Cowards and Cripples.' And I've heard many other units refer to Rear D as, 'the Cowards and Cripples.'

...There was a helicopter crash [on deployment] that was a direct result of inattention to detail and fatigue, and I have not read the report, so this should be taken with a grain of salt. But speaking to one of the NCOs who was in charge of this individual, the tail rudder—the bolts that hold the shanks on the tail rudder, were not secure. They were basically finger-tight. So that aircraft took off, the tail rudder slowly worked its way off, and then both pilots survived, but the aircraft was a total write-off. And come and talk to one of the NCOs, he's like, “Yeah, specialist so-and-so was having a hard time, his wife's running around on him, you know, he's in a bad way,” et cetera, et cetera. You know, they're running him ragged.

...Basically, [R-SRP is] same as SRP, except people care even less, and will say anything to get out of there quicker.

Editor's Note: When asked if he thought soldiers generally answer questions honestly in R-SRP, Nicolas replied emphatically.

Not at all. And I have a suggestion for that—don't make it all day for two to three days, a day or two after you get back. My experience was, we get off a plane, we had the rest of that day, which is like four hours 'til midnight. You know, we got back late, late, late. So we had the rest of that day, and then the whole next day off. And then we reported to SRP. Well, hey, I got what, three hours with my family, then I gotta go to sleep. I am jet-lagged. You sleep 14 hours, you know. You're on completely reversed now. So I gotta spend maybe seven or eight hours with my family, total, and then I'm right back into the freakin' Army square, taking accountability. And now I got two to three days of stations ahead of me? If they just took it where they were like, “Hey, you know, take some time” —there is not a single thing that they do in Reverse-SRP that is so critical that you couldn't do it after like, a week of leave.

And another thing is, you know, PTSD is normal over there. It's just, that's the norm. People are like, “Yeah, we didn't notice.” Yeah, that's 'cause that's how everyone's acting. Everyone's angry all the time. You know, everyone's having trouble sleeping, et cetera. So you know, when you get home, you're in that halcyon period of, “Yay, I'm back with my family,” I mean, a lot of that is gonna override. Plus, you know, the drinking. Hey, man, everybody parties down when you get back from a deployment. How do you determine an alcohol program, versus somebody who's binge drinking after being dry for a year? So...

Basically, some uninterested doctor asked me, "Did you ever get in a blast?" "No." "Do you have PTSD?" "No." "Okay, you're free to go."

I did not [answer the questions truthfully]. And you cannot have PTSD as a pilot. I mean, kiss your career goodbye. You're done.

And here's the other thing—hypothetically, and this is not me, but let's say, you get home, empty house, wife took the kids. I know people like this, where you know, they get home, there's nothing for them. Mom and dad don't have the money to fly out to Texas, wife took the kids and the house and every other dang thing, there's no one there to pick them up. You know, that kid is a huge suicide risk. However, that kid also wants to go out and experience the freedom of being able to go places and drink, and eat good food, and et cetera, et cetera. If he says he's a suicide risk, they're gonna lock him down, give him an escort, send him to mandatory counseling. I mean, it's so painful, no one would ever say yes to that. You know, because the Army's gonna do what the Army has to do to protect itself. I personally don't believe that the Army gives a dang one way or the other if somebody smokes themselves, other than the financial and political ramifications.

...You see [PTSD] briefings ad nauseam. And they always make the main character look like a total weakling, to where even I'm unsympathetic to this individual. It's just so corny. You know, I've had reactions to combat, but watching that screen, I'm like, "Oh, come on, Sally! You know, grab your balls and get on with it."

...I think a big part of the whole PTSD thing is advertising. And here's why: all you see all over the walls, PTSD. "Do you have PTSD?" And you turn on the television, AFN's on, every other commercial's about Post-Traumatic Stress Disorder. Then you go to briefings, every other briefing is having something to do with PTSD. And by that I'm saying, Coca-Cola does a lot of advertising. When you're thirsty, you reach for a Coke, right? If all you ever hear about is PTSD, you know, you're feeling angry, you're a little down in the dumps, "Oh! I must have PTSD." I've seen this get pushed to me, and advertised, and advertised, and advertised, to the point that I think anybody who has any of the super-vague symptoms that the Army puts out for PTSD, you know, they're just gonna jump to that, because that's just been rammed down their throats.

An example...a neighbor of mine in California was a bomber pilot, World War II. And after 15 missions, they were so fried, they had so many stress issues, they would send them to a chateau in France, and all they did was eat and sleep and do nothing. Listen to the radio, whatever. And I think that's something we could use. You know, it's always go, go go. And a lot of these quote-unquote programs to relieve your stress, are stressful. Like, "Oh, I have PTSD." "Oh, better send you to go hang out in a counselor's office for three hours, have somebody ask a bunch of really personal, invasive questions. Oh, and have your chain of command breathe down your neck." You know, just send them someplace with a pool and a martini. Give them three days off, and see if they don't come back without combat stress.

[Screenings for PTSD were] just questionnaires. Somebody asks you, "Do you have PTSD," you say no, and then you get to go home. It's typically at SRP or R-SRP.

Editor's Note: Nicolas was asked if he has ever experienced symptoms of post-traumatic stress, and whether they have affected his personal life or work.

Yes, I have. It was really difficult to fly, for a while. Because the problem is, you're worried about yourself, like, "What's wrong with me?" ...It's almost like you're repeating lines out of a movie. I called my wife, I have a very supportive wife. And I called her, and I'm like, "Hey, I'm having these auditory flashbacks. And you know, I'm having these anxiety issues, at certain times and places. Do you think I should sit?" And she's like, "Well, you know, it sounds pretty normal. If you're comfortable flying, I wouldn't worry, it doesn't sound like anything's wrong with you. I would just, you know, pretend."

...A lot of it is not necessarily post-traumatic stress, so much as it is just the prolonged, motivational exhaustion that's accompanied with a year deployed, a year home. Like, this last year that I had home between Afghanistan and Iraq, I was only actually in my house for nine months of that. I was at an Alpha II training course for a month. I was at the ATA extra training exercise for a week, I was at another school for a month. I was in the field for gunnery for two weeks. And if you add up all this time, I spent a year away from my family, then I had a very rigorous training schedule, in which I only spent nine months in my house, and then I was right back into the grinder.

And I have a nine year-old girl, and a two year-old boy.

One of the most helpful things that I've taken advantage of, is Military OneSource has absolutely anonymous, absolutely free counseling. The wife and I—you know, we were just bickering, it was just over nothing. We would get into huge fights over who drank the last Diet Coke. And we both realized that was ridiculous. So I called Military OneSource, I talked to them by myself once, and then we had two or three couples counseling sessions, and it's been good to go after that. She really, really helped. They picked up the phone right away. They're falling all over themselves to get you an appointment when it's convenient for you, and they help.

That was on base. If it's a referral, then you have to do paperwork. Anonymous stuff, you just call in and, "Hey, my name is Nick." "Okay Nick, what can I help you with?" And that's it.

...I cannot overstate that this unit at this point is pretty much just combat-ineffective. We did a 15-month rotation in Iraq, spent a year home, did a 12-month rotation in Iraq, spent a year home, did a 12-month rotation in Afghanistan. That's where we're at right now, in the deployment cycle. And those quote-unquote 'years home,' were anywhere from seven to nine months, depending on your job. So in the last four years, I've spent more time in combat than I have at home.

Editor's Note: Nicolas continued to reflect on what he sees as the long-term effects of multiple deployments on soldiers and families.

I personally have horrible anxiety. I never had problems with it before, I was very confident. I'm a nervous creature at this point. Especially in this, you know, nonlinear battlefield, where I'm forced

to operate with these Afghans, who every month they kill four or five dudes, so I'm having to sit there and shake hands with them, hang out with these guys with loaded guns, who half of them want to see me dead. And then there's all the indirect fire, and the suicide bombings, and just everything. You get wound up so tight, and you're constantly on guard, to where when you get home, it just doesn't go away. You're still just on guard. Like, anything could set you off. You just have this real anxiety.

...And we're forced to play nice. Another thing, and this is politically incorrect, but I'm gonna say it anyway... Humanizing the enemy, essentially, talking about the enemy's hopes, dreams, feeling, families, et cetera, really I think has a detrimental effect on those people who actually have to go out and kill them. And I'm just not gonna mince words here, I hope I'm not making myself sound like a monster. But for me personally, the first brief I get in country is what a wonderful people the Muslims are, and how peaceful they really are, and it's just a couple of bad eggs that are really messing everything up for everybody. And, you know, I'm not allowed to use any derogatory or pejorative terms for either the insurgents, Muslims, anything. I have to respect their culture. I'm not allowed to touch a Quran, but they can burn American flags and Bibles, and that's fine. And et cetera, et cetera, et cetera.

I get rammed down, and I get in trouble, for saying anything derogatory about their culture?! And then, later on that afternoon, "Alright Addison, go kill 'em." ..."I thought these were our buddies." "No, no, no. No, go kill 'em." "What?!" In every other war, you dehumanize and you vilify the enemy. In this war, we've done the exact opposite. You know, "These are our buddies. These are our partners. These are our friends." And then, well, what happens when your 'friends' kill you? What happens when your 'friends' are supporting the insurgency? What happens when you have to kill your 'friend?'

These are big Army policies. And when I use the term 'big Army,' I mean from the national policy level, down. The doctrinal policy...it is mandatory that I receive a cultural brief. It is mandatory that I go to training to teach me about their customs and courtesies and culture. These are mandatory briefings. These are standardized slides that are shown to everybody, and they're shown over and over and over again, in addition to all of the policies put out by ISAF, International Security Assistance Forces. For example, after the Quran burning, you're not allowed to touch a Quran. Not like I was going to anyway, but you know, the double-standard. They are burning Bibles, burning flags, and I'm not allowed to touch a book?

I'm sorry, I know it's a religious text. At the same time, that's ridiculous. You're telling me that I'm not allowed to touch a physical object because it might offend the enemy? It's frustrating, and that's another thing I'd like to bring up, is they place more emphasis, more validity on the culture of the insurgents, than they do on our culture. And they are absolutely at odds. You can't say we're here for freedom and then support policy where women are property, and are oppressed. That's not freedom. You can't say, "Oh, well, this is the Afghan government's way. They can marginalize this portion of society," women, children. I can't pronounce, but there's certain ethnicities that are not considered worthwhile. And we're supporting this. You can't tell me that that's right. So basically, I'm being forced to go risk my neck, and kill people—I mean, you know,

risking your neck is bad enough, but when you're gonna risk your neck and kill people, et cetera —and for what? We're placed in handcuffs.

A great example, I was flying around and I saw people that were setting up an ambush. Like, “Hey, permission to get these guys?” “Well” —and I can't get into the ROE²⁰¹ because it's classified, but because of several things, that were complete nonsense, I was not allowed to engage that target. To me, I'm flying around, and I'm like, “Great. Just let the dude who's about to kill my friend go.” 'Cause what do you suppose they're gonna do? They're out to kill Americans and NATO. You know, so I had to let them go! Do you know how many bad guys I've had to let go because of ISAF policy? That I can tell you, it's about 25, 30. I've had to let about 25, 30 murderers go. Because of nonsense rules.

I believe that we need to address the threat of Islamic extremism; we need to address the threat of countries that support and harbor terrorism. However, we are going about it in such an ineffective and counterproductive way, that in all seriousness I think this war actually helps terrorism. And we could table talk this all day, but basically, instead of just going in, using a punitive action, like, “You have done these things, we're gonna destroy your material, personnel, et cetera. We're going to take away the ability for you to project your” —you know, forced rejection, for their forces to injure Americans. And then leave. Instead, we've gone in, we did that at first, and then we set up and we just basically let them take shots at us, and we're not doing anything back. So it's basically, “Okay Addison, your turn to go stand and let them throw rocks at you. Hopefully you don't get hit.” “Well, can I throw rocks back?” “No. Sorry. That would offend people, and probably piss some Muslims off, so no.”

Editor's Note: Nicolas was asked to reflect on what the general perception soldiers on profile.

It's one of those where we are not a police force. We are a doctrinal, conventional, mechanized Army. That's a hammer. A hammer's not a scalpel. The Army and the Air Force, we are a hammer. If you want something just destroyed, no problem. But if you're trying to just get the little cancer that's eating away at a society out, that's not our job. That's not what we do. We can't do it. We're not equipped for it, we're not trained for it, there's no doctrine for it. It can't be done. So we need to just get out. We need to find other counter-measures to prevent the spread of terrorism.

...I think that a couple of things are the most feasible [to address soldiers' trauma]. Number one would be to effect the policy of how the war is being fought. It's very traumatic. Soldiers expect a fair shake. It is not fair to say the insurgency can use anything at their disposal to kill you, but you must operate within very, very strict guidelines, in order to engage the insurgency. So that's number one. We have to go away from this sort of schizophrenic policy of, “They're our friends, but kill them.” I think that's very traumatic to soldiers.

I've read a statistic that, percentage-wise, people in World War II were not coming down with as much PTSD as these veterans. Because when they came home they were heroes, everybody high-fived them. You know, it was ‘kill them at any cost,’ however you want to do it. So that's the objective, it's horrible, but people knew what they were doing, it was a fair shake, and everybody

knew what the rules were. So that's number one. We need to address the policies that are causing soldiers to have these...philosophical questions, "Is what I'm doing right?"

And then, number two is we need to get better R&R policies. If you really did have some time to decompress and just relax, without five thousand regulations on you, then I think that would really help.

[The TBI briefings] are actually pretty good. They sit you down, there's a card that they hand out, I'd have to go get my wallet, but it basically says, "Hey, these are the things that cause TBI, these are the symptoms of TBI, here's what you do if one of your soldiers gets it." And then it just lays out a couple policies, for example, "If they get TBI, mandatory three days of nothing," which I agree with. They're likening it to a sports injury. All of these super-type A personalities can understand a sports injury. "Oh, Addison got hit by an IED. He's got a concussion, he's got TBI. Okay. Sit him for three days. He's got a sports injury. I can understand and respect that." So I think they're doing a much better job with TBI than they are with anything else...

Yes, I did [take the ANAM]. We took those before deployment... I was not [exposed to blast pressure]. In aviation, you really don't see [TBI]. If you get TBI in a helicopter, you're probably going to die.

Editor's Note: Nicolas was asked to reflect on sexual assault and harassment trainings he had received in the military.

Just ad nauseam. Any excuse they possibly can, to make me sit through another "Don't rape your buddy" class, they will. This is going to be politically incorrect too, but for example, consent without all involved, or some of the nonverbal signs that your partner might not be open to a sexual experience, that I can understand. That's not necessarily common sense. But to just continue to hit people over the head with the book of like, "Don't rape your buddies," it's ridiculous. You know it's wrong, either you're gonna do it or you're not gonna do it. Those who are not gonna rape somebody, a class ain't gonna help. And those who are gonna rape somebody, a class ain't gonna help either.

It's what we refer to as 'death by PowerPoint.' It's just slide after slide after slide, in an auditorium with 500 people. And another thing that I think turns a lot of people off, again, the vast majority of the people in the military is male. That's the primary demographic. You're gonna see a lot more males, particularly white males, than anybody else in the military. And a lot of the training is almost accusatory. Anytime there's a vignette, it's always a male aggressor, which—don't get me wrong, I'm pretty sure that is the norm for sexual assault, I don't really know the statistics—but it's always a white male, who is displaying wildly inappropriate behavior, that nobody would do, or if they did, I would hope that somebody would correct them. And it's just over and over and over again, just basically indirectly calling us all rapists...

I do [think sexual harassment is common], but I kind of disagree with the military policy on what quote-unquote 'harassment' is. The official Army policy on harassment is it varies from person to person. Essentially, if I say the word 'chick.' In California, that's a very common word, it's not

considered pejorative, I'll say, 'This chick.' That's sexual harassment, right there. That sexual harassment is the same as if I made an inappropriate comment about somebody's physical appearance or endowments. So it's just...you can't address the policy of sexual harassment when there is no line.

I don't know where you'd put the line anyway, but... I personally, I do see that somewhat in the culture, but you get the problem where some of the women in the military—I personally go way out of my way not to say anything around them. 'Cause it doesn't matter, she could be saying x, y, or z, or talking about suggestive subjects, and that's fine. I couldn't say anything—I mean, if you go up to your chain of command, you're gonna get laughed at. “Oh, she was? Go away.” You know, “She was talking about sex,” or, “She was talking about pornography, or whatever.” And you bring that up? Like, “Okay, well, whatever. Were you offended? Really? You were? As a dude? Get out of here.” If it's the other way around, you can be hammered. So there's a double standard there...

I'm guessing here, but I think [MST] is probably less [prevalent] than in the civilian population. Harassment I would say is definitely much higher. The typical topics in a military smoke-stack break room et cetera, are definitely what could fall under the category of harassment. Pretty much all the time.

There's some [women in the unit]. And I think they feel a lot of pressure to fit in. You come into the unit there as a female pilot, no one's glad to see you, myself included. I'm sorry to say that. The problem is...I don't want to say they cause problems, but problems always arise from having a female in the unit. And the reason is, and I'm not saying that this is their fault, it's just how it is... How it is, they come in, and it might not even be their fault, but someone will say something that we as guys say all the time, she gets offended, and then we all get in trouble. Or, you know, she'll come in, and then now we have no more peeing on the T-wall barriers 'cause bathrooms are not easily accommodated... You know, no more pictures of girls on the wall, et cetera.

Editor's Note: Nicolas spoke about an incident of sexual harassment, and how he responded as someone in a leadership position.

...It was a specialist that worked for me, indirectly. She's one of our radio transmitter operators. She came up to me and she said, “Hey, Mr. Addison, you know, so-and-so has kind of been bothering me. I don't want to make a big deal of it, I don't want anybody to think I'm a twist, or whatever”—that's somebody who causes problems for their own amusement. “Could you maybe go do something about this?” So I pulled the kid aside, and I was like, “Hey, I'm not getting on you, I'm not gonna report you, but this has to stop now. This kind of behavior's inappropriate. If she didn't answer to you the first three times, she's not gonna answer to you the next six, okay? You're lucky she came to me. If she'd just reported you, it'd have been your ass.” I just counseled him on his behavior, and the behavior stopped.

I personally don't [know of other incidents], and I wouldn't tolerate that. If there's someone in my unit that has assaulted another person, I want them gone. Period.

I don't know a single person that thinks [sexual assault] is okay. I realize the position that [victims] are put in, but you know, let's say he's a colonel, and colonels are scary. Generals are scarier. Go to the first general, he'll see you right away. You get that dude hammered.

...It's one of those things where it's typically a younger victim, they're impressionable, they're in a regimented system. [Assailants] use that intimidation to get themselves off the hook. But hey guess what? His boss does not care how scary he is to you. His boss is going to crucify him for this. So you need to go to his boss.

...What do they say, three out of four aren't reported? ...That's unfortunate, but based on what I've seen in the military, I would say that those who do step forward, I'd say that it's taken seriously once they actually do file an unrestricted report.

I think that, just speaking only from my unit, if [sexual assault] happened, I would say absolutely, that person would be insulated and applauded for helping us get the scumbag out of the unit.

14 Mark Simons*

Editor's Note: Mark* is a white Army veteran in his mid-twenties who is from the Northeastern US. He served as a Tank Crew Member and deployed once to Iraq, from December 2008 to December 2009, where he severely injured his shoulder. He was also exposed to blast pressure from explosions while in Iraq and experiences symptoms of PTSD and a possible TBI. Mark's VA disability rating is 70%, and he says he can handle very few responsibilities due to ongoing traumatic symptoms. Mark has usually been on five to six medications as treatment for physical and psychological issues, including anti-depressants, anti-anxiety medications, headache and pain medications, mood stabilizers, anti-psychotic medications, and prescription sleep aids. He was not diagnosed with PTSD until his first visit to the VA. At the time of the interview, he had never been screened for TBI. Mark was constantly pressured and ordered to violate his profiles during the last year and a half of his time in the Army. He was subsequently discharged as a Conscientious Objector.

I was going through some personal issues in my life. I was doing drugs, and alcohol issues, and I wanted to clean up my act a little bit. I'd also been very interested in the foreign policies that were going on at the time, about the Iraq War and the Afghanistan War, so...killing two birds with one stone, I decided to clean up my act by going into the military while also seeing for myself what was going on over there. I guess I wanted to be able to be proud of myself, to be disciplined, and a well-rounded member of society.

Healthcare was hit or miss, really. If you wanted some serious counseling or holistic-based stuff it was almost impossible to get any of that. Seeing a psychiatrist? That was reasonably easy. You might have had to be on a waiting list, it might take a few weeks unless you were suicidal or homicidal at that moment. But, once you saw the psychiatrist, they gave you the whole cabinet full of pills and they sent you on your way, pretty much.

To get a referral, first you have to find somebody that is willing to listen to your story seriously and give you what you tell them you need. So in that sense it was difficult, and once you did get the referral, you had to wait like a month. Some people need help, where they're not necessarily suicidal, but I don't think anybody should be waiting a month to see a doctor. Especially a psychologist.

The care I got, I would say it was fair to poor. I had physical issues and also psychological issues. The physical stuff, that was pretty fair. I eventually got my surgery done even though it took almost two years for the Army to accept giving me a shoulder surgery. Once I did get it, I saw a doctor somewhat regularly, and he checked up on my surgery and how my arm was healing. But the fact of the matter is that I could have gotten out a lot earlier and my arm might not be as messed up as it is now. Psychologically? Like I said, I only got to see a psychiatrist. I don't think I ever got to see a counselor. I asked to see one but they really didn't give me that option.

I was usually on five or six different types of medications at any given time. Once I got to see a psychiatrist, he tried different combinations of it. He tried anti-depressants. Anxiety, sleep medications, headache medications...some kinds of mood stabilizers.

Some of the medications are for the same thing, but I didn't necessarily take them at the same time. I can't remember all of them. Some of the stronger ones that I remember are Xanax, Klonopin, Ambien, this other sleep medication...I can't think of it off the top of my head. But, Topamax...Abilify...Tramadol, it's a pain medication...I can't think of what it was called, the other sleep medication. It really messed me up, too. Klonopin, that was an anti-anxiety medication.

It's been a couple years since I've been on those particular drugs. My psychiatrist prescribed them, a civilian doctor. I was diagnosed with sleep disorder, anxiety disorder, depression. I think I had maybe personality disorder...

They would not give me PTSD. I mean, the way I look at it, they would give me everything but that diagnosis. I later would get it at the VA. The first day, I was diagnosed with it.

I was on profile. I could only work eight hours, a nine-to-five hour period each day. So there was no 24-hour duties or anything like that. I couldn't go out to the field. I'm thinking more psychological stuff, but during that time I also had my shoulder injury, so I couldn't pick anything up more than 20 or 30 pounds.

I had those two profiles, pretty much, consistently, during the last year and a half of my time in the military. The psychological one was based on, "Okay, he's on these heavy-duty medications. He shouldn't be working more than eight hours a day. So that he can get the proper sleep he needs, so that he can function during those eight hours."

There's pressure on soldiers to violate their profiles all the time. Me personally, I was pressured to do that, or was told that, "You're gonna do it anyway. You're gonna do the work anyway." And I saw that with other soldiers as well. Soldiers would come back with the diagnosis of PTSD, have a certain work schedule that they could do, and it would be disregarded by the command. They'd say, "Suck it up."

My psychiatrist at the R&R Center issued the profile for my psychological stuff. The other one was a doctor at the Darnall Hospital, who was my surgeon and doctor. And he was giving me the shoulder profiles, because of my injury. I got surgery on my third AC separation in my shoulder, and there was a ligament that they put into my arm, to re-attach muscle tissue to my shoulder.

Once I got on the profile, I was on it 'til I left the military. A year, year and a half. My psychiatrist would always replace my profile with the same profile, pretty much, very little difference. Obviously, my shoulder, over that year and a half, was recovering, so the profile got a little bit less strict. Eventually I didn't have to wear my arm in a sling, stuff like that. Or I could now pick up maybe ten more pounds, or something like that.

People in my unit wouldn't believe that I was having these issues, and would say, "I know you're on these medications, and I know that your profile says that, but we don't care. We need you, and we need you to do this work now. And we don't care if your profile says that you're to leave at five o'clock, and go home. You're staying here all night."

This was from non-commissioned officers, and officers...My chain of command, like my squad leader, platoon sergeant, and lieutenant. And in some cases, higher than that, too. The first sergeant.

Eventually, they [knew about MEDCEN-01], because I brought it up to them. But most people in my position, that were going through the same issues as I was, didn't know about MEDCEN-01, and I don't think my unit knew about it until I started showing them.

I found that out [about the policy] through a third party that gave me information about certain rights that I have, when it came to medical issues that I was going through. I think the best way to [work toward MEDCEN-01 being enforced] is to have a third party come in to the units, and have a training on it. It should be somebody that's not in the unit, and can explain the policy, who can't dilute the importance of that document.

I've heard [NCOs talk about having quotas for combat readiness]. Not in the sense that "We need this soldier, even though he's messed up, but we need him for the quota." But I've heard those conversations like, "We need this certain amount of men in our company to deploy," things like that. Usually [those pressures come from] higher up...like battalion, brigade.

[The attitude overall towards soldiers on profile is] that they're faking it, that they're weak. That they just want to get out of work. They just don't have any of these problems, they're just using the system.

One of my best buddies in my unit had severe PTSD. He actually just got discharged, 60% for PTSD... A long story short, there was an incident in which people saw him have a severe panic attack, to the point where he had to go to the hospital, in the middle of some training for a funeral. And they came to find out that it was PTSD-related. At first they were like, "Okay. It's okay. Take your time." But a couple weeks passed, and they're like, "Hey, sergeant, you need to get your act together and get your head back in the game." And he obviously wasn't ready to go back into that environment, to the level he was before. [He] had a few episodes during that time. He was threatened by the first sergeant that he was going to take his rank away, because he wasn't being the soldier he should have been, because he was seeking medical attention.

I think [negative ideas about people who need care are] part of the military culture that you're supposed to be strong all the time, and you should keep your problems quiet, and just deal with them. I don't think a lot of people have conversations about their medical issues unless they're physical. Psychological issues are quite taboo in the military, even though I think they're pretty rampant.

A lot of soldiers have families and things like that. And they feel that if they ruffle any feathers in the wrong way by seeking care and being on the radar, so to speak, of their chain of command, that that could negatively affect them and their family in the future, with maybe pay cuts, maybe they try to kick them out of the military, or take away their rank, or something like that. So these soldiers don't seek care. They continue with their problems. They suffer. Some of them end up in a coffin. Because they're not getting the treatment when they need it.

My buddy that I mentioned, right before he started getting care, and then he started getting harassed about it, he had called me and he had told me, "Hey, man, I need help. Now. If I don't get help now, I am going to hurt myself." And that is when I gave him information about the R&R Center. He called them immediately. They got him an appointment the next day. And he was taken care of. I think he got a profile at that point. They got him some medication. He was going to see a psychologist. Things were going well. And I think eventually they were gonna put him in the WTU. So there are people that are getting to the point where they feel like they're gonna hurt themselves or commit suicide.

I don't think anybody thinks it should have to get to that point [before somebody gets help]. I think the idea is, I'm seeing this first-hand, I'm getting the phone call from my buddy that I know very well. But somebody who doesn't know him as well, that's in the chain of command, who has these concepts of what PTSD or other psychological issues are, think that that person's faking it. But I'm actually experiencing it on the phone with him. My best buddy is planning on hurting himself. So I think that any case of somebody seeking help should be allowed to go through that process relatively comfortably, and make sure everything's okay. And I also believe that people that get deployed should have a larger psychological check-up. Everybody should have a TBI check. Things like that. Why not make sure that everybody's good, so that they're combat-ready? I know sergeants...and some staff sergeants, who were on some psychological medication and probably weren't supposed to be handling a weapon. Maybe they will take the pill but they won't take the profile type thing, because they're afraid that if they do both then they could be looking at their career cut short, or some type of harassment.

They were on medications that you shouldn't be driving a vehicle on, or handling weapons. I'm sure if you're not supposed to be driving on them, you're probably not supposed to be handling a weapon on them either.

I came back from Iraq in December '09. Just like anything else in the Army, SRP is a bunch of hurry up and wait. And once you get into one of those stations in which they're checking you up, it's real quick. You get in there, they ask you a couple questions, they sign your paper, and you go. And the psychological part of it, at least, was maybe five or ten minutes. Which I don't think is sufficient.

I don't know. I wouldn't call it a screening [for PTSD or TBI], if there was a screening. They asked a few questions like, "Have you had any disturbing dreams?" Or, "Do you feel different since you've been back?" Things like that. They might've asked, "Have you been hit in your head?" Basic questions. But there's no necessary screening for a particular thing. There's just a few questions and they said, "Alright. Well, seems like you're good." And if you said, "Hey, I've had some issues," they might say, "Okay, we'll put in a referral."

I don't think [people always] answer truthfully [at SRP]. Honestly, you just got back from Iraq. How are you going to know within a week if you're that different? I'm sure there are some cases where people come back and they're really messed up right away. At least in my experience, in talking to other soldiers, that stuff usually comes up two, three months later. After they've been really exposed to regular society, they see those differences and are dealing with their friends and family. So I think at Reverse-SRP, asking those questions when they first get back is good. But there needs to be a follow-up or two after that, just to say, "Hey, how you doing? Anything new? You've been back a couple months, have you noticed anything this time?"

I think some are nervous [to ask for care at R-SRP], they don't want to make a fuss about it. Because I had some issues while deployed, around my own personal morality, I was a little bit disturbed when I came back. So I did get a referral, just to talk to somebody. But I don't know about other people, I don't know how they felt, to be honest with you.

[Before that], I think there were a couple [briefings about PTSD]. Pretty basic. "Hey, there are all these programs out there that could help you, when people come back and have some issues. And you know, you guys get the help you need, get fixed, and get back in the game." It was pretty much quick, 30-minute trainings.

I know there were some people who were very iffy about whether they should [deploy] or not. Some of them thought that they shouldn't be going. They had a couple tours under their belt, they weren't in the best health, and they were fighting to get care. Some of them got it, some of them got deployed. I'm not a medical doctor, but I think some of those guys probably should have stayed back.

That was during when I was about to deploy...it was very intriguing to me, because they had gone to war already, and they were already having these issues, and I questioned a few times, "Is this how I'm gonna be treated when I get back?" Am I gonna have to deal with this stuff? And then hearing from platoon sergeants, "Look, this guy is trying to do this, doing that. He tried to get out of deployment." When I would know that soldier, and it would seem like he's going through some issues. I didn't know them in detail, they were usually higher ranking than me. So I didn't get too personal with it.

I knew there was [substance abuse] going on while we were deployed. At least alcohol-related. There were a couple occasions. There was one occasion where a medic who was obviously not right in the head got extremely drunk before patrol, and was unable to go on patrol with us,

because he was totally trashed. There's a larger story and some reasons behind that, but even from the start he was not so good for that tour. That was either his second or third tour.

[Multiple tours had something to do with his state of mind], he was pretty messed up. He had some family issues too. There were a couple times they found bottles. But I didn't really see any illicit drugs. I'm not saying that it didn't go on, but at least within my platoon, I didn't come across it too much.

In my unit, I don't recall any suicides during deployment. I do recall an incident where a soldier was brought back in, and he was definitely distraught. He just pulled out his pistol in the middle of patrol and just started shooting. I don't think he was shooting at anybody particularly, but he just started shooting in the air. He was obviously psychologically not right in the head. And they brought him back in, and I never saw him again. I guess they sent him back to a cop. We were on an outpost at the time.

My platoon had just moved to this outpost. This probably was one of the first days we were there. They brought him back in, and they brought him off the outpost, and back to the FOB. I don't know what happened to him after that, but I would assume was seen by some doctors.

I didn't really get screened for PTSD. The only time I got really screened psychologically was by my psychiatrist, when I saw him. And that was pretty much it. If you want to call it screening. And that's when I got medicated, and that's when I eventually got my profile.

[Before I saw the psychiatrist, I had talked to] maybe two people about my issues. Maybe I went to a clinic on post, I don't know if it's still around, I think it was called the Resiliency Center. And you can go there at any time, and just see a counselor, and talk. So you can just pop in. I remember going there once or twice. Then I went to the R&R Center. So yeah, about two or three times.

While in the military, I had sleep issues, anxiety issues, trouble driving. Certain things on the road would freak me out. Anger issues, I'd get angry a lot quicker. I think my memory was a little bit off. It still significantly is. Sometimes it would just be anxiety, and then sometimes I would lose touch with reality, more like paranoia. I also had one other symptom that was strange, where something would trigger me, and I'd be up for 48 hours doing stuff, like cleaning, or just I had all of a sudden discovered ten things that I need to do, and I'd just continuously do them until they were all done. But at the point I'd get it all done, it'd be 48 hours or more, and I'd be really, really tired, and also kind of not there.

While I was in the military, because I had a profile I was working less, which caused me stress, because my unit didn't particularly agree with that profile. So it was a constant battle. Currently, I'm 70% disabled. I attempted to go to work pretty much right when I got out of the military. It didn't work out well. I'm currently unemployed. I've been unemployed for a little over a year now. I'm thinking about trying to work again, but I can only handle very few responsibilities right now. The more responsibilities I have, the more angry I get, the more stressed I get. I can't handle it. I can't juggle as many tasks as I used to.

Personally, I think [the military] has some things that help. They do have counselors available, they do have psychiatrists. I think pharmaceutical drugs can be good in helping psychological issues. But that needs to go along with counseling. And I think if counseling was a lot more accessible, the psychological health of the military would improve, to some degree. I just think the soldiers are purposefully unable to get that access. Or, they don't have enough people to take in the massive numbers of soldiers that are seeking counseling.

I have a buddy who can barely leave his house. He has an alcohol problem. He's been in the hospital a couple times for nearly drinking himself to death. My other buddy, that I told you about earlier, he also has a severe alcohol problem, and he is addicted to certain medications. And I don't really see a clear-cut plan for him to recover and assimilate back into civilian life. Most people I know who have gotten out of the military are struggling to get by and figure things out. Especially the first years are extremely tough for people, outside of trying to find work or going to school.

There's another soldier I knew that was in and out of the hospital. He was suicidal. Because he had potentially a lethal weapon on him, I had to work with other people to get him into an ambulance and get him to the hospital. He wasn't in my unit, he was a friend of mine who was in the military at Fort Hood. Nobody directly within my battalion, that I knew of was suicidal or committed suicide.

I think [the way the military is dealing with suicide] is a big smoke screen. We hear all this stuff about stigma, but stigma goes both ways. I think it helps the military, and it also plagues the military. Because it destroys some readiness, but at least it quiets a lot of the masses that are actually suffering and going through these traumatic experiences, and reliving them, and could really use the help. We've been in these wars for what, ten and eleven years? And our military is pretty tired, as a whole. They are doing what they can, taking steps to help the soldiers out, but without actually doing it, just to continue getting through each year. It's like a bandage. They'll still put out a few programs that usually don't work that well, as a PR type thing, to say, "Hey, we're doing things." But really, people are still suffering and falling through the cracks, and getting harassed for seeking help.

...After your first deployment, you have a different perspective. And the more you get deployed, the more that perspective changes. Some people come back with psychological issues and physical issues. And maybe they really got their heads in the game, they're ready to go get deployed to Iraq or Afghanistan, but now they have these other issues coming back. And they're trying to get help, and finding out that getting that help is very difficult. Which then puts them into this kind mindset that, "Well, the military doesn't give a damn about me. I thought it had my back, but I guess it doesn't, now that I'm not as useful, or having trouble."

[The major cause of soldier trauma is] the day-in and day-out threat upon one's life, whether you're consciously thinking about it or not. Because if you're on patrol every day, you're in a state of fear that you're gonna be killed at every second. You're on alert, so it's in the back of your mind, but it's not normal for a human being to experience that. Whether they're getting contact every day, or only every so often, this danger is still out there, and it still affects them

psychologically. And then, the other half is a morality question. I think that no matter if you're for the war or against the war, I don't think it deals with politics. I think the idea of killing your common man can directly affect people psychologically, that have to deal with that. Even if they're obviously engaged by them, like they're shooting at them, it still has an effect on that. It will still resonate within the darkest parts of your brain. I mean, who was that person?

I think [we need to hold] the military accountable to respecting the diagnoses that soldiers are given by their doctors, and to give those doctors complete freedom to diagnose those soldiers, without being told by the military that they're not doing their job right. And when they're diagnosed with PTSD and TBI, to give them the help that they need. And let them go, if that's what they need to do.

[I got briefed on TBI], clumped together with PTSD. But I don't recall [ever taking an ANAM test. I think I was asked a couple questions about if I bumped my head, or if I was unconscious at any point. But that was the only thing that would relate to TBI.

I experienced explosions, but I never was, as far as I know, knocked unconscious. I've never been screened specifically for TBI. I'm not familiar completely with [TBI's] symptoms, but I do know I have issues with my memory, that I'm certain that are from going to Iraq. Because I'm a totally different person now than I was before. My memory's a lot cloudier now.

[The explosions] weren't frequent, but there were definitely a few occasions. But I've never been screened for TBI.

I think right now they're trying to get people out [of the military], and if people are having some medical issues, maybe they're getting treated a little bit better than in previous years. I don't know if they're necessarily going through Med Boards. Maybe they're getting them out on other things. During my time, it was more like they were trying to keep people in, no matter what.

[To get soldiers the care they deserve], it's something that's gonna have to take time. Because like I said, the military culture doesn't allow much room for people to seek psychological help. So it needs to be drilled in now, continuously, even after these wars are over, that getting psychological help is not a problem. If you're having issues, you need to go get help, and that's fine. You'll take that time to do that, and if you're capable of coming back to the unit, then come on back. If you're not, then we'll get you where you need to go and taken care of. Allowing people to feel comfortable with that concept will allow people to seek that help more frequently.

I don't look at it as something like, a program that you can make. I think it runs a lot deeper than setting up some new facility on Fort Hood, or nation- or world-wide around the military.

15 Oscar Laguna*

Editor's Note: Oscar* is a Latino NCO in his thirties. He is an infantryman who has gone on three deployments and was in the midst of the MEB process at the time of his interview. He is married and a father.

I am a former NCO in an infantry unit. I had three deployments. I got an MEB for my back, my shoulder, my knees and my ankle.

I am on profile for my shoulder and my back, from injuries in Iraq. My profile says no bending, no stooping with my shoulders. I have to just put my right hand at my side when I pray or rest. No overhead activities.

My unit makes me break my profile, on occasion, when they want us to pick weeds and stuff. They want me to bend down. They told me to do it without questioning. Even though they know about my conditions. And I've seen others forced to break their profiles many times.

At SRP, people are just pushed through and get deployed no matter what. Mainly with PTSD problems, TBI.

There's stigma for soldiers who go to sick call. They get called like, "sick call ranger." Or they just get told, "Aww, you're fine, you're not sick," or, "You're not hurt." On occasion, I have not gone to sick call because that's how they treat you.

The stigma comes from bad leadership, at every level. And it goes for mental health too. So I won't go, because they'll be saying, "You're a shitbag," or, "You don't need to be seen, you're fine." It's Army-wide. And the leadership doesn't care if people are getting in trouble because of PTSD or mental health issues.

All they do is just give the soldiers drugs for their problems, and nothing else. No help. It's happened to me many times. I've been hurt for a couple years now. I've had one surgery, just on my right shoulder. But that's it, and I had to get a second opinion in order to get it. All the Army doctors did was hand me narcotics. And they sent me to physical therapy.

When I had soldiers under me, whenever they came back from sick call, I was told to give them a call and have them come back to work. They make me make people work even though they have a profile. And there's pressure on battalion commanders to deploy soldier who are non-deployable. They're just about the numbers. They just trying to deploy as many people as they

can. It's not about if you're injured or not, it's about whether they need people.

As an NCO, if you try and stand up to it, you get turned down.

And the trainings we get, they're a waste of time. Because we get nothing out of it. Soldiers don't take it seriously, and it's not very in-depth. If they want to make it more effective, they should have actual trainers come and do it, instead of doing it through the unit through a PowerPoint presentation.

The unit never talks about PTSD or TBI. You'd only find out about the symptoms or if you have them if you're seen or admitted by R&R. I've also never heard of MEDCEN-01 until it was mentioned by this campaign, and other NCOs in my unit don't know about it either. I don't think every unit in the Army understands the command policy.

16 Ryan Holleran

Editor's Note: *Ryan is a white veteran in his mid-twenties from California, who served in the Infantry and completed one deployment to Iraq. At the time of the interview, Ryan was an active-duty soldier at Fort Hood, with a pending ETS date. By the time we followed up with him in January 2014, he had been successfully discharged and had moved away from Texas.*

I was born in California, raised in California, moved to Portland when I was about 19. [Enlisting was] an escape. I had a reason to believe it was a life change for the better. Education, the GI Bill. And also life experience and the prospect of being exposed to a part of the country I'd never been exposed to, having been raised in super-liberal West coast. And also the more platonically intimate connections with other men.

...It's difficult to get quality care. There's more of an attempt now than there had been in the past. But in a way, that makes it more complicated. There are so many different agencies and options, I tried to go to the R&R Center, it's just basic mental health triage on post. It took me a few weeks to build up, to get to the point where I could go. And I walked in, and then walked out, the first time. And then finally got a friend to come with me, and go in. And it was basically nothing they could say they could do for me. It was like, "Well, unless you want to kill yourself, you have to go back to your primary care" who I'd have to make an appointment with and wait a few weeks for.

When I go to the doctor's office, when I go to my clinic, you have to fill out one questionnaire before you go in, where it's like, "Do you want to kill yourself?" You're asked by a couple lower enlisted before you see your PA, again, if you want to kill yourself. And there's other series of questions, a really long list, that's kind of invasive. Really personal questions. And I'd just become really jaded, and I'm like, "Fuck you, man. I'm not telling you." And then, by the time you get to your PA, there's such a stress on [suicidality]. Nobody really cares about preventing you from getting to that place, there's no effective damage control.

...Through that process, I was trying to get out of network coverage to see a mental health provider that's not in the immediate area. And it was like pulling teeth. This counselor was TriCare approved, and it was all set up with the paperwork. I had already been seeing her through the Army OneSource, it gives you 10 free sessions, and I think that's amazing. But at the same time it's only 10 sessions. Ten sessions or three months, whatever comes up first. And it's like, I hope you're well by then.

So, I was trying to get an extension. It was difficult. I fought, I got into a number of fights with

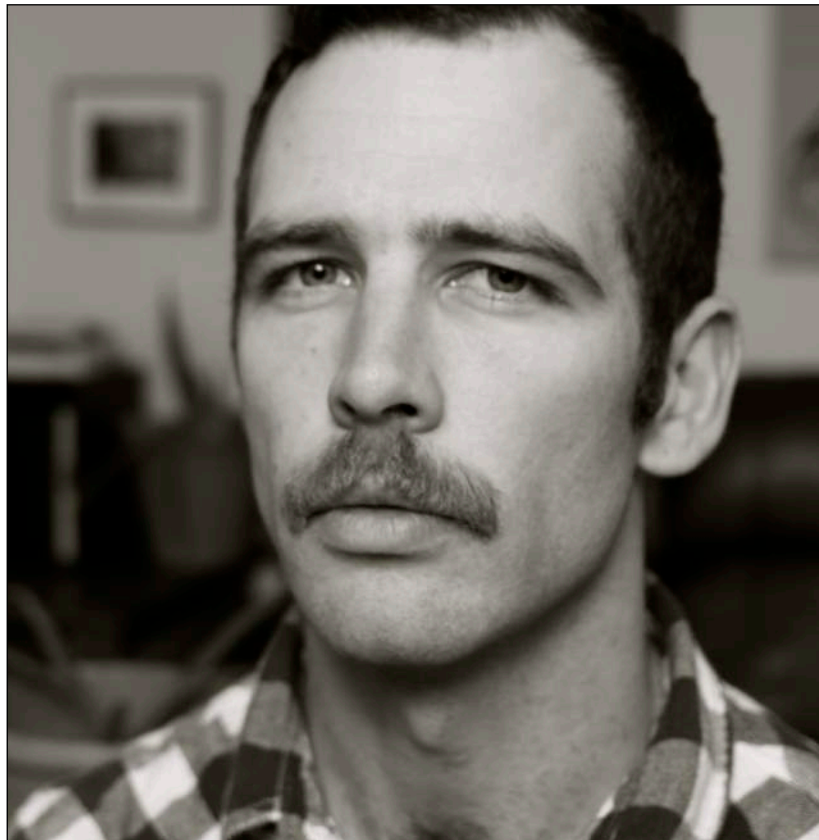
these civilians who I'm talking to, who just didn't want to do it. And I eventually had a lieutenant colonel come in the room, and I explained the situation, and he's like, "Yeah, it's no problem. Go ahead and do it."

This was the second time I went to R&R Center. I finally got to talk to somebody. I waited around for about an hour or two and then was escorted to another building and asked a bunch of really basic questions. And, then she's like, "Well, what do you want?" And I said, "Well, I want you to do this for me. I need the extension." And she just fought me. She's like, "Well, why do you want that? Why do you want to see somebody outside?" I guess somebody less motivated to achieve those goals would have been blocked. Would have easily been just turned away and forced to seek whatever was accessible on post.

Editor's Note: Ryan continued by speaking about what made him wait to seek mental health care.

It's kind of known that the R&R Center is the first step to getting locked up. "Going to the fifth floor," that's what they call it at Fort Hood. It feels like there's these traps, it's so easy to say the wrong thing, and all of a sudden you're locked up. And going to the R&R Center also has a lot of stigma, soldiers that couldn't really take it anymore would resort to there. They would show up to the R&R triage and just be like, "I want to kill myself." And then they would be locked up and the chapter process would begin. They didn't know what to do when I showed up and said "I need to talk to somebody." And then personally coming to the decision that maybe I need help. That's

kind of a hard position to get to, getting to the place where you could ask for help.



Ryan in Killeen, 2014.

...I got the out-of-network extension. But even that was time-capped. I can't even remember how long it goes, I need to find out. But it wasn't indefinite, and it wasn't even six months. They tried to push me back to my primary care, my PA—who initially recommended me to go to the R&R, and then I got pushed back to my primary care. That process was a few months of bouncing back and forth. Even the R&R Center will push the Army OneSource. The R&R Center will be like, "Call Army OneSource, and get your sessions." And that's usually locally. If it's not internal, then it's local. Which is just a sea of

mental health providers that are just, in my opinion, leaching off of the Army OneSource program. I just don't think [the criteria for providers] are extensive enough. I haven't seen it be very effective for soldiers, they don't feel very comfortable or they don't walk away with much. It's a very flag-waving, uber-patriotic group of people. Who I think are also terrified of losing a soldier under their care, and are also kind of waiting for an excuse to get that same soldier locked up.

I'm really fortunate that the person I'm seeing was sought out from somebody at Under the Hood, who had done all this research, and found me somebody who was understanding. And I can tell her a lot of stuff, I can be completely honest about my life. But out here—and even more so on post, if you see these counselors, they have to report anything, if you want to cause harm to yourself or others. But also, they have to report a violation of UCMJ, it's a condition of accepting TriCare, for mental health for active duty. So if I were to say that maybe I had an illegitimate marriage, or maybe I was speaking out against things that I didn't agree with in the military, that could be held against you. It's their obligation, just as much as it's an obligation to report you if you're gonna kill yourself, it's their obligation to pursue disciplinary action if you're in violation of UCMJ.

...My counselor I see weekly has diagnosed me for depression and anxiety. 'Cause those are the only two screenings that I specifically requested. But that hasn't really translated into work yet. And I've also asked for those same screenings from my primary care, and he said that my personal therapist is just gonna do it. So there's some kind of communication that I need to push, for [the Army] to recognize them. 'Cause I make an appointment any chance I can to see my primary care, 'cause it takes so fucking long. It takes a month for me to get in there. And this last time I'd been looking at medications, finally thinking that maybe that would be a possible solution. And he gave me one drug, it didn't work, gave me another drug a month later, 'cause that was the next time he could see me, was in a month.

I saw him a month later, and he gave me something else, and he said, "Well, why don't you make an appointment with our psychologist, who just came in. And come back in two weeks," which is this week, "and then make an appointment." So I had to wait two weeks to make an appointment to see my psychologist, who I still can't disclose everything to, to get a military-stamped diagnosis. How are you gonna fucking give me drugs if I can't tell you what's going on in my life? How you are you gonna appropriately diagnose me or find the right medical treatment, if you don't know everything about the condition?

Editor's Note: Ryan confirmed that his primary care provider, his PA, had assigned him medication for depression and anxiety, but he had not seen a psychiatrist at that point. He explained that he was under no medical oversight while trying out psychotropic medications for the first time.

We started with Paxil. And that made me insane. And then we tried Effexor. When I took the first one, the Paxil, I was crazy. I was kind of cracked out, I talked to my mom for six hours straight, just rambling. And there was a period where she kind of found it entertaining, she was like, "Oh, this is kind of funny." And then she got really concerned, 'cause I guess I hadn't talked to her, 'cause I'd been depressed, shut down.

I wanted to tell my doctor, “These drugs don't feel good. I don't want to take these any more, but I don't know if I can just stop. Or is this a normal feeling? Are the first few days always kind of crazy.” And I can't get ahold of him. I don't have his number. I had to make an appointment for another month out. I'm not just gonna keep taking something. For a month, before I fucking know if it's good or bad, before I know if I'm doing it right.

I probably could've just gone to the ER. But I called my counselor, and I was like, “I'm feeling kind of crazy right now” And she said, if it doesn't feel good, then don't do it. So I didn't, I stopped.

I'm waiting [for follow-up now], I got an appointment. I walk out of his office, and I make an appointment on the appointment hotline. I kind of just stay on the books.

[The PA] said just walk in and say I have a follow-up with him, even if that is breaking the rules. He was like, “Hey, just come in, tell them you have an appointment with me, I'll come out all angry and pissed off, because you're not supposed to do that.” He told me to just come in anyway, and that he'll yell at me initially, but that he would probably remember my face. And tell him that I need to make an appointment with the psychologist, and that he would remember. That's what he told me to do.

Editor's Note: Ryan also clarified that he did not receive any diagnoses upon being prescribed medication by his PA, or anyone else he had seen at the time. He added that he had never been on profile for any of the care he has sought.

...When I went in that last time I asked him is if [medication] triggers the release of the drugs, or is this a direct drug? And he's like, “I don't know.” He's like, “Dude, I took one class. I took four credit hours. Every PA has to take four credit hours in pills,” in mental health drug therapy. He's like, “I'm not qualified for this. So I'm gonna send you to this other person.” So, okay, yeah, I saw this psychologist who wants me to do that. So it was impressive that at least he said he didn't know, but at the same time half of my buddies are on meds right now. Everyone I know is on something and most of it's from the PA.

...My commander stumbled upon [my treatment]. 'Cause I'm the company Armor, and so his boss, my commander's boss, the battalion commander, was gonna come down to check out the arms room—I have millions and millions of dollars of equipment that he's actually accountable for. So, all of a sudden he starts freaking out and pretending like he cares, and he is trying to schedule an appointment, but I had my doctor's appointment.

Every Friday I have to leave work just a little bit early, so I can get down to Austin and go see my therapist. So this one Friday, he wanted me to stay behind. And I was like, “I can't. I have an appointment.” Which is this big, very heavy word in the military, 'cause if you miss an appointment, you could be just fucked up really bad. “Abusing post resources.” So he was like, “Well, what's the appointment for?” ...And I was like, “Head stuff.” And he's all, “What type of head stuff? PTSD and TBI and shit?” And I was like, “Well, I don't know, no. It's just head stuff.” And I was like, “Hey, if you want to talk about this, Sir, we can buff it out. But I have an appointment on Fridays, where I have to leave at 14:30.” And then he kind of backed off. But I'm

pretty sure he forgot about it since then. He has no fucking idea. When I first told my first line supervisor that I was seeking care and I had gone to the R&R Center without consulting them, they were mad at me! They were really upset with me not talking with them about shit.

I was like, "You're not qualified to treat me. I'm not gonna come to you with my life problems. There's professionals for that, and that's what I'm doing." They were afraid of having a soldier get locked up, be sent to the fifth floor, and have that reflect negatively on them. Although, my platoon sergeant now is actually a really good guy, and has stuck up for me to get mental health. He's like, "Hey man, you need anything, let me know." He's been phenomenal, and it's unfortunate that he's stuck in this system. He had offered to come down to R&R and use his stripes, and he's like, "Hey, if you need anything, I'll be there in a second." Which is cool. 'Cause he had to navigate the same process, he's on a bunch of pills, he's got really bad PTSD.

...In the morning when we line up for PT formations, and you salute, the first sergeant will be like, "Okay, all profiles fall out to my right, your left." 'Cause platoon sergeants conduct PT. And then, all the platoons go off and do PT. But the fall-out rate, of the people falling out of formations, was like, another platoon. It was like 30, 40 people falling out. And last time I did PTs last week, one.

They're getting rid of profiles. However they can. We chaptered out like, eight dudes, for not passing weight tape. Some of them, multiple combat tours. We were chaptering out dudes for disciplinary action, failing piss tests, everything. They just started cracking down. And specifically, the guys that had profiles. 'Cause that looks bad.

Every company has to have a record of everybody who's on profile. That record needs to be submitted through the first sergeant to the sergeant major, who keeps track of everybody in his battalion, so he knows what the combat fighting force is, and the limitations. It's his job to keep that number low. But instead of keeping that number low by providing treatment, or maybe preventing [injuries] from happening, it's like, "Get out," because we have new guys coming in. We have new, healthy, fresh bodies coming in. And we just kick all the "broke dicks" out. That's what they call it, "broke dicks."

If you got a "broke dick" profile, it means you can't do shit. It means you can't lift anything over 25 pounds, you can't walk more than a hundred meters a day.

The only guys that are actually going through the Med Board process and being chaptered out for their disability, is two of them, and they're both E-6s, who have between four and five deployments each. There's a certain amount of admiration there. Anybody who's claiming PTSD from just one deployment is not taken seriously. My buddy Greg* got chaptered out for being fat, as opposed to the mental health care that he was attempting to seek. He was on the fifth floor and he got chaptered out for being fat, on short order.

They still get an Honorable discharge, for overweight, because technically it's a failure of the military for not keeping their fighting force in shape. However, they don't get all the benefits. His contract was ended prematurely, so there's no separation pay, there's nothing like that. I believe he has access to a GI Bill still.

...So a lot of times these soldiers will miss formations, will be sleeping in, just have a lot of objections to the system. They just start to challenge that shit. They get into domestic disputes, they're not where they need to be when they need to be there. And they're not good soldiers anymore. So they get a series of counseling statements, they start to get Article 15s, and then eventually they lose their stripes, and at that point it's just over. When you see an E-6 reduced to a Private, they're like, "Fuck it." Everyone still treats them like a sergeant, which is kind of funny.

The Med Board process means they leave the Army on disability, which is an assumption that you're getting care from day one, as opposed to having to navigate the VA system, and you have to validate your disability. The mentality of the company toward you [is different in MEB]. I only know of one in my company, an E-6 who was a Private. And everybody was like, "You're still legit. We fought with you, you're cool." But there's a couple other cases where they've completely given up.

Like Sergeant Carter* completely gave up. He went on a crack binge last week, and nobody knew where the fuck he was at. When he came into my platoon two years ago, he came from a Sniper Recon unit, and had gone on multiple deployments, super-high speed. He came to us with really intense physical training, really intense tactical training. When everybody was doing nothing, he'd sit down with us and show us tactics. And then he started drinking a lot and smoking a lot of spice, and then spice turned into weed, and he just totally gave up. But the mentality of the company toward him is that he's a fucking piece of shit, because he gives us a bad name, because he comes up on the battalion list of criminal offences... But in my eyes, [his] conditions aren't being addressed.

...[Soldiers] understand that by seeking care, or admitting that you're not 100% super-badass soldier—it's nearly impossible. It's almost like forfeiting enlistment. Which is why I've kept my search for care so personal. I just don't think there's a process where you can get that care. They don't understand that my appointment is treatment. I'm going to seek treatment, in almost like a physical therapy way. This is my emotional therapy, this is my treatment. And they're like, "Well, how much longer do you have these appointments?" And I was like, "I don't know. Until I'm treated."

Editor's Note: Ryan was asked if members of his unit are aware of MEDCEN-01, and where pressure on NCOs to violate profiles stems from.

No. Not unless I've told them. Which, I've told most of them. But no...

The strength of their team, or their squad, or their platoon, is a reflection of their competency as an NCO. And there's this constant wheeling and dealing and trading soldiers internally, and they usually end up in Headquarters, which is the platoon I'm in. So in my platoon a handful of us have these really intense, stressful jobs that require a really competent person. Accountability of equipment, and accountability of personnel, and supply.

Those are the three people in Headquarters that are really squared away. And the rest of them are

just people who got kicked out of their platoon. And nobody wants to invest the time. That's not a virtue that's valued, like an NCO recognizing a problem with a soldier, and then walking with him to get the treatment and supporting him in whatever way he needs. That's not valued as much as having guys that are just dedicated and have a "whatever sacrifice is necessary to accomplish the mission" mentality.

[NCOs] get credit for numbers. But I do want to do a shout-out, because I have seen some NCOs do some amazing things to cover down for soldiers. But it's out of their hands. They only have so much power. Their power is basically lying and getting them out of work. Or, hiding them from the first sergeant, sergeant major, the commander, battalion commander.

Editor's Note: The interview turned to address Ryan's experience of SRP before he deployed.

It was another box to check. Pre-deployment, you have to get a bunch of equipment, specific to wherever you're deploying. You have to get a thousand briefs. Like, "This is how you save your money when you're deployed." And you have to go through the SRP process. And those are all parallel, in most peoples' eyes. They go through your medical records real quick, and they're like, "Okay, any non-deployable conditions?" and they'll give you all your shots, get you all your vaccinations up to date. Ask you that basic spreadsheet, "Do you want to kill yourself? Do you want to kill anybody else?" And then you're good. I've never seen anyone turned away from the SRP process.

There was a soldier who had a bad knee, I don't even know what it was, but it was really fucked up, and he had to go to surgery regularly. And he had sought care inside the Army, outside the Army, had diagnosis. And I think his personal doctor said it was a bad knee and he's non-deployable, and so then it went up to the battalion commander, and then it came back to his primary care, saying, "You need to make this okay." So he had to change the paperwork.

And so, when Ross* went back to his primary care, he was basically told, "Hey, you're going anyway." That's when he went for civilian care, and then they said, "Oh, you'll just get the care you need over there." So at this point, he'd seen three doctors, and an Army surgeon, who thought he was trying to shitbag out of it, who thought he was just trying to get out of the deployment, and wouldn't support him.

He ends up deploying. He had started the process of addressing the Congressional aspect for an appeal. But it never solidified, I guess. So, we're in Iraq, and he got flown to a larger base a handful of times. And nobody knew what the fuck. And then, basically the answer was, "We don't have what we need to take care of you here." They were told, "We don't have the medical equipment to give you or the time to fit you in." 'Cause we were shipped into the bigger base, and that same medical installation is receiving soldiers who are getting blown up, from all the smaller ones. So their priority list is combat loss, combat loss, combat loss. And then medical problems. And so he immediately goes to the bottom of the list, and they're like, "Well, you know, we'll stand by to see if x, y, z ever develops, and maybe we can take care of you." And we came home before that day ever came. And then he got out of the army almost immediately after that, through just ETSing. He just waited for his ETS date.

They deployed him in Headquarters. He was a radio operator, so he would stay in the Headquarters, receiving radio messages, running the radio. But we received almost 300 rockets over ten months. You hear the incoming alarm and even then, a lot of the times, the rockets would come and there'd be no incoming alarm, or sometimes there'd be an incoming alarm and no rockets. So, there was a lot of fucking sprinting as fast as you could to a bunker. Soldiers diving out of a bunk bed, and sprinting, and there was a case of an NCO throwing soldiers out of his way to get to a bunker. So it's this really intense thing. And he's forced to dive out of the talk, and sprint to a bunker, and he couldn't.

And he'd be limping along. So everybody would be [in the bunker], would be getting head counts, to make sure everybody's sure that should be there. And it would always be like, "Oh, no, Ross is on his way. He'll be here in a minute." You know, we lost a soldier who got hit by a rocket. My commander fucking got sent out of Iraq, because while sprinting to a bunker, he slipped on gravel and bit the corner of an air conditioning unit, and lost all of his teeth, and broke his jaw and shattered his jaw and shit. So, just to explain, even our commander, who's supposed to be the big dude spazzed out and wrecked himself on the way to the bunker. He couldn't get there.

Editor's Note: Ryan reflected on how the safety or morale of his unit was affected by having at least one soldier present who should not have been deployed.

...There's this [feeling], when you just submit to the system, where they're like, "Well, that's just the way it is." Like, "It's too bad he got fucked." And you know, he was a really good soldier. They knew it was fucked up, it did affect morale, very much so. Because our commander fucked him on this. He got fucked. There's no reason he should be here right now. It's not contributing anything to the operation, he's not an able-bodied soldier. It's like trying to push somebody around in a wheelchair in a fucking combat zone.

What's funny though is they're like, "Oh, well, women can't cut it because they can't maintain the physical burden." But we're still deploying soldiers who are medically diagnosed for not being able to hold the burden, but are still sent there anyway.

...We had Sanchez,* attempted [suicide]. And went to the R&R Center in Iraq, and they gave him a bunch of pills, he came back a zombie. Pretty useless, he couldn't really function. There was a soldier who was successful at killing himself, a week before we came back. So we were in Kuwait, we had turned in all of our equipment. And some dudes still had live rounds, and he killed himself in his tent, around all of his buddies...days before he got home.

At that point, the entire brigade was together, essentially. So it was a brigade formation [afterward], which is a lot of soldiers, it's like 5,000 soldiers form up and do this big ceremony of delivering and putting his body into the C130. And a couple people talk, the Chaplain talks, the battalion commander talks about how good of a soldier he was. And then that was it.

It was treated as a combat loss. It was treated as if he had been hit in an IED or something. It was the same ceremony but also kind of neglecting to look at why or how that happened. When we

were in Iraq, we lost a soldier in an IED, and then immediately after that, there was a bunch of briefs and train-ups, on how to spot IEDs. And then we were a lot more aware, we changed our tactics and we changed the way we functioned.

When this soldier killed himself there was no change to the tactics... I could tell that some NCOs were like, "Hey, how you doing? You dealing with this situation okay?" And they're like, "How'd you deal with that?" And, "What's going on in your life? You doing okay?" But that would happen to maybe one or two teams in the platoon, and the rest of it, it wouldn't. And it would happen with some platoons in the company, and then only in some companies in the battalion. So it was selective, just based off the character of NCOs. Which I don't have much faith in. So if there was a change, it was on that level. It wasn't on the brigade commander or anything, changing what may have lead to that situation, looking at why a soldier would make that ultimate sacrifice. Like, what was so unbearable about his life?

I think when they get [suicidal], you feel like there's no way out. Like you're trapped. And like you don't have any more options. The military's so structured. You follow this path, or no path. It's the only way you can live. And anybody who tries to live outside of that is very quickly pushed back into it... The conditions that lead to that would be like, failed marriages, extremely early, premature marriages, that suffer from the stress of regular deployments; the combat.

Primarily being deployed in a fucking place where you're forced to kill people, you don't know why, and you're forced to fucking watch your buddies die, and you don't know why. Even to the mentality of the day-to-day, you're living in a world who's foundation is violence and domination. And I don't think those are very natural ways to live.

Short of the very specific experiences some soldiers have gone through in war, I blame the structure more than anything else. And just living in the military life is so detrimental to somebody's soul...the environment in which a human is supposed to live couldn't be farther from the environment that the military embodies.

Editor's Note: Ryan also reflected on soldiers' attitudes towards Iraqis while deployed.

Everybody who was on our first deployment were warmed up to the locals. We'd always go to the dining facility and steal a bunch of Gatorade packets and waters, and energy drinks, and even food, which is kind of a big thing. You've got enough shit to worry about before you go on a patrol. But to remember to keep your pocket full of granola bars is... There was a lot of soldiers who would do that—they're almost always the new soldiers, all the first deployments. And hand those out and take pictures with the kids and make sure to give the kids water.

But the guys who had been around longer, and had more deployments, were so detached. And they used a lot of ways to detach, like the Islamophobia and racism, to dehumanize. I think a lot of the newer guys were a lot more compassionate. A lot of the older guys that were there, they'd just learned that that's what it'd take. 'Cause we weren't in hand-to-hand fire fights. We were being rocketed and then supporting air strikes. And so there wasn't so much of a personal [combat element].

...The deployment before, which would've been two years prior, in '08, was very similar to the 2010. But the 2006 deployment was fucking a lot different than both of those to follow. That was a lot more of kicking in doors and so much chaos and so much not knowing what the fuck is going on and just kind of being on their own and having to make decisions.

'Cause that was the biggest thing, we didn't know who was a fucking friend and all. You'd have these kids come and give us this flatbread, trying to feed us and stuff, and then later that night we'd get rocketed. We'd be like, "What the fuck?" It is so easy to combine, 'cause all you see is Iraqis. You see a nation. And they don't see a nation. They see either tribes, or... What later came out, but wasn't spread enough, was that it wasn't even Al Qaeda, it wasn't even these big, heavy words we heard about, but it was terrorist cells. So there were three terrorist cells in operation, and our whole point was to disrupt smuggling from Iran. And I could mentally distinguish between a smaller operation of a handful of individuals who could get their hands on this equipment and launch it at us. But most other soldiers either weren't made aware of that, or could care less, and would just say, "Oh, the Iraqis are attacking us. Why are you giving them water?"

[Reverse-SRP] was pretty bad. They do all the medical stuff, like TB and re-check your vaccinations, and go through the same shit, "Were you exposed to any concussions?" And then, when you get to the mental health part, there are questions like, "Do you have dreams about Iraq?" And it's like, no shit, motherfucker! I was there last week, dude, like, yeah! If I spent ten months in Disneyland I'd probably be dreaming about Disneyland, you know. And I said as much, 'cause I answered a lot of those honestly. I was like, "Yes. Yes. Yes. Yes." A lot of the questions were like that, "Do you want to hurt yourself, do you want to hurt somebody," you know, the red card.

...So we spent like, two weeks in Kuwait, after we'd come back from Iraq. And you know, you have to turn in all of your equipment, and you're so close to being home, but you're not home yet. And then finally, you get on the flight, and I don't even know how long that flight is. I did it four times, I can't even remember. But you fly from Kuwait to Europe, then Europe to the States. And there's a big ceremony and then they put everybody in the barracks that night. After the ceremony some people were able to go home, the married men were. But they put everyone in the barracks, you can't leave a 20-mile radius. You're not allowed to drive, you're not allowed to drink. You're not allowed to do anything because you have to come back to work the next day, and do SRP. So like, you can taste it, you know.

And so, the SRP process can be a three-day process, or it can be a one-day process. It's up to you. When I went through it, and I filled out the forms appropriately, I was put off to the side, which is also a very alienating process. Because it's in a gymnasium, the whole SRP process. It used to have its own facility, and they moved it over to this gym. Where it's basically these little walls, these tiny little walls, blocking up. And you have to sit in the open, with the bleachers full of soldiers waiting for their turn to be called, staring down at the people who are getting treatment and whatnot or waiting in various lines. So the mental health care line, you go through your initial evaluation, and then you either walk out—'cause it's the last stage. You either walk out of SRP, or you go into another line. And if you're in the Other line, then you're gonna be there for a while.

And you have to talk to somebody, a lieutenant colonel or colonel, mental health provider.

When I talked to my woman, she was actually in BDUs, she was one of the seven uniform services, not OSHA, she worked for the organization that sends people, mental health care providers to environmental disasters internationally. And the Army didn't have enough providers, and so they called upon them. It was one of these federal agencies, and she was wearing BDUs, which is hella old school. And I was like, "What are you doing?" And so I'm talking to her, and I revealed a bunch. And I was like, "Yeah, I was cutting in Iraq, and like, I don't feel too hot right now." I was just really honest. But when I mentioned the cutting thing I had to be very clear, like, "I don't want to right now. Like, I'm not saying this [right now]—but I'm saying this is what lead up to where I am at." Even though it happened again shortly thereafter. She's like, "Well, okay. A lot of this is kind of normal reaction." So at the time, I was going to AA. And I had a group of friends that I was gonna go connect with. And she was like, "Okay, well, that should be good. Just come back to the next stage of Reverse-SRP." And I was like, "Okay." So I walked out.

There was nothing significant enough on my records to have somebody follow up on me or make sure I followed up on the process. And you have to go back immediately, three months, and then six months, I think. And I went to the three month one, and I was like, "I'm still pretty fucked up. I'm having a really hard time adjusting." And still no result. I was given an Army OneSource card. You know, "Call these people." And I was just left alone. And finally, by the time I went to see them the third time, I was like—every time I went through this SRP process, I would be going into the second room. And I talked to this dude, and I was like, "This whole process is fucked up."

His records didn't even show anything I had said in the prior. And I was like, "I need fucking help, man. Like, I need—I need help. And I don't want to fucking get handcuffed and put in a small room with no sharp corners or objects. Like, I just need to take care of this." And he was the one person that was finally on par. The other two were civilians, the first one was a uniformed service-member. And the rest of them were all civilians. And I think it's pathetic. There's no way the people are getting the care they need. It's not done in the way that is appropriate. All they're really looking for is, "Do you want to kill yourself or somebody else?" "If you were involved with a concussion, then we'll send you to the TBI clinic." And, "Can you sleep?" That's a big one.

...I believe everybody had come back with some form of PTSD, that it's a sliding scale. Everybody comes back a little bit more twisted. My company is right next to the division parade field, so every time there's a big ceremony they'll shoot off these massive canons, with these blanks. These fucking massive cannons, "Boom," and you feel the shock-wave. And every time that happens, in my company, everyone ducks, and your heart-rate goes up, and your pupils go crazy and shit. Normal people don't do that... But I guess what they're trying to find out is, is your PTSD so bad that it affects your ability to be a soldier? That's what they're trying to find out. Does it affect your ability to do your job on a daily basis?

But they're not even looking at the long-term. [PTSD] gets worse over time. Carter* didn't really get bad until years after his last deployment. It escalates, and there's not even a tracking process for that or a case worker. You're on your own.

...I'm more aware than the average soldier, so if I can't remember [the PTSD trainings], I doubt anybody else picked much up. But...it was probably something along the lines of, "Keep an eye out for your buddy." It was the ACE card, "Ask, Care, Escort."

Editor's Note: Ryan was asked if he wanted to say anything about the post-traumatic stress symptoms he's experienced.

I don't know—I guess I still have a stigma about it. I'm afraid to say that like, yeah, I've got PTSD. 'Cause even in the activism community people always hold it on a scale, of like, "Well, were you in Fallujah?" A then I'm like, "No. I wasn't in Fallujah." But my therapist pointed out to me last week—she said, "You'd been through some trauma," and I'd been like, "What trauma? I really don't think I've been through any trauma." She's like, "Well, did you go to sleep knowing you were gonna wake up?" And I was like, "Not really." Just being in an environment where you can die at any moment.

...Sleeping, sleeping tremors, convulsions in my sleep. And I've started drinking again, after a long period of sobriety. My depression, I'm just emotionally unstable. And I mean, it could be any number of things but as far as Post-Traumatic Stress Disorder, things specific to Iraq, I think maybe the dreams and the tremors...are all I can see the direct relation to. I mean, I don't know.

The more aware I am of this shit, the more damaging it is. That seems to have been the progress of my work in IVAW and Under the Hood and stuff. The more aware I am, the more vulnerable I am... [Some] people are more vulnerable or maybe people who held on to more, through Basic Training, held onto more of that individuality or their soul. Or maybe their soul starts to speak to them more as they go on. But I feel like now I'm more of an individual person than I ever have been in the military, and so when I see the bullshit, it's more painful, I see it more often, it's basically incorporated into everything I fucking do. You know every time I fucking drive on post, it's like I'm victim to this fucking barrage of shit.

But I see my friends who have a lot more contract time than me, and they're shut down and they shut down from the truth of their heart, or whatever for their own safety. And I wouldn't be surprised if that's what the majority of the military is doing. A lot of these soldiers and these NCOs are like, shutting down, which makes them even worse. They start to embody and contribute into that fucking bullshit.

...[Multiple deployments] sets the standard. It's expected. How has it affected them? That they've spent more time in fucking a warzone than they have Stateside? They're more familiar with that, they're more comfortable in Iraq. I hear that a lot. A lot. Where, "I just want to go back." I wanted to—immediately after coming home, I was like, "I want to go to Afghanistan, like, right now." I tried really hard, and I was almost successful, in kind of hacking into all these different enrollment programs, and trying to get my name on a list to go to Afghanistan, 'cause it was just like, "I don't want to deal with this shit," 'cause I don't have to deal with this shit over there... End adjustment, because I'm already adjusted to that style. Just life, just going to the store, crowds and loud noises, being surrounded by people who don't understand. And it's an option to go back. There are aspects of Iraq that I miss. Just the camaraderie between specific soldiers and stuff.

...I was really good over there. I was an asset. I was a radio telecommunications operator for my platoon, the platoon armor, so I kept track of all the commo equipment—anything technical, all the commo, all the weapons systems. Maintenance, odd daily operations, all that shit. I was the platoon sergeant's gunner, so any time shit would go down, he would be like, running the show. So I'd be going between being prepared to find my weapon and light some shit up, and then making sure his radio is operating. 'Cause that's the biggest thing, communications. And his commo was always straight. I couldn't help but think, "People are going to Afghanistan and I can help them." I was an EMT Basic as a civilian, I have this combination of shit that makes me great as a soldier.

Editor's Note: Ryan said that he had taken the ANAM pre-test prior to his deployment, but that he was not post-tested upon his return. He also shared reflections on the prevalence of sexual assault and harassment in the military.

I mean, I was never blown up, and I never got hit. So I think if I did check that box, then they would send me back to that process.

My platoon sergeant had TBI really bad, before he even deployed. He was kind of my buddy, too. We always called him "Crazy Eye," because one of his pupils would be extremely dilated, while the other one was really small, often after sneezing and yelling. He had TBI really bad, and he had to take enough pills to kill a horse, on a regular basis. And it was funny that that wasn't even considered a non-deployable condition—despite the effects that had on him.

...You can't see a female in a dining facility without everybody going apeshit. And that mentality carries through, where you start to hear, "Hey bro, are you gonna hit that?" There were a bunch of females in my installation that were always in packs, and I'm really glad for that. A lot of them were queer, but that wouldn't have saved them. Actually, I think it almost made them more of a target.

It's a cultural change that needs to happen. And I don't know how that can exist. Can you punish it out of them? Because the Army can implement whatever change they want, but these people are not gonna change until they want to, or until they're absolutely forced to and observed changing. And for something as intense as their daily interactions with females...it's a ways off.

...I mean, I've heard stories of soldiers that I was with in the deployment before. They would call this thing, called "eggs and bacon," on the net. They're doing enter and clear operations for villages, looking for terrorists or whatever. And somebody calls "eggs and bacon" on the net. Probably internal squad, 'cause you have different freqs. And they would call the squad, that code, and everybody else would come around and surround the building, and just be like, "eggs and bacon, building 27." And then, everybody would surround the building whoever had called it, would be in there having their way with somebody in the building. And then they would tag out or just leave. And there were occasions where they would just fucking burn the house down, as they walked away. Throw a bunch of frags in there, like grenades and shit. And these are dudes that are fucking teaching the SHARP class. You know what I mean?

I never heard “eggs and bacon,” [personally], because we never did mounted ops. This was the deployment before mine. And when I asked a soldier—a buddy of mine, who I actually kind of looked up to, and I heard that he was a part of these. And I was like, “Hey, what do you know about that?” And he was like, “It is what it is. Shit happens in Iraq.” And then implemented a dozen other people that were in the platoon that deployment.

But this last deployment, the MST and the sexual harassment was limited to like, any woman on the base having to walk by a crowd of other dudes and be hollered at.

I didn't know about any assault [on deployment]. I think assaults may have happened, but I didn't hear about it, or I didn't see it. We just saw reactions to it, all of a sudden a policy would change. They'd be like, “Hey, nobody out after dark on this base, anymore,” or not out after dark without two people. And no women out alone.

...Most of [veteran friends] are unemployed still. Everybody who'd been out in the past year—well, except for one, Niles.* Niles* got out on being fat, but his brother works at the VA. And he knew what he was doing, he got all his paperwork for his disability squared away, and then saw the prospect to get out earlier, under this thing, and literally ate his way out of the Army [to get an overweight discharge].

Editor's Note: Ryan reflected on his experience as a gay soldier, and specifically how that affected his health care in the military.

...The dude I talked to, when I went to R&R in Iraq, he was a major. And I saw him for three sessions, and he eventually came out to me. And he actually did his dissertation on DADT. And he'd been gay in the military for 25 years. And I was like, “How the fuck could do you that?” Also he sexually harassed me. You know, tried to go down on me.

...Even STD testing [is affected]. Luckily some of these civilians that work at the clinic, are amazing and very informed. I do [feel comfortable being out] now, 'cause I don't care. 'Cause I'm willing to pick that fight. I'm more empowered, I'm more informed, I won't stand for that shit. Where, in the past, I lied.

Rowan,* a woman who I love to death, her and I talk all the time. I go into my STD test, and it takes like, three hours, 'cause we're bullshitting. But she tells me about soldiers that come in and have like, anal warts, and have no explanation for it, because they're still not comfortable about disclosing it. So, there are a lot of soldiers who are having unprotected sex and don't feel safe...can't talk about it. Not good stuff to go on.

It's dangerous stuff. And they had the HIV outbreak recently. Seventeen people seroconverted, in the last three months. Those are just soldiers. That's not even civilians in the area. That's a huge number. That's the biggest number Fort Hood has had, ever, in the history of Fort Hood and HIV. I wonder if they're gonna try to backfire that shit to DADT.

Editor's Note: The interview turned toward Ryan's thoughts on how families are doing amidst current conditions at Fort Hood.

Not that great. I mean, I was talking to my buddy last night, who'd been in this awesome marriage, and they got this beautiful daughter. And he's considering divorce now. [I know of] maybe one or two healthy marriages. I can't think of many. But this is my criteria of healthy: them not cheating on each other. You know, sleeping around with countless dudes, going out with countless women, getting into domestic disputes, getting into physical altercations with each other. [Those happen] often. Even the soldiers—these men are coming back with black eyes and shit. And everyone's like, "Oh. You got beat up by a girl." And I'm like, "Well, I guess he must have deserved it."

Editor's Note: In closing out the interview, Ryan shared what he thought it would take to get soldiers the care they deserve, and the right to heal.

It's not making sure there's enough care when they come home. It's not sending them away. It's not having an environment where they need [care] at all. I think an environment where a person gets the care they need is where the care is not needed.

Are these treatable conditions? Some of these guys, are they gonna ever be okay? Are they ever gonna come back? History doesn't say so. Based on the homeless rate of mentally disabled veterans from Vietnam.

Who went on one tour, and maybe two, as opposed to five and six. Our streets are gonna be flooded. I keep telling people that. They don't believe me. But I joke about it—it started as joking, and now I'm kind of preaching. I'm like, "Hey dude, 'cause you're gonna see most of these dudes on the street with a fucking can, asking for change," and they're gonna be an Iraq vet.

17 Brandon Harris*

Editor's Note: *Brandon* is a white Army veteran in his thirties who is originally from suburban Texas. He served four deployments between 2000 and 2011 as part of a Military Police brigade. At the time of his interview in 2012, he had relocated from Fort Hood elsewhere in Texas, and continued to struggle with moral questions surrounding his military service.*

From the time when I was really young, I always just knew I was gonna join the military. I remember doing exercises in class where we'd try to think about what we wanted to do when we grew up, and I never really had an answer. I thought of things like being a taxi driver—something very monotonous. Something about military life and having everything be clear-cut appealed to me. I liked the idea of not having to make a lot of decisions. My perception of the military was that for every single situation you're in, there's a certain thing that you should do, a procedure or something. And so that appealed to me, I think.

I was hoping to serve 20 years in the Army and retire at the age of 38, and then for the rest of my life have a pension and full medical benefits. Then I would have the freedom to do whatever I wanted, with that amount of money coming in. I wouldn't have to worry so hard about getting a good job. I could work literally anywhere, and quit on a whim if I wanted. So that's kind of what I thought, "Where else can you work for 20 years and then draw a paycheck for the rest of your life?" So that's what I wanted to do.

I never sought mental care. But throughout my entire time, I would say that it was always a little bit frowned-upon to seek any kind of care. You were looked at as weak, or just...inconveniencing other people. Especially with MPs. If we weren't deployed, we were constantly working shifts. So if you have to go to sick call, or do something like that, you have to get taken off the rotation of work—which means somebody else loses a day off. So it's like a domino effect. I rarely, if ever, went. I was usually in good health anyway. I know one time, I had what I thought was a cold, and so I just toughed it out for as long as possible. Eventually I finally went to the emergency room, 'cause I realized I actually was sick, and I found out I had pneumonia. So it was something that probably didn't have to get that serious, if somebody had just said, "Yeah, when you're sick, go to the doctor." But instead, it was, "Why don't you just take something over the counter? Dayquil or something, you know."

At least in the majority of my career, I never had soldiers who needed to go to mental health either. But my last tour—in Afghanistan, from 2010 to 2011—that's the first time I was with soldiers who had been deployed multiple times, and so some of these guys did have mental

issues. My unit, at least, seemed pretty okay with them making appointments and going. A lot of them had prescriptions, and my chain of command really understood. If I told them, “We need to make a special convoy soon, because my soldier's about to run out of meds,” that was fine, and we made it happen. But we did have problems with MPs. We were usually underneath a different command. So sometimes, especially among the higher-ups, they didn't understand our situation as well as our own command.

There was a time when one of my Team Leaders needed some kind of anti-depressant, and he was out. I think he had gone a couple days without it. You could tell in his mood: he was much more aggravated, and so it was a serious situation. We basically got it cleared to take a convoy back to the nearest base that had those meds. But just by coincidence, some lieutenant colonel, the squadron commander—I mean, MPs don't even have a squadron, so I didn't know who the fuck he was, but I'm sure he was basically the equivalent of our battalion commander—wanted to go to some village in the area. So we had to help take him out there, and escort him, and that turned into a long deal. Our battle-space commander, who was a captain, tried to let him know, “Hey, the MPs have to go, because they need to get there before nighttime to get this guy his medicine.” Of course, the lieutenant colonel kept finding stupid-ass things he wanted to do. So I mean, it's just a matter of priorities... That was really the only instance I can think of. It was usually when dealing with people who were not familiar with us, someone who I wasn't just able to go talk to man-to-man. I could do that with my first sergeant or commander, and make them understand. I couldn't do it with somebody else's squadron commander.

I think most of the time [the quality of care] was poor. Some of the guys knew exactly what they needed because they had navigated the system so long. Like this guy who had that prescription, he knew he needed the specific brand of anti-depressant. One of those times, we made the special trip to go get it, and then the clinic didn't have it. So they had to give him something else. I do remember there were a couple times where he just kept getting more and more pissed off at that medical facility. We would call in advance, and they would tell him that they had something. We'd say, “Okay, we're coming on Friday to pick that up.” We'd get there, and whoever was there would say they didn't have the authorization to give it out—that only a certain doctor could give out meds and he wasn't there that day. Or something like that. So it was a lot of something that should've been easy, and instead it was constantly getting jerked around.

...It was definitely a burden on all 20 of us who were located together, when he didn't get what he needed.

...The only ones that I'm thinking of were not super-open about it. I don't know that they were ashamed or anything. They certainly didn't get into the details or tell me anything. They just said they needed their pills, and it was obvious when they didn't get their pills that their mood and their irritability changed drastically over time. But I don't know if that soldier had PTSD [diagnosed], if it was related to prior combat, or if he just had an issue.

If he was on his meds, that was great – but that's why it was so important to get back when he ran out. Especially if that guy wasn't on meds, he was more irritable, he made poorer decisions.

So it would endanger other people, or could possibly endanger other people, if he's not in the right frame of mind. It could make a normally innocuous situation turn real bad.

We all did some kind of screening [for PTSD], went through and got our shots, and all that stuff [before deploying]. And as I remember, having to talk to a mental professional was one of the log-jams when we were having to do that. So, they definitely talked to someone. From what this guy told me, it was really just kind of confirming what his prescription was, and making sure he had a three-month supply when we left. That was pretty much it.

...I think [my commanders] were pretty responsive. Obviously, just like I said before, there was still a little bit of the...I wouldn't say it was a stigma. You could tell things were an inconvenience. I'm thinking about a different soldier, a private who definitely did not have PTSD —this was his first deployment. But for some reason, he started having suicidal thoughts. So when I called the first sergeant and said, "We must come back tomorrow, 'cause this soldier has suicidal thoughts," it was still a vibe of, "This is inconvenient." But I think we had reached the point, in 2010-2011, where the first sergeant realized that he has to let us come back. It would be a serious problem, so they made it happen.

I was on a profile a couple times. After having a surgery, stuff like that. Especially when I was at Fort Bragg...that was a really big deal. I remember specifically telling other soldiers when I was either an E-4 or below, that one day, when I was a first sergeant, I was gonna make a bright orange or a bright pink T-shirt, and it was gonna say 'broke dick' across the front. I was gonna make my soldiers wear that if they got a profile. That was the mentality at Fort Bragg. So as a soldier, I obviously learned that from somewhere. I learned that from the environment and the way we all looked on people with profiles. And later, I obviously wised up and realized that was ridiculous. But as a young soldier, that's what I aspired to, so that's what I expected of myself and others.

I would say that the farther in my career I got, the more evident profiles were. I don't know if that was because my first eight years were at Fort Bragg where everybody prides themselves very much on being Airborne and being better than the next guy. It was more frowned-upon. The other units that I was in, in the second half of my career, were what I considered to be POG²⁰² duty stations. They were much more relaxed. So I don't know if it was just because people held themselves to a lesser standard and they didn't mind getting a profile, or if it was that over the years of constant deployments people realized, "Hey, I have to take care of myself, 'cause maybe the Army's not gonna do it." Or if it was over years of having such a taxing experience, of deploying constantly, that people thought, "Hey, I really need a break. I wouldn't mind getting a profile to be on quarters for a couple days." I don't know what the cause was, but I would definitely say, around 2010, 2011, there were way more profiles. It was way more common for a soldier or an NCO to get profiles than it was in 2000, 2002.

I think by the time I was an NCO, I no longer was as dismissive of profiles as I had been. Even though I personally still was opposed to myself getting a profile, I never looked down on any of my soldiers for it. And certainly, towards the end, I didn't discourage anybody from it. It was irrelevant to me. We would just work around it.

I don't think [soldiers on profile] were directly pressured [to violate it], but certainly, there is to an extent. What would usually happen is there would be a task that needs to be done, "Hey, we need to unload this Connex." So everybody's expected to be working hard. If one person is slacking off and they get called out for it—and if they happen to have a profile—in order to not get made fun of or not get reprimanded they might mention, "Yeah, I've got a profile, I'm not supposed to be lifting more than 15 pounds," or something like that.

Nobody's gonna say, "Hey, you will violate your profile. You will lift more than 15 pounds, 'cause we have to accomplish this." Instead what they would say is, "Well, come here, I'll find something you can do that's within your profile." So, to a certain extent, it was still like they were getting the short shrift, or almost a punishment. They got the message that if they told someone, "Hey, I can't do the current task because of my profile," it would be worse for them. So the unsaid message was that if you've got a profile, and what we're doing violates the profile, it's probably better to just go ahead and do it, rather than bring it up and end up getting a worse situation that's actually within your profile.

Editor's Note: Brandon also testified that he did not see soldiers receive re-evaluations for profile eligibility, either for permanent or temporary profiles. He went on to reflect about how combat readiness quotas played out during his service as an NCO.

I didn't have the details, but in 2010, when we were getting ready to deploy to Afghanistan, they did say that there was a certain threshold. Each unit is supposed to be assigned a certain number of people, and if you didn't have a certain percentage, then you were non-deployable automatically. So the idea was, as we got closer and closer to our deadline, and we started losing people—either because at that point we were already stop-lossed, or stop-movement, or whatever, so it wasn't like people could PCS—but as people would become non-deployable, it became a very big issue. If somebody broke their arm or broke their leg, then the next day we'd hear about how everybody needed to be really careful. We could only afford a couple more people, and then we wouldn't be able to deploy. So I think we did take people with us who were actually on profiles that, according to that profile, they could not do combat duty.

Apparently, though, they could sit behind a desk in a combat zone. So we would still take them, because that meant we had enough numbers and would be able to deploy. I don't know if the Army would really have prevented us from deploying, or whether it would've just meant that the commander looked like a shitbag for not being able to keep his guys from not breaking their arms for two weeks.

I think [the quotas] were stemming from Army policy, or someone higher than the company commander. 'Cause it was always the company commander who would stress at safety briefings on Fridays, "Hey, we're gonna be deploying soon. I know you guys are gonna have fun this weekend, but make sure you're smart about it because we can't afford to lose another person. Each one of you is needed." Actually it reminds me that this became really, really evident when soldiers got caught—non-medically related—for abusing drugs. Normally that would've meant they'd be kicked out of the Army, or at least get some kind of punishment. But because we

needed those people, we took them instead. They were still flagged, and they couldn't get promoted, and stuff like that...but we still took them on deployment.

...I mean, there was the substance abuse program. But that's just a week or two-week long course that you would send them to, and they would sit through, and then come back. It's kind of like everything else: check the block. I was in a different position prior to that deployment, so those two were not even in my platoon, and I don't know what they did with those guys. I don't know if there was any conscious choice to try to see, "Okay, why are they doing drugs?"

For the most part, a soldier on profile is just usually considered to be making life harder on those around him—no matter what, at a minimum. Even in the best case scenario, when it's a legitimate reason, "Oh, he broke his leg." There's nothing he can do about breaking his leg, but it's still undeniable that now that he's on profile and can't work, everybody else is screwed. So sure, we can all agree that it wasn't your fault, and that you weren't intentionally screwing us all over. But it doesn't change the fact that you are screwing us over.

I think [these ideas] stem from basically just the organization of the Army. When you look at an MP unit, which has to work law enforcement, they might have 160 people in the company or something. A certain number of those are allowed to work the road, and if they don't have enough, it's not like they can call in more people. You only have what you have. It's like you get 200 bricks to try to build a shack, and if in the course of building that shack, you break 20% of the bricks...tough shit. You can't get another 25% bricks replaced in order to build the shack. Instead, what you have to do is modify the shack to make it work. It's the same thing.

No matter what, we had to have a certain number of soldiers working three shifts, around the clock. So if a soldier got a DUI and was no longer allowed to drive, and then another soldier broke his leg, and then another soldier just went to sick call 'cause his back hurt, and they gave him a profile saying he can't wear body armor, now he can't work law enforcement on the road either. It's the same thing. Just because three of your soldiers in your platoon cannot work the road doesn't mean you don't have to provide 12 soldiers for day shift, 12 soldiers for swing shift, and 12 soldiers for mid-nights. So it means those three soldiers just screwed Private Snuffy out of his three-day that he was gonna get this month. And it screwed some other private, and instead of working a five and two, he's gonna work a six and one.

[The 12-soldier requirement] is probably from the installation. Because every installation—whether it's Fort Bragg, Fort Hood, Camp Zama in Japan, another place I was—in order to do law enforcement, they divide the whole post up into a certain number of sections. Then each section needs a certain number of police per shift. I don't even know which installation I'm thinking of in my head, when I think of 12, but I'm pretty sure one of my installations needed 12 soldiers to be able to cover a shift. So that meant that there were 12 patrol areas, one MP in each patrol area. Or maybe 11 and one supervisor, or something like that. And when you did the schedule, you made sure there were 12 on days, 12 on swings, and 12 on mids. Then whoever was left over would be off, and you just had to work out the rotation.

I think it absolutely did discourage [soldiers] from getting the care they needed, because there would be self-imposed stigma. If you've been fucked out of three days, then you've gotten screwed out of the good schedule you had on the 1st of the month. By the 10th of the month your schedule sucks already, because so many people have screwed over everybody else, in your view. Once you've been on the receiving end of that enough, you don't want to be on the giving end. So for some of it, without any outside pressure, the soldier's just already gonna start thinking in that way. He doesn't want to screw his buddies. At the same time, I also had platoon sergeants who sucked at making schedules. So I'd make that schedule, because that 12 for three shifts would stress them out. So when they have to make a schedule change every day, they get frustrated—and then they start putting pressure on the soldiers.

So now, not only does the soldier not want to do it because he already in his own mind knows he's screwing everybody, but other soldiers are also hearing from their platoon sergeant, "Hey, just so you know, so-and-so got a profile today, so that means all of you got screwed." I know that one of my platoon sergeants at Fort Hood, when he would have to call a soldier on his day off, or the day before his day off, would say, "Hey, I'm sorry man, I know you're supposed to be off tomorrow. But you gotta work. Torres,* or somebody, went and got a profile." He would actually use the name, so now that soldier knows that because Torres went and got a profile, he has to work tomorrow instead of being off. So that's part of it, too.

I don't think anyone ever retaliated or targeted others for it. Probably ridiculed—name-calling, and stuff like that. The two most likely outcomes, I think, would be for people just to complain, but suck it up and endure it. Or the other option was to basically become the person who screws everyone else, rather than getting screwed, "Okay, fine. If that's the way it's gonna be, then what I'm gonna do is, every time I'm off, I'm gonna drink alcohol. Because that means when you call me and say, 'Hey, I know you're supposed to be off today, but Torres got a profile so you have to come in,' you can say, 'I'm sorry, I'm drunk. So I can't work.'" So that passes it along to the next guy, who gets screwed.

...Similar to the way profiles were, I saw [substance abuse] increasingly the longer I was in the Army. In the early days, everybody drank or binge-drunk. And everybody understood the trick of getting drunk when your day was off so you wouldn't get called in. But I was not aware of many people who I would consider had a substance abuse problem. Closer towards the end of my career, I started noticing it more. Just like with the profiles, I don't know how much of that was because I was at a different installation, or how much of it was because of those soldiers. When I was in Japan, which is a very chill duty station, I can remember we had a specialist who absolutely was an alcoholic, who was getting in trouble off-post and blacking out. He had PTSD, and I think he was basically self-medicating for that.

I think [SRP] changed a lot, too. In the beginning, when I was deploying from Fort Bragg, it was just a joke. Usually what it involved was you doing a survey, just saying what things you did or did not experience. Then you would go through and hand that to someone, and they would maybe ask you follow-up questions. The big joke back then was that we were active duty, and we were at Fort Bragg, and we prided ourselves on being hard-core. So we would come back and out-process through the SRP at the same time as National Guard units or Reserve units.

I remember that even the doctors told us they liked it a lot more when we came through, 'cause active duty soldiers didn't own up to anything. "No, I'm not worried about this. No, I'm not worried about that." When they would ask questions, "Hey, do you have nightmares? Do you have any mental problems that you need to see us about? Are you concerned about your health? Did you see anything on your deployment that could be bad for you?" The active duty soldiers always said, "No, no, no, no, no, no." But the doctors claimed that the Reservists and the National Guardsmen were drastically different, because they were going back to civilian life. They didn't want to get screwed, so they wanted everything documented.

Maybe only one doctor might have said it to one guy. But then that guy told us, so we all knew. We looked down on the National Guard soldiers at that time, for that reason. It wasn't until we realized, "Oh, we're gonna keep deploying over and over and over again," that maybe it is a good idea to have some of that crap on paper.

Editor's Note: Brandon testified that he thought soldiers were pushed through SRP who should not have deployed.

I think so. I had a team leader whose back was really fucked up, and he absolutely should not have deployed. But because we were hurting for numbers, even though his back was fucked up, the first sergeant and the commander wanted him to deploy anyway. The doctors, I think, did not want him to deploy. Either because they genuinely believed, "Hey, you're too fucked up, you shouldn't deploy," or, who knows, it might've been because they didn't want to have their name on paperwork signing on for him to deploy, and then something comes of it. I think the big difference, though, was that the individual soldier wanted to deploy. So I think most of the time, that's kind of what it came down to. If the soldier wanted to deploy, then I think that carried a lot of weight with the doctors and stuff. More so than what the commanders or first sergeants, or whatever, thought.

I know on one of my deployments, to Iraq, I found out after the deployment was over that soldiers had been getting drunk. I guess while they were on patrol they would go to the Christian neighborhoods, where they actually sold alcohol, and they would buy it and bring it back to the base. Then at night, they would drink. But I never even knew about it. I never saw anybody drunk or hung-over or anything. So I don't know how much it was going on, and whether it was just them trying to relax or whether they were abusing or what.

We had zero suicide attempts, and zero suicides [while deployed]. I did have one soldier who said that he was thinking about suicide. That was the example I gave earlier, where the command was very understanding about it. I just called the first sergeant and said, "Hey, I've got this soldier, he told me this and this, and that means I need to come as soon as possible, to let him see a doctor. So should I come tonight, or should I come tomorrow, or what?" They said, "Yeah, come tomorrow." So we came and he saw the doctors, and the doctors let him stay with us or whatever.

...I never got blown up or anything. I'm pretty sure that you had to check a mark whether or not you'd ever been hit with an IED. And if you said no, then of course you're not gonna get screened for TBI. So I don't know what that screening was or wasn't, because it didn't apply to me.

Same as I said for a few different things, I think these days [soldiers] probably [tell the truth at R-SRP], because I think soldiers are more aware of...the need for being honest. I think in the beginning people were not. People were definitely lying.

...I don't think [we ever got briefed on PTSD]. At least none that were significant enough to make a difference for me. I personally read a book, just because I wanted to read it. It was called *On Combat*, which was talking about the physiological effects on your body when you're in a lethal force encounter. Its idea was just to let you know what is gonna happen, "If you get in a fire-fight, you're gonna experience tunnel vision, this, that, that." And that talked about PTSD. When I was a squad leader, prior to our deployment in 2010, I forced my entire squad to read that book. It not only talked about what happens in a fire-fight, but it also did talk about after the fact: what happens immediately after you kill someone, what happens a couple weeks later, what happens maybe several months later. It also had what I guess was just the author's theory on ways to deal with it, and stuff like that. So I forced my soldiers to read that book, but that is the only thing that I kind of went back to, or really considered a good source. If the Army ever told me anything, I don't remember it and it wasn't significant.

Editor's Note: Brandon was asked how often he was screened for PTSD.

...When you came back there was an immediate screening, when you did your SRP for returning. Then, a couple weeks later, you had to come back and do different things. And then maybe a month later, you had to come back and do something again. So I'm not sure. I don't remember when they asked me, because I have no PTSD, and did not have any cause to think I was going to get it. So it's kind of similar to the TBI, in that I don't think I paid as much attention. I know I've been asked and had to fill out questions at some of those SRPs, where it was just asking those questions, "Have you seen a dead body? Have you seen someone you knew die in front of you?" So it's the same kind of thing—if you say no, then they're not gonna waste their time on you, more than likely. 'Cause there's no reason to.

The only distinguishable effect I've seen [from PTSD] is just the fact that some of them are on medicine, that apparently they're gonna have to be on either for a long time or forever. And the impact that makes on them...that's pretty much it. All the soldiers I know of who definitely had PTSD, I only knew because they said they had PTSD—because they mentioned it, or because they were on medicine.

I think [multiple deployments] connects a couple issues. One of the things it connects is why I ended up getting out of the Army. Most Americans can look at World War II, and they think that was a worthy cause. I don't even think that was a worthy cause, now. But most Americans, I would say nine out of ten Americans, are gonna tell you World War II was worthy. If you experience a lot of hardship and have a lot of problems, and experience all the things we experienced—whether it's TBI, PTSD, and whatever—there's a certain level of comfort from knowing that you did it for a worthy cause. I don't know, but I think some veterans today who

have PTSD and TBI and are having trouble—who still believe in the wars and think they did something good in Iraq, and think they did something good in Afghanistan—I suspect that a lot of those guys, if they ever change their minds, are going to have a much harder time.

That's kind of the Catch-22 about it, in talking to other vets. I have a vet friend in Dallas, who I know has killed children in Iraq. I know he's killed civilians. He admits it, and says he has PTSD, and I know that bothers him. But I also know he specifically is unwilling to go so far as to think that Iraq was not worth it. He still believes in what we did. And I think that is, at least to some extent, self-preservation. Because once he adopts the idea that, "Wow, not only did hundreds of thousands of civilians die for nothing, but civilians that I killed died for nothing," that is a huge weight to land on someone.

...I was lucky, because I'm 100% positive I never killed anyone. I was in fire-fights, I was shot at, I returned fire. But it was suppressive fire, and there's zero chance that I've killed anyone. So any guilt that I've had was more from occupying peoples' countries, and being there in general—just being there gives a certain bit of support to the others who actually are killing people. It's kind of an indirect amount. My guilt is much smaller than it could have been. So in that way, I'm lucky.

But in no way am I proud of any of my deployments anymore. I absolutely think that every single deployment I went on did more harm than good—without question. So if I had done anything on that deployment that I wasn't proud of, it would just be a multiplier. It would make it even worse. I think that element, to some extent, might account for the levels of PTSD in vets, for suicide in vets, and for whatever amount still believe in the wars. 'Cause to some extent, some of those people, even if they don't realize it, might be supporting it against their logic, just out of self-preservation, as far as I know.

My opinion for PTSD is based on that book I read. I haven't really seen anything to change my mind. My opinion is that PTSD is caused by basically three things... One is a traumatic situation, or a dangerous situation. The second is you're helpless, and you're without the power to do anything about it. Three is just that later it comes back to you.

...Another thing I have read about is the studies going on right now trying to figure out whether moral injury can result in PTSD. So [this would be] if somebody had 100% pure intentions, and they were trying to kill somebody who they thought was going to kill them, but they accidentally killed a kid. Maybe later on, when they get a chance to decompress, that event could be characterized as moral injury. That still might fit into my criteria. Even though they were the perpetrator, they still might feel like that situation was: one, traumatizing; two, beyond their control. 'Cause what are they gonna do, not return fire? So it still kind of fits into that thing.

I think the major cause of the soldier's trauma is there's nothing to be proud of. That's my personal belief. I don't even think that everybody understands that that's what it is. But I think, deep down, everyone knows that there is no reason for the Iraq War. I think, deep down there, everybody knows that. It's impossible for someone to not know that, except for the most—I would start to say the most ignorant, honestly just oblivious person. At this point, you almost have to be willfully ignorant; you have to actually put on blinders to not see it. Afghanistan is still not like

that, but I think it gets more like that every day. The more people go to Afghanistan, and especially if they go back again, and see that nothing has changed, then the more it happens. I think it's like a light switch. If one day you realize, "Shit. Everything I went to, everything I did, was bullshit. It didn't matter," then that changes all your experiences.

So everything you thought you were doing...everything you were proud of, it's the opposite. So...I feel pretty lucky, 'cause I don't have a lot of stuff which gets too changed. The only thing I feel bad about is just that I felt like I was patriotic, like I'm doing great things for my country and I'm worthy of this praise that people give me when I come home. I'm proud of one time when I stopped at a school and took down their flag, 'cause it was tattered. 'Cause that's the honorable thing to do, right? 'Cause you don't want to fly a tattered flag. And that's bullshit. That's a symbol. Maybe if that symbol stood for something good...but once that light switch is flipped, you realize what you were doing is not like that.

You can still admire yourself or others for what they originally thought. In my opinion, a lot of soldiers today—including myself in 1999, when I joined the Army—are like the child who tries to help his mom. His mom starts a kitchen fire, and it's a grease fire, and the child comes in and wants to throw water on it. He comes in with a water hose, or a pitcher or whatever, and he's trying to help, but it makes it even worse. And his mom dies. Well, he's got great intentions. You can praise him for wanting to help, but the fact is he's making it worse. That's kind of the way I see it. And he doesn't understand, all he knows is, "Man, that fire was super-bad, my mom died." That's terrible. Then years down the line, he finally learns that, "Oh, you're not supposed to put water on a grease fire? So what you're telling me is my mom didn't die from a grease fire—my mom died from me throwing water on the grease fire." I think that has a big part to do with how people are.

...But you probably can't...do much better than...talking to people, or making situations for them to be able to talk about it, to get stuff off their chest.

...I know of soldiers when I was in who made accusations [of MST], and then those were either founded or unfounded. But I wasn't close with any of them. Currently I'm not in contact with and don't know of anyone I ever was close with who was affected by it, one way or another...I still don't think [MST] is taken seriously.

...Combat experience is enough that everybody pays attention to it, or at least acknowledges that it's a real problem. I think MST is still not seen as a real problem. Plus, since...at least the perception is the majority of the victims are gonna be females, and females are a minority in the military. So I don't know if that has anything to do with it. I think the majority of male soldiers simply don't really see it as a big issue. I don't think they realize the true number, the true amount, that it goes on.

Editor's Note: In concluding the interview, Brandon reflected on what he thinks it will take to get soldiers the care they deserve.

I think it'll take...popular support from the civilians, from the Americans. As long as the only ones who care about it are vets or active duty, I don't think it will happen. We're not a big enough number.

18 Jake Leighton*

Editor's Note: *Jake* is a married infantryman in his late twenties from the suburban West Coast who did not identify his race. He has had three deployments during his seven years of Army service.*

I've been wanting to be in the military since I was little. First it was a cop, and then I started seeing soldiers walking around, and I was like, "Huh, I can do that." I enlisted in 2003. I hadn't even graduated high school yet, and I was already taking the ASVAB.²⁰³ So as soon as I could, I was in the Army. I was 19.

I wanted a little more discipline, and something to be proud of. And the big reason was, to actually fight for the country. Especially after 9/11.

On my second deployment, I got hit by a pretty big IED. And I was having problems with it. I was angry all the time, and all kinds of stuff. And when I went to my platoon sergeant to tell him what was going on, he just said, "Oh, stop being a pussy. We're in the Infantry, stuff like that happens." So at that time, I thought, "Maybe you're right, maybe I should just suck it up a little bit," and keep doing my job. And then stuff kept happening, and kept happening. And same thing, "Stop being a punk. You're in the Infantry, you're supposed to be the hard ass of the Army." And again, I thought, "You know what, maybe he's right."

And then, it started affecting my job. Most of the time I couldn't think, concentration was all messed up. I'd be walking in a patrol, and I'd just zone out. I would be there, but I wouldn't be there. And that's not good. I was supposed to be watching the rear... It makes me angry.

I also lost a lot of my hearing from that IED. So every time somebody would talk to me, and I could barely hear them, it brought up that experience, of the blast. So I couldn't get away from it. And I still can't, because I still have ringing in my ears. And they just say, "Oh, that's normal." I'm sorry, I've had ringing in my ears since 2006. When you go out and shoot weapons, you get a little bit of ringing for five minutes, and then you're good. But this is not normal.

And at that point, this was still kind of new to me. It was my second deployment, but I hadn't been through this stuff yet. My first deployment nothing really happened, we didn't lose anybody. So the platoon sergeant actually got mad. And he just said, "Oh, why are you acting like a little punk now? Like you can't even do your job." And I told him. And he said, "You need to stop being a punk. Now get ready to go on a mission." So I get ready. And we go on a mission, like nothing ever happened...

It shouldn't be that hard, you know? If you go up to somebody and tell them you have a problem, right then it should be, "Okay, we're going to fix this problem first. And if we can't fix it now, we're gonna fix it soon, and you're going to come back and work." And that would've been fine. But they just kept saying, "No, you're not going off work. No, you're not going. Get ready for the mission; no, you're not going; get ready for the mission; no, you're not going; get ready for the mission."

Physically, of course, you're not ready. If you're physically hurt, of course you're not gonna be able to go do it. But mentally, that's what people don't understand. If you're not ready mentally to go out and do that job, guess what? Either you're gonna end up getting killed, or you're gonna end up getting somebody else killed. And if that happens, it's gonna end up being even worse on you. So after a while, I just said, I don't care, I'm gonna go get help. I gotta help myself before I can help you guys on a mission.

So I went to mental health. But I didn't like it so much, because yeah, you got to talk to people, but once you talked to them, they'd just say, "Oh, here are these meds. You should be fine." And like I said, at the beginning, you think, "Okay. If I take these, I'll be alright." But then you take them, and then you don't feel any different. I'm still pissed off all the time.

And then, all they say is, "We're gonna increase your dosage, so you can just sleep through it." That just makes you walk through it like a zombie. So I stopped going. I didn't think they could help, after that. And I was in Iraq, so I just went back to work. Apparently, I was gonna have suck it up anyway. I went back on missions, and everything pretty much fell back into place. I put it all in the back of my mind, and just said, "Whatever, I'm gonna just get this deployment over with. And once I'm done, I'm done."

But then, I got hit again. And I just thought, "Oh, man. Here I go again." This is the time I got my Purple Heart. I had shrapnel everywhere, in my neck, on my arms, my knees. I was pretty bad. I was in the hospital for a while. And while I was in the hospital, I found out that one of my really good friends passed away. He got hit by an IED, in pretty much the same spot that mine was. But his was a bigger one. And that sent me down... It was bad.

But after that, I healed up, everything was fine, all the shrapnel was out. And I needed something to take my mind off of what had happened. So I went back to work. I just thought, "Alright, I'm gonna go back for these last couple of months and get it over with." But when I went back, they said, "You know, you're not ready to be back on a line²⁰⁴ yet." So I stayed at the main FOB, with all the injured people. But there, all I could do was think about it. And whenever I thought about it, about my friend dying, I would get worse.

It was weird, because I felt guilty, even though I was in the hospital when he died. But I thought, "If I would've been there, maybe it wouldn't have happened to him." All that stuff you feel when you lose somebody that's close to you. But a couple months after that, I got put on a plane back to Germany. I thought the care might be better there, and I went to mental health. They just said, "Here's some meds. They're gonna make you tired." The meds make you walk around like a bunch of zombies. And so again, I just thought, "If you're not gonna help me, then I'm not gonna

come back. I can help myself more than that!" But then, it was horrible, because I started drinking. I used to drink in the past, but it wasn't enough to be scared.

Other people in my unit knew I was having a hard time. I used to talk about it. But they would just look at me like, "You know, you're a piece of shit. It didn't scare you that bad." So I was like, "I almost died!" I'm sorry, but you sit in your office, and you're chillin'. And I'm out there actually bleeding. You have no idea how I feel. And they would just give me looks. My platoon sergeant would just look at me like that. That's one of the reasons why I waited to go to mental health until at the end of my tour in Germany, the first time I went. At the end of it. Because I felt like, "I'm clear now. So you can't say shit to me. I'm not even in your unit anymore now."

So yeah, command knew what was going on. They just didn't address it. They didn't care. As long as you're ready to deploy, they don't care. They don't give a shit about you, as long as you can deploy and do your job. But like I was saying, you can't do your job if you're thinking about tons of other stuff.

When I went back Germany, though, after my second deployment, I started drinking heavily, every day. I didn't even care if I had to work. I would just go out and drink. I thought that might help a little, but of course, it didn't. For a while I was in a pretty bad place. Never thought about hurting myself, but it was bad, and everybody could see it. I wouldn't hang out with any of my old friends. Because they all had that same mentality—"Suck it up. Don't be a punk. Just go out and do your job, and come back." It was weird, like they got brainwashed. I felt totally alone in the whole situation.

The drinking made it worse, and worse. And then, it got so bad that I really couldn't even do anything but sit there. Some nights I would just cry all night. It was horrible.

Eventually I got in trouble, because of the alcohol. So they sent me back to Fort Carson. At Carson I was still a big drinker. Every day after work I'd have like, a 30-pack of beer, wake up in the morning and go do PT. So I got in trouble for drinking again. They gave me Article 15s²⁰⁵. I just thought, "This is horrible."

I went to mental health there, and they actually helped. Of course, they still gave me meds. But I also went to an anger management group, and it helped. But a lot of people there really didn't go through the experience that I did. So when I would talk about it, everybody would be like, "Oh my god. That's so—" I didn't think they could relate. I had that feeling again, of just being alone.

So I stopped going to the group. I got a little bit better, since I stopped drinking so much. And then, they started talking about deployment. I was still nervous. But then, for the deployment, I made team leader, which made me feel a little bit better. It made me feel like I was still in there, I'm still good, still doing my job, and apparently I could do it good enough to be a team leader. To actually go out and lead four guys, take them to Iraq and bring them back. So I thought, "Okay! It's alright." And I got deployed. My third tour. And the beginning was easy.

But then, we all went down to the detention center. And for some reason, an American soldier

hadn't been in this place for about five years. So I just thought, "Here we go again." It was the same story in the last city. I just couldn't get away.

We kept doing patrols, and nothing happened. It was okay until the last three months. And then, in not even a week, I got hit by three IEDs. The first one they had set off wrong, so the only thing that went up was a blasting cap. Which was good, because it was a 155, and if it had gone off, it would've been bad. The second one was again, set up horrible. But the weird thing about that one was that, for me, I don't want to see what is going to hurt or kill me. We were rolling around looking for stuff on roads, and I saw a plate. And I didn't have enough time, because once I saw it, we were already on it. It didn't kill the truck, and nobody got hurt, but for some reason, that was the breaking point for me. I was a passenger, behind the driver. And I just sat there in the backseat and I cried, the whole time. I was broke down.

And so, we went to go look for them. Of course, they're so stealthy, they were gone. As soon as it went off, they were gone. And that pissed me off. I felt like since the new ROE came up, we couldn't do anything. It was really frustrating.

When it was over, I called my wife, and said, "I got some news. I got hit." And she was stunned. She couldn't even talk to me for 20 minutes. I was fine, but it scared the hell out of her. This was when I was in the unit that was actually cool about going to get help, and actually giving us time to get over it. They talked to us and said, "You guys get a couple days to relax." I chilled out, played video games. And a couple nights later, I was sitting in my room, and my squad leader came in and said, "You guys don't have to, but if you guys can, we really need your help tonight." And I feel like, if you're okay, you're not hurt, then you're thinking, "I really don't want to leave my platoon like that." So everybody just said, "Okay. Let's roll. We're down."

It was weird. The street that we rolled down to get to the Initial Point, there was a street and then a burg, so we couldn't go past that. We had to take a detour around it, on a little path, so the trucks barely fit. On the other side, there was a river.

When we were heading out, everything was good. We stayed out there for three or four hours, and then we were told to go back. I thought we might get back alright. So we're rolling. We hit the detour. And once our back wheel was in the detour, the IED goes off. And this one was huge. It was so big that the windshield broke out of the truck. And you can't even break that thing with a 50-cal round. We almost flipped. The back end raised up. We were at about a 45-degree angle in the air. I hit my head on the glass. I was knocked out. When everything was settled, I kept hearing yelling. I was still dazed. I went to open a door, but the blast had blown a tire off on the opposite side of me, so the truck was standing at an angle. And the doors are 450 pounds, easy. The truck was on fire, and I was just thinking, "Man, I gotta get out of here." I still had my seatbelt on. Fire was right next to me, and all around in front. I was looking around like, "I don't know about this."

I'm trying to open this door. I got it a little bit open, and then it closed. So I was like, "Dammit." And then I heard a whisper. It was weird. Everybody was yelling, but I heard a whisper. And the door opened. I pushed it a little bit, and it opened. I still had my seatbelt on. I unhooked it. But

this time I was stuck. I couldn't even move. The guy that was sitting behind me had shattered his whole arm. The driver broke his neck. He didn't die, but he broke his neck. The gunner got a piece of shrapnel in the leg. Lucky we didn't lose anybody. And I had a bad headache. When we got out, we got behind this building, and I just sat there. I couldn't do anything. I couldn't even cry. It scared me so much I couldn't do anything. And my platoon sergeant, again, he came up to me and said, "You alright?" I just said, "No, I'm not alright. I'm not okay at all."

The next day, we had a meeting about the IED. Saying what happened, how we felt about it. And it really pissed me off, because we had injured people, and the medivac bird took two hours to get there. If I had known where they were, I'd have probably went in there myself. But everybody was pissed. Everybody thought, "Forget this." And I was sitting there feeling like, "Whatever."

I really stopped caring about stuff. I felt like it didn't really matter anymore, who cares? I talked to the Chaplain, and he asked me how I felt, since I was in the truck. And I said, "Mentally, it's hard." So the next day, I got sent to mental health in Iraq. I stayed back from work for a few days, and it was alright. I was still very, very angry. But everything was okay. I was drinking heavily. So after that, I went back to Germany. I didn't deploy again. I was still injured from my third deployment, with mTBI.

Back at Fort Carson, I went to the clinic, but they were full, from everybody coming back. I went to the hospital, because the blast blew my ear drum out again. I had already gotten surgery on it, and then got in that next IED, and blew it out again. So I got surgery, and went to Germany, on Rear-D. Everybody was already deployed. That was the perfect time to go just drain everything out. I went to the mTBI clinic, and that was it. They started checking me out, seeing how my memory was, and diagnosed me with the mTBI. I found out my long-term memory was good, but my short-term was pretty rocky. You could tell me something, like at the beginning of the interview here, where you were naming off a list of things to say about myself, and I would forget most of them. Somehow my vision got messed up. I had 20-20 vision before, and then I had to get glasses. But they did the same thing, just said, "Oh. We can give you some meds." And I told them I was getting tired of it. I said, "Every time I come in here for something like this, all you guys do is try to give people meds." People don't understand that you don't only need meds. That's not gonna solve your whole problem. It may take one symptom away, but then all the side effects make it even worse. So why even give a med if one of the side effects is thoughts of harming yourself? I said I'm tired of it. And they just said, "Well, that's all we can do for you." And I thought, "Man, there has to be something else."

After my second tour, I was on anti-depressants, I was on nightmare pills. They actually gave me pills for nightmares. It said that on the bottle, "For nightmares. Take one before you go to sleep." My headaches were bad, migraines. Horrible. But they gave me Tylenol. So I was like, "Maybe I shouldn't go back there. I could buy Tylenol." I still have the headaches.

After the third deployment, I was on anti-depressants again. And when I got to Germany after that, they put me on the nightmare pills too.

They told me, "Take one each day" and, "Eat before you take one." That's it. And, "It may make

you drowsy.” They gave me paperwork. If you wanted to know anything else you had to read it yourself. But I would take some, and I would get bad headaches. But headaches were one of the side effects.

I went to follow-ups. I guess you could say I was evaluated. They would ask if the meds are working. And if they weren't, they would just up your dosage.

They said I had mild PTSD, after my second deployment. And mTBI after my third. But they never scheduled me for an MRI, they never did any of that stuff. Nothing really happened after I got diagnosed with the mTBI. Actually, I think I need to go for that now, because I've been getting really bad headaches. On a scale of 1 to 10, sometimes it's a 5. And sometimes 7, when I just need to go in a room, turn off all the lights, and just ride it through.

I want to go to mental health here. But I'm nervous that all they're gonna say is, “Oh, here's some pills.” If it's just going to be pills, I would just rather do what I'm doing right now. I'm just getting through it myself. Which is working, but not really. Because I could flip out over the littlest thing. It doesn't have to be big. It doesn't matter.

You always go through SRP before and after, but it's a joke. I was like, “This is it?” Is that all you have to do or say to us? I saw plenty of people get pushed through that shouldn't have been deployed! It was crazy. It's horrible.

Look at me, alone. I was okay to deploy, apparently. They just whispered, “Oh, no, you're good. Actually we just need people to deploy. So you're good.”

I didn't see anyone about mental health at SRP. It's just medical, and not even actual PAs. They were like, line medics. And actually, they didn't even start telling us about mTBI until the middle to the end of my third deployment. I didn't even know it existed. But I'd already been blown up twice. I was thinking, “Oh, okay. Maybe if you would've told us that a little bit sooner, maybe we wouldn't actually be ready to deploy.” But like I said, if you got the big thing with the diamond in the middle,²⁰⁶ you're like God. You can do whatever you want.

And it affects the unit. Because if one person walks around sad, pissed off, everybody's gonna worry about them. Everybody worries about them, and then there goes a whole platoon. It's all gonna fall apart. So to me, if it's gonna be like that, why even take them? Because if morale's gone, complacency's gonna start. And then what's gonna happen? Somebody's gonna get killed.

But for me and my team, every chance I could, I took them outside, away from everybody. And we did our own thing. Whatever they wanted to do, I said, “What do you guys want to do?” Throw a football? We could throw a football. Go play a little bit of video game? Okay, cool. So that last deployment, I was good. Because we actually had time to get away. But I've seen it in the other squads in the platoon at the time. All they would do is run, run, run, run, run.

We didn't have any suicides in my unit. But when we were deployed, right around where we lived,

a guy committed suicide. Put his M-4 in his mouth, and that was that. I think that woke us up to what was going on. And that's when my platoon got big on, "If you guys have a problem, go get help. Because we don't want that to be you." As long as it took. For like, the last four months of that deployment, I didn't even go on patrol. Because I didn't feel I was ready to go back. My platoon sergeant just said, "This is how you feel. It's all about how you feel. I'm not gonna call you anything." He said he had even gone through it. But it just sucks that that needs to happen, for somebody to actually say, "Oh, so this is what's going on." And you can see it for miles away, if somebody's feeling like that.

We got a big briefing on MST during my third deployment. It was huge, the division commander did it. So yeah, we've been briefed a lot. But me personally, I don't know of anybody. But I know there are people.

If we were going to prevent MST, the Army would need all new leadership. And they would need the rules just beaten into them. And then, if it did happen again, the leadership would have to make sure that the person who did it is absolutely hammered. I mean, just take everything. You know, make that example. Some people need it.

When I got back from my third deployment, in 2009, I got a non-deployable profile, after they diagnosed my mTBI. It was for mental health reasons, for PTSD and TBI. But, because the treatment didn't really help me, I stopped going. So the non-deployable profile got lifted.

They just lifted it. I didn't go to one appointment, before that happened. I checked my meds, and it was lifted. It was gone. They even tried to make me deploy again. But they looked at the duty roster for Rear-D, and the deployment roster, and they read over my record, and it said I had been going to mTBI treatment. So they said, "You stay back. You can do some staff duty." But it's just a bunch of garbage. Horrible.

When I got to Germany that time is when I got married to Nora. And everything started to get better. She helped me a lot. Just sit down and talk to me. That's really all I need.

Going on multiple tours is hard. It's draining. I am exhausted. Physically and mentally. I mean, if I had to deploy again, would I? Yes I would. Because yeah, I did join the Army to do a job. But it's exhausting. Mentally, physically, spiritually, emotionally, exhausting. And when people don't understand that, that's when I get pissed off. Like, if you were that exhausted, but somebody said, "Okay, this is how we're gonna work this. We're gonna give you two days of patrol, a day of rest, and a day on the guard tower." It would be a little bit better, because you would actually lie down, and get your mind right, to go back on patrol. But it's not like that. They want you to push, push, push, push, push. Which I understand, we got a war to win. But if everybody's not there, it's hard to win the war. It's hard work. And a lot of people don't understand that, how hard it actually is. I wish it was easy. I wouldn't care. I'd say, "Sweet. Deployment? Let's go." But it's hard work. Especially being on three deployments. That's just insane.

That's why I'm glad I did get married when I did, because the memories were still pretty fresh right then. Because you go on so many deployments, all the memories get shifted around, and all

you have is memories of stuff blowing up, and buddies with their legs blown off. You have those memories, and that's all you can think about. I don't even know how I actually deal with it. I know a lot of people that have been through the same thing, but they're gone. They're gone. If I was still a civilian, and I knew, I wouldn't even know what to say.

Then we came to Fort Hood. You can ask her—I get pissed off easy. I could snap easy. But it's a lot better than what it was. Yeah, I have a temper. I can get very angry. I still have headaches every day. I still think about what happened, of course. It changes your life, either for better or for worse. And at the beginning it was for the worst. You can't really do anything but get better. You have to. We have a kid on the way. I can't be just snapping on a little baby. And then I hear the same stuff here at Fort Hood: “Oh, you don't need it. You don't need mental health. You don't need that.”

The leadership is just weird. I understand that you guys been through some shit too. Nobody is the same. I know you have problems. You just need to take care of it differently. Some people need help so they don't go out and do something stupid. Like either kill somebody else or themselves. You never know.

This unit I'm in now is the first unit I've been in that's actually pretty respectful toward people on profile. It's because of the leadership. Like, even if you don't have a profile, and you just aren't feeling well, or they know you're all pissed off, they'll say, “You know what, just chill out. Just go into an air-conditioned room and take your mind off of it.” If you have any kind of profile, they tell you, “You better sit down [laughs]. Don't break your profile. You break your profile, I'm gonna give you an Article 15.” And that's how it should be. If you break your profile, you should be hammered, just like if they try to break your profile. But of course, it doesn't work like that.

I think everybody here at Fort Hood is scared to actually go get help. Just like me at the beginning. I was thinking, “Don't want to be a punk. So I'm just not gonna go.” And then I learned, to me, you're a punk if you don't go.

But people are scared because if you do go to mental health, you're titled. People say, “Oh, you're a piece of shit,” “Oh, nobody's gonna want you in that unit.” Because you're not showing that you're ready. Because when you join the Army, you're thinking, “Oh, I'm gonna be on high speed.” And then you get that title, and people say, “Oh, you see that guy Leighton? He's a piece of shit. No, don't put him in your platoon.”

People have said that about me. They say, “Dude, you're a punk.” And I tell them, “You know what, I'm smart. I'm getting help.”

It depends on your job, how much shit you get. If you're 11-Bravo like me, and you even talk about mental health, they think you're a piece of shit, and you're not supposed to be there.

It depends on your unit too, whether they respect your profile. Some people say, “Okay. You have a profile for this? You don't come to work until nine.” Because we have one soldier that is going through mental health problems. And they say, “Okay. We'll honor that.” He comes in at nine. So

to me, it's all about the commanders here. Because it used to be a profile is a recommendation. They didn't have to follow it. And I guess that's how they still feel. But it says in III Corps policy that you're supposed to follow the profile as orders. So what's going on?

It needs to be enforced. Because you never know what that soldier's capable of. One day you could piss him off, and he'll come back with something, and it'll be a bad day. You never know.

To get it actually enforced, I think we would need brand new leadership in III Corps. Beat it into their heads. That's the only way they're gonna get it. These old commanders, they're old school. They don't care. They're just like my old platoon sergeant, saying, "You're a punk." And there needs to be consequences for not following profiles. Because if there's no consequence, they're just gonna look over it, like everything else.

I'm not on the meds now, I stopped taking them because they weren't helping. I didn't see the doctor before stopping. They're supposed to tell you, if you want to stop taking them, that you should wean yourself off of them. So that's what I did.

None of the meds have ever helped. And whenever I said they weren't helping, they would just up the dosage. They wouldn't even try other meds. And I never felt anything different after they upped the dosage either.

I guess now I just live with it. It's hard, though. Because I know that if somebody pushes me the wrong way, I'm really gonna snap. And I know myself. It's not gonna be good. Somebody's gonna get hurt.

I feel like if I really snap, I'll hurt somebody. When I'm at the verge, I feel it. Stuff starts getting darker. It's weird. And I don't want it to get that bad. But I don't want to go try and get help if all they're gonna give me is pills. I'm sorry, that's not all people need.

The stuff I go through, it even effects my mom. When I went home, when I wasn't married, she whispered, "You changed." And I said, "Well [laughing], a little bit!" She said, "I could see it." It changed me. I changed from the little nice one, running around, playing, to the one who's angry most of the time. Sometimes it's like, don't even talk to me today, because I'm really not in the mood. And when people don't want to talk to you, because they're scared that you're gonna flip out, or that you'll yell at them, it starts to put a strain on relationships. For a while my mom didn't even talk to me. Because I was angry. She didn't even talk to me. I'm calmer with my wife. That's just because I started to cope. I started to say, "You know what? I'm not gonna let it get me down anymore." I'm gonna just push through it. It's in the back of my mind. If somebody said the wrong thing, I would snap. But other than that, I just feel like nobody else is helping me, so I might as well help myself.

19 Nora Leighton*

Editor's Note: *Nora* and Jake Leighton* had been married for two years at the time of the interview, and were living on post at Fort Hood. Nora is white, in her mid-twenties, and originally from the Rocky Mountain region. Nora testified to their experience as a military family member struggling to cope with multiple deployments, relocation, and isolation at Fort Hood. At the time of the interview, she had recently become pregnant with their first child. Nora also described her husband's experiences with post-traumatic stress and traumatic brain injury, along with how it affects her as his wife and primary support person.*

Two and a half years ago, we met on MySpace. It was kind of weird. I didn't know him, really—he was just somebody you add. But we just talked and talked and talked. And then he came to see me once and I was like, “Oh, yeah.”

He was deployed in Iraq, and I think that's why we actually started talking. He just wanted somebody to talk to, I think, and I didn't mind. So, it just started out as friends talking. Then he came to see me, and that's about it.

...It might have been his third deployment. We got married in summer 2010...shortly after he got back, and as soon as we could—with his deployment and everything.

I think he was ashamed of [what he goes through] at first. When the first IED explosion he was there for went off, he called me and said, “Oh, this just happened.” And I asked, “Are you ok?” And he said, “Yeah. I'm fine.” Then the second time, it was a big one. He called and I could just tell in his voice.

I thought, “Oh my God, something is not right.” He sounded like a whole different person. My friend was there, and I sort of dropped the phone to her and said, “Hold on, I need to get some fresh air.” It was that drastic of a difference. After that, he didn't go back out—I think they call it ‘field,’ or leaving the gates. We talked about it for a while after it happened, and he was really torn up about it. It was something that I couldn't understand. You imagine it's terrifying, but you can't really wrap your head around the idea of an explosion happening to you.

I just kept saying, “You should probably tell somebody.” He would break down a lot, and his attitude changed. He used to think, “Yeah, I'm kickass—I've got these people, we can do this.” Then after, it changed to, “These people [we're fighting against] are really smart and they know what they're doing.” They got to him, and ever since then I could tell it was different.

...That it was our first summer together... Ever since then, it's been different—even seeing him at home. When he came home from deployment, he was always just the coolest guy. But after that, he was just so—I don't know—reserved. Standoffish.

There were two [explosions]. The first...was just a small one. Nobody got hurt. He didn't even seem shaken up. He was just telling me, “This happened.” His attitude was the same: kickass Jake,* we've got this. And then after the second one...you just get that feeling in your gut, and you know something is going on. It was pretty scary. There are some days when you're totally at peace, thinking, “Yeah, I haven't heard from him in a couple days, but I know it's fine.” But after that one, I just thought, “Oh my God.” Then I realized it was the second day in a row that he had to go through that, and I don't know how hard that would be... I wouldn't want to go through that.

I guess he was defeated, and that was his attitude ever since. We would always talk about him going out there, doing his job, getting it done—and he was really proud. He had it under control. But after that second one, he was traumatized. You could hear it. He said, “These guys. The enemy. They're smart. They know what they're doing.” You could tell it shook him up. Before that, it was, “Ah, they're stupid. They don't know who they're messin' with.” But after that, I think it changed the ways he saw things...a lot, actually.

I talked to my parents about it, and I don't think they really understood because they didn't hear his voice right after it happened. You know when you hear somebody's voice, and it's cracking and about to break down? That's how his sounded. And I was honestly waiting for him to say, “I lost my leg,” or something like that. It sounded like, “Babe, I'm gonna have sit you down and tell you something really bad.” And I was expecting worse, but it was the worst. He's intact and everything, but... Thank God he's still here—but it takes a toll on him.

He's been different ever since. I still love him. But sometimes I feel he's just so disconnected with me. Before, he used to tell me everything that he did that day, anything that he was feeling. After, there was maybe a week when he said, “That was really scary.” And then a wall went up. He didn't want to talk about it with me. I could tell the difference in him. He seemed drained. It's been like that ever since. There will be a certain week when I'll say, “You should just talk to me. What is this about?”

There was a time that was really bad, when he was in Germany. We would sit there for hours on Skype, and he would say a couple words. That's totally not us. We used to talk and talk and talk. I think 14 hours straight was our record.

It was always, “Hey, I've got to call you back—somebody needs this phone.” So he'd be hopping phones, and I'd be hopping cell phones and house phones, trying to keep everything charged and talking the whole time. So going from a record-breaking 14-hour phone call to sitting on Skype—when you can actually see somebody—and him saying, “Yup,” or “Yeah,” to everything...

I'd say, “You should try to talk to somebody, because you're different.” And he'd say, “Yeah,

maybe you're right." But then I'd say, "You really should. You might not see it or feel it, but I can tell." I guess he did, but it took him awhile—and then they just gave him some pills.

They're not doing anything. It's like saying, "Well, try somebody else." But I don't really know what goes on in there, and my personal thought is that he just needs somebody to talk to. He says he can't relate to these people. They haven't been through that, so they can't grasp anything. They just want to give you pills, get you out of there and back to work. So, I think that was the only time I know of that he went in and tried to get any help. He was discouraged after that.

I still nudged him a little bit: "Well, try it again. Nothing's going to happen one time." As for pills, I don't even know what they have out there now that would fix this. I don't really think pills would be the answer. I think it would take more than a high dose of something. I don't really know what his thoughts on that are, but I don't think he took those pills very much. I think he took pills for nightmares. But I still think after that he was scared to tell me a lot of stuff—thinking I would be worried, which I am.

I don't hear a lot of this stuff because it scares me. I think that when he goes back [overseas] again, that's the first thing I'll resort to. Worrying, and thinking about previous stories and stuff like that. I think that after he stopped having the attitude that he could defeat everybody, he stopped telling me stories the way he used to.

...Until now, it's always been the same. In Germany, I guess he was busy a lot. He told me he didn't really have time to [get help]. But the time that I know of, when he did try, just set him back more. I told him he should go there just to talk to somebody. My thought is that even though they haven't been there—the therapists or the doctors—they've still talked to a lot of different guys who have. So I think they can kind of relate through that, but I don't know.

I think he needs somebody besides me, because I think he feels he's got to hold it back some. He can't just pour everything on me because that's where I get my worrying. So I think he just needs somebody to lay it all out there and not worry. That's what I told him he should try to do, and then he told me, "Well I went." And I said, "Well how did it go? Do you feel any better?" And he said, "I got pills."

[That] was when we went to Germany. I think it was his third deployment... Then they got to leave, and he was in Germany. So that's when I think he tried to get help...I don't really know if he tried [in Iraq] or not. I would hope he did. I think that would have been a good time to do it.

But I don't know—he might have just been taking a break, too. He was really excited that he didn't have to go [outside the FOB]. I remember one time when he showed me all this candy that he got. He said, "Look at all these candies that they have here!" He was so excited.

...I keep saying that the IED is what changed everything because it was literally just after that. He used to laugh so much, these big belly laughs. He never has those anymore. He used to be playful and fun and everything.

I didn't really get to see him for awhile. He came home for a little bit and then he had to go to Germany. Then it was just Skype all the time, and when I got to Germany I just thought, "Wow, you're a totally different person." He was kind of a jerk. No offense to him or anything—I can understand. But at the same time, as a wife, you feel like, "Ugh."

...You can only take so much. I promised no matter what I'm always gonna be there for him, and I have been. But it's crazy sometimes... In Germany, I was really struggling. I felt that even though this happened, this isn't the guy that I married and want to have to deal with. Because one second he would be chill and happy, and then the next just so aggravated. It doesn't take anything to turn him that way. It will just—in just a second, he'll turn.

If you want to sit close to him or cuddle, the affection is just gone in a second. His attitude changes. He just won't want to talk to you—that's how I know. You can just tell when you love somebody that much and you're with him. Well, not really with...but when you Skype with somebody every day for so many hours, you get to know their personality. In Germany, that was the first time being with him for more than 15 days. So I thought maybe that was just how it is. Maybe that's just him. But at the same time, it's just not. That's the main thing that puts a damper on us...being nice, not over-the-top nice, just being him, and then an aggressive jerk the next second. It's—I don't really know.

He's not crazy, not abusive or anything, but it's just his attitude. When you want affection and he's in that zone, it hurts to get shut down by your own husband.

You think, "Well, what did I do?" That's been the hardest part: trying to accept that maybe something really is going wrong in his head and that it's not something that I'm doing. Still, even to this day, I have to try and weigh out—did I do something wrong, in a second? I don't really know if I said something or if I changed or if it's just something that happened in his head.

That's the most confusing part. I understand that people just wake up in bad moods...but it's just so weird living with somebody who can one second be laughing and watching a movie, and then you lean over again and he's just straight-faced.

"I don't feel like it. No. I don't want to hold your hand right now. I don't feel like it. I have a headache." It's different to adjust to that.

...I understand how maybe a war movie would send him into that or something. But it is literally just a split second change and he will be a totally different person. It's weird. It's one of those things, you just have to see it, and you feel like, "Whoa." A lot of the time, it's just to me. Like with drinking—he's done drinking now, thank God. Because he'd just say, "I'm gonna break your phone." I was like, "What!?" He was buzzed—not to the point that was crazy or anything, it doesn't hurt me—but he just wants to break things.

And I'd think, "That's weird." I've never really been around somebody like that and he wasn't like that before. I've got to guard my breakable stuff because I don't want him in the electronics. I don't want him to snap. Just like I said, he just gets in one of those moods. I've learned not to cry

at it because that just pisses him off even more. So I just act like, “Whatever,” and I just leave. I just leave him alone. Because if you sit there, he just goes further away. The closer you get, the more he goes, “Absolutely not. No.”

It's like he doesn't even notice it happens... I turn my head and he's a totally different person. I've asked him, “Do you realize when you're like that?” He says, “Like what? I'm not like anything.” He's usually in his angry mode when I have to ask him, and it's just so aggravating. We'll have unnecessary fights because of it, or he'll pick a reason—something so small, like the music was too loud... Just the other day I left the room and came back, and he was a totally different person. I asked, “What happened?” He said, “I don't know. You did this.” And I was like, “No.”

I guess there are little things that I do that aggravate him. He'll forget what it was and still be mad hours later. I'll just say, “Do you even remember why you said you're mad at me in the first place?” And he says, “Don't talk to me,” because he doesn't remember. As much as I want to leave him alone, I just want to shake him and say, “What is wrong with you right now?”

...It's been like that for a while, too—I noticed it in Germany. That was a couple years ago now. It's our two-year anniversary coming up this month. I love him to death, but it's just hard sometimes—that aggravation that he gets from nothing or from the littlest things... You can't help, but you think, “Well, what am I doing wrong?” The first thing that comes to your mind isn't, “It's something that he's dealing with.” ...But 98% of the time I'll just be sitting there, I'll turn my head, and then I'll look back and he's aggravated.

Usually I am the only one around. I struggle with that, too, because my family is who I go back to so much. This is the first time I've been more than a block away from them. Besides Germany, but that was different. That was kind of like vacation, but this is like, “We have a house here and we live here.” And as much as I want to vent to [my family], they say, “That's not Jake. Jake's a nice, hardworking guy.”

They've met him a lot. I think with my dad, of course, he's gonna be on his best behavior. And they just look at him like he has no flaws. Which is fine with me. I'd rather them think that. But sometimes I'm just like, “Oh my God, I can't handle them today.” It's like every other second he wants to be close and then he wants nothing to do with me...

I think it would almost be easier if he could say, “I'm in one of those moods. Can you just go away?” ...And everybody's just says, “Well, it must have been a hard day at work.” I'm like, “Yeah.” I don't want to say, “No! That's not it. He didn't even go to work today!” So, I don't know. It definitely would be easier if he could see when he's like that.

[My family] hasn't seen it firsthand, who only sees Jake at his absolute best. And I feel like when we're home he's a lot better—when he's away from the Army. Not living on base, and when he doesn't have to stand up straight, wear a uniform and stuff like that. He's more laid back, so it happens a lot less.

[But] it still happens. I think I just bring it out in him or something, and that's what's so confusing.

I've seen him talk to other people, and he's not like that toward them. And his family and his friends—he's not like that with them. It's just when we're alone that he changes. That's another reason why I think, "Oh, it must be me." Or else he would do it to his friends. I don't really know [why] I trigger that in him.

I always did promise him, "No matter what, if you come home with no legs or if you come home and..." I never thought it would be that real. You see on movies when they're just sitting there and they just start screaming—or whatever from the war. And I'd say, "You know, I'll still love you if you're like that." But never was I actually thinking that it was going to happen. And I still love him, of course. But it's just a lot harder than I thought it would be to deal with that.

...He told me he has PTSD and mild Traumatic Brain Injury... So I was like, "What is this?" He just had that attitude of, "There's nothing to worry about." And of course I Google it. I've got to watch myself on Google, though. I get way too into it and then I'll just freak out. So he'll just tell me, "It's fine." I'm thinking, "Okay, if you say so." I've never really seen any physical health problems with him—except he smokes like crazy.

Editors Note: Nora also testified on what kinds of support she has received from the military. She said she had never had any briefing or training as a military spouse about traumatic injuries.

I don't like [the FRGs], to be honest. They're just so organized. You know what I mean? There's the mandatory ones that I go to. But I can't really see myself doing that. I don't know why...just being honest. It just doesn't seem like something I could get into.

I think his unit had family days or whatever. So that's the only thing I'm into. And then there was a neighborhood thing that we had to go to. And that was just—oh my Gosh, I couldn't imagine staying... I love strangers that are down to earth, but I've noticed here everybody's just cheesy.

I was just thinking, "I don't think I could handle these people." Because they're just... Like Stepford people, you know? Maybe I should give it a chance, but just from the little things that I've been to, it just seems you've got to watch yourself. I showed up here barefoot—that's the kind of person I am.

I've seriously had conversations with three different people on the whole base. Like actual conversations. Tiny small talk here and there, but nothing that I think anybody would actually open up about [PTSD] or anything.

I know my neighbors and stuff, but I feel like I can't talk to them. I don't talk to her husband much; her husband and my husband just chill and barbecue. But if I talk to her, I feel like she says, "Ohh. No, I don't go through those problems. We don't have those problems." Almost in a judgmental way. So I just don't tell her anything that's going on.

...If Jake will be ok, I will be fine. Because I'll have my best friend again, I won't need any friends on base. I think the main thing is the... 'bipolar' thing. I think he needs help for that. That's just what I can see; I don't really know what's going on in there. But if I had to say [what would help], I

would just say somebody that can relate to him. Let him know that he's not crazy, that people go through that.

...My mom was bipolar and they gave her pills. And she was really bad with it. Summertime she'd be fine, wintertime would come and she'd be a totally different person. So I can relate to that in a way. But you're more prepared for that, because you can tell, "Oh, the weather definitely affects her." But as for Jake, it's just everywhere.

I feel like we have it under control for the most part. I think for young people starting out, we're good. I think we should do marriage counseling sometimes because it's something that will just force us to talk to each other... And I want to be able to see what he's thinking. It's not really arguments or anything. It's just like we need help having a conversation, something that will go on. I want to have a conversation with him so bad. And I get nothing. It's just one word responses. Even if it's just, "Oh, that commercial was stupid. What did you think of that commercial?" Or, "How was dinner?" So that's a struggle, too.

Like I said, we used to talk for 14 hours. We definitely talked about the most random stuff. We could talk about it for an hour. We used to talk like that. And now I have to pry a conversation out of him, and I've tried every conversation, from just even football. I know nothing about football.

But I just feel, if you have conversation with me, I'll do my best to keep up with you. Or work. Or whatever. And he's just blank with it. He just doesn't want to talk.

But I love him. Because when he's his normal self, he's the best guy in the world. But when he's in one of those moods, it's just like he's in a trance. He's just like a zombie.

Editor's Note: Nora continued to describe what specific kinds of symptoms her husband goes through. She began by saying that he has both short-term and long-term memory problems.

...It's just conversations or weird little things, like having five drinks next to you and having to tell him, "Babe, you have five drinks next to you. Why are you getting another one?" And he's like, "Oh, I didn't know. My bad." Just little stuff like that. Or memories that I have from previous dates or our honeymoon that were big. And he says, "I don't remember doing that." I didn't know [trauma] could relate to that. I haven't really read about it because I scare myself too much...

It's mainly anxiety, I guess. You're just like, "Oh God, I don't want to wake up today." You just want to throw up for no reason, I guess. I don't know if I'm the only person who has that.

But sometimes it's just like you're so worried about absolutely nothing, you know? Just thinking, "Oh my god, I'm seriously gonna throw up and cry." And I don't know why that happens. It's been since I've been [at Fort Hood], for some reason. When I first got here, I thought, "Well, maybe it's just the stress of moving so far away and having to deal with a lot of stuff." Getting into housing and the car, the money. We used to be able to blow our money and now we've got bills and stuff like that. But now that we're settled it still happens and I don't know why. And then pregnancy hormones...

When he was in Germany and when I was in Germany [it was already happening]. It was really bad when I went to Germany and I saw what was happening, and then when I came home. That's when it was the worst.

And I got put on pills and everything. It mainly happened at night, so the doctor was like, "How about we just put you on sleeping pills?" Because I guess some other pills have risks of suicidal thoughts and stuff like that, and I'm not that kind of person. And I don't want those thoughts in my head. I don't really know why that comes up. It's confusing to me because I'm like, "I'm not worried about anything." My life can be doing just perfect and then all of a sudden I'm just worried. So worried it makes you nauseous about nothing. I don't know why. I don't know what that's from.

...That's the weird part about it. It's mainly when I'm alone. If I feel like if I have a moment to sit down and just think of nothing, I get that feeling.

When he was Germany I thought, "Maybe I'm just lonely." Because I'm kind of always by myself. Because when he was in Germany...it was just drinking. His friends were a bad influence. So I thought, "Well, maybe I'm worried about that." Because at night your mind wanders, I guess. So maybe I'm thinking of so much stuff I don't even realize it. My body's feeling it. I don't know why that happens... But I never had that before—it was really just in Germany that it started.

During the day it was less; I would feel worried over nothing. But at night it was really bad. I would just want to sob uncontrollably for some reason. And that's totally not me. I'm a happy person. So that happening is scary in itself. What made that happen? I don't know.

...I know Jake was ashamed to go [get help] because I think he felt people looked at him bad. Like he couldn't handle it or something. I just think Jake can't be the only guy going through this.

...So I just feel that if these guys could just not worry about what people think of them— just go there and...not have that over their head. Feel that they'll be able to go to work, and nobody will ask questions and just let it be their personal thing. And I know Jake is worried about his job, too. He's thinking that this is how he's supporting me and the baby, and that's how we have our house right now and stuff. And I think he's worried that with talking to people, they might do something. I don't know if he's worried that they're gonna kick him out or what's gonna happen. I don't know the rules. I don't know if you can stay in the Army if you have these things. I just feel like they've put him this way, why can't they help him out?

I understand Jake's worry about the job thing. That's scary to think that with just one doctor's appointment they could just discharge you, if they don't think you can handle it. That's not very fair. I'm sure there's other jobs that they could put you to.

I'd say that's what Jake is thinking from what he's said and the vibes that I get from him. And I'm sure that other people think that, too. A lot of people depend on this. It's a job. I've heard of people going in [to get help] and from stories that Jake has told me. They're going just to talk to

somebody, and then later they find out that they're getting discharged. Whether it be medically or whatever, I still don't think they pay you the full amount.

...I think he would like [civilian help], so that he doesn't have that weight over him. So that he doesn't have to watch what he says.

...I like just being able to come here [to Under the Hood] and talk to somebody that's not paid to do it, I guess. I don't know. Relaxing. I know Jake felt a lot better after he left here.

I asked him, "Well, how do you feel?" And he said, "It was nice just being able to talk about it." And that's good.

20 Malachi Muncy

Editor's Note: Malachi is a white Army National Guard veteran in his late-twenties. He served as a truck driver, including two deployments to Iraq between 2004 and 2007. Malachi testifies to his own experiences with post-traumatic stress, moral struggles, and the toll his service has taken on himself and his family—his wife and young daughter. At the time of his interview in early 2013, Malachi had recently become Manager of Under the Hood Cafe and Outreach Center, after having been involved in the coffeehouse's activities for several years.

I was an Army brat, and so I was raised around the military. And I joined because I needed a roof over my head. I was 17. I just needed a place to stay and I wanted to get some college too.

It seemed like the biggest concern [for the Army] was whether or not I could be deployed, not necessarily my well-being. That was largely during the troop surge. And I was in a critical MOS, so I think that's where a lot of that came from. And then, upon returning from deployment, it seemed like we got ushered through pretty quickly with threats of like, "Well, you're gonna have to stay here in the Evaluation Processing Center if you have any problems." And, "Don't you want to go home?"

In my experience, commanders tend to take a little bit too much liberty with decisions that should probably be left to doctors. You know, whether or not to take troops, and stuff. I think a lot of people end up getting taken on these deployments that, if the decision were made by a doctor, probably wouldn't be happening.

A lot of times, commanders take discretion over whether or not training overrides medical care, and stuff like that. And I think really, that's the wrong answer. You shouldn't be missing appointments and missing out on medical care because the unit has to deploy to Iraq or wherever. That ultimately affects the mission as well. Even if it's a bunch of injured soldiers overseas, you're putting the unit's security at risk. I think the Army's a little different landscape right now than it was during my deployments, so I'm speaking to some experiences that are from 2004 to 2007.

I was diagnosed both with Bipolar and PTSD, between my two deployments.

My care began when I was in Iraq, after an incident where I pointed a weapon at somebody, and I had to go see a shrink. They had my weapon back in my hands within three days. And I was



Malachi at Under the Hood in 2014.

back on missions. I don't think the quality of care that somebody who had issues while they're deployed is very high at all. I think that it's sort of assumed that the soldier's trying to get out of deployment, or something like that. I don't know what they're thinking. But I think it's very poor over there. Upon returning, the transition period's a little weak. I'm actually pretty satisfied with everything I've gotten from the VA so far, other than the bureaucracy of it. But I have a much better time dealing with the VA than I had dealing with the military doctors for sure.

I was prescribed Prozac and some other drug, during my first deployment. And that was part of what they said made me suitable to go back on the road so quickly. Like, I had a prescription, so I was good. And then again, in between my two deployments, I got a new prescription for Lamictal.

It seemed like prescriptions were just another box to check for somebody who had an issue. "Well, okay, you have an issue. That adds a box to check, to make you deployable. You need to have this pill." And so, "If you have this issue but you have this pill, you're deployable." I don't think that care is often considered in many of those decisions, so much as deployability. Like,

“Can we get them deployable?” Not, “Can we get them to better?”

I was never put on any of those dangerous interacting drugs. But I don't feel like the caregivers listened to my input on my own. I'm not a doctor, but I know how these things make me feel. And I don't feel like they listened to me very much.

And mission tempo was the excuse that they used for people to go out on missions in Iraq...I was given a profile for a few days, when I was in Iraq, that I couldn't have my weapon. But that resolved pretty quickly. That was pretty much it, I had my weapon back in three or four days.

Editor's Note: Malachi was asked if he ever saw any pressure put on soldiers by their leadership to violate their profiles.

All the time, especially physical profiles. Again they're all citing mission tempo and stuff. I think mostly there were just a lot of people in Iraq who shouldn't have been there. For example, on my second deployment, they deployed somebody that had a profile that restricted them from wearing their flak vest. Even if you never leave the wire, technically speaking, when there's incoming, you're supposed to put that fucker on. But you're gonna take somebody to Iraq who has a profile that says he can't wear a flak vest?

It's like, “What the fuck?” They can't put their fucking protective gear on, wow! It's ridiculous. That's probably one of the most absurd things that I saw while I was in the military. That, and there was another guy who was on a cane, the whole time, same unit.

...[To enforce MEDCEN-01] It would probably take a couple people, full time positions—you'd need some sort of hotline, you'd need some sort of check services, some things dedicated just to enforcing that policy. There'd have to be a number of people who would seriously investigate those. And it would have to be disconnected from the military chain of command in some way. I'm normally against civilian contractors, but go civilian. Just because it's an oversight thing. In fact, I think it would be much better to be civilians for the quality of oversight.

A head doctor in Iraq [issued my profile]. That was sometime during my first deployment. Somewhere near the middle of it. It was probably about a week later that they lifted it, and I talked to some doctors there. It was very disjointed—at the time, I think the medical centers were very disjointed there too. I don't think they were very good with records. I still got the Article 15, from the time when I pointed the weapon at the dude.

...I was just really stressed and sleep deprived and an NCO got smart with me, and I threw a tantrum. In my version of the report, I lost muscle discipline, 'cause after the fact I didn't feel that I was going to shoot anybody. I didn't pay attention to the fact that the weapon was loaded. I just picked it up and waved it around like an angry kid, and then threw it on the dash. But yeah, when he wrote the report, he made it sound like I had pointed the weapon at him with an intent to kill.

It sounds like an interesting story afterwards, but really I was just throwing a tantrum. I lost my fucking temper, and I blacked out for a minute too. I'm glad nobody got hurt. They took my

weapon right after that. And then I went to see the shrink and he gave me a profile saying I couldn't have the weapon. I got back to Kuwait, did three days extra duty, and then they sent me to see the shrink and he said I was good to go. And I was on drugs. I can't remember if it was Prozac, or the other one, I went through two prescriptions while I was in Iraq. And then, just before my second deployment, they put me on the Bipolar drugs.

I think the biggest thing that didn't get addressed was there was very clearly, on both deployments, people who should've been receiving care back stateside, who were in fact in Iraq, and before being in Iraq were not receiving the care that they needed. And then, they were a liability to the unit, and they issued them security, and they weren't being taken care of.

I don't know what goes on up in the higher levels. But I'd imagine that somebody's pressuring somebody somewhere [to ignore profiles and health needs]. 'Cause it doesn't make sense that one human being would just deny care to another human being for no reason. I think there's some sort of force being exerted, onto some positions, somewhere, somehow. Whether it's in policy or under the table, I don't know exactly. I don't know what goes on at the top, or at the office. I never really even knew NCOs. I was really just at the bottom, trying to stay out of sight, not be shat on.

There's all sorts of name-calling [against people on profile]. Really immature behavior, name-calling, and not letting anybody play reindeer games. You get ostracized. The one guy who deployed on the cane, everybody called him "Broke Dick," and "Faker," and shit like that. In actual fact, he shouldn't have even been there, he should've been taken care of. But, in fighting to try to get that taken care of, everybody ostracized him and told him that he was lying

Being lower enlisted, I just tried to stay off the radar. Often times looking for care puts you on the radar and most of the time it's better that nobody even know your name. But like, we're gonna know your name if it's all over a bunch of paperwork, which means you're "The Guy Who Needs Help." I think it's definitely discouraged on a cultural level, with stigma and things of that nature.

In both [SRP and R-SRP], they just wanna cover their ass by getting the boxes checked, and getting them checked as quickly as possible. And then on the return trip, it's even more pressure to just get it over with. It seems more like an administrative process than a clinical health process. It seems less about fitness or readiness, and more about pushing numbers and stats and stuff like that. And it's really impersonal, and a little bit dehumanizing.

Before my second deployment, like on my first deployment, I kept to myself as much as I could, because I didn't want to get in trouble. 'Cause I was always seeming to get in trouble. But on my second deployment here was a lot [of substance abuse]. We had like, I want to say, six to eight DWIs in the six months before we deployed. And I think two people popped the first piss test. They had to write 500-word essays. But then, while we were in Iraq, we took another piss test, and I think somewhere between 10 and 20 people popped. And they all got demoted and/or kicked out, at varying levels.

I thought that was interesting. Like, you pop a piss test before a deployment, and you write an

essay. You pop a piss test at the end of a deployment, and all of a sudden we don't need you anymore. There's another instance of numbers being more important than individual welfare or health, or readiness or any of that bullshit that they try to say they're doing.

And then, when I got to Iraq, there was a whole bunch of hash, and there was a whole bunch of alcohol. I don't know anybody over E-5 who smoked hash or weed. But that went around a lot in the lower enlisted. The NCOs and the ring leader for our side of the camp was an E-6, for alcohol. And when we got there, the KBR²⁰⁷ folks were running the alcohol game on our side of the camp. But an E-6 took over. He just undercut the prices. Really cheap McCormac's, half-gallon jugs, refilled them for 80 bucks. He got them for nine bucks and refilled them for 80 bucks. He made more money selling alcohol than he made as an E-6, even with the Combat Duty Badge.

And then at the end of our deployment, one of our more troubled soldiers was selling coke to them. And that started going around. And I remember thinking, "Well, this must just be our unit." But then, when it came time for us to leave, the unofficial change of command, and all the weed connections and alcohol connections sort of get passed off to the new unit. And there's a market on prescription pills too, for sure. There were people getting pain pills and muscle relaxers and stuff, and trading those for weed and alcohol, and/or selling them. I don't know too much about that, but I know it was going on.

There was a suicide attempt on my second deployment. I did not even see her again. She was back in the States in the hospital within 48 hours of her suicide attempt. I think they handled that pretty well. I think there was some people who were probably on the verge of suicide, and the unit was just waiting for them to fucking do it. There was some people who I didn't want to be around, because I felt that they might be homicidal.

But there was a suicide attempt, and the unit got her the hell out of there as soon as possible. But I think there were plenty of signs beforehand, with her and a number of other folks who should've been sent home. Thank God they didn't try anything. At that point, they definitely pay attention. But that's a pretty dangerous place to draw the line in the sand if you're trying to take care of people. "Go ahead! Try and kill yourself! Then we'll take care of you. But we're gonna let you get there."

...When you come home, you don't get to go back to your shitty life until you clear [R-SRP], and they make that very clear to you, that like, "You're gonna be on med hold here, eight, nine or 10 hours away from your home, and you're not gonna be able to go home during that time. Are you sure you're not okay? 'Cause if you're okay, you can go home." And I think that's a more common experience in the Guard and Reserve. Just trying to get people to check all the boxes, so they can kick them out the door. 'Cause if they've got people on med hold, they have to have somebody there processing stuff too. They get to go home if you get to go home too. And they know that.

There's a PowerPoint [about PTSD] near end of the deployment or during the out-processing. I don't think there was a whole bunch to do about it, just a PowerPoint. And it's bunched up with the Chaplain's briefing about coming home, and things like that. Some bullets with the

symptoms. There's just sort of mashed stuff. I don't think there was any one-on-one time with somebody to talk about it.

I think they're doing something, but too much of the time it's big presentations and just push-people-through sort of situations. And when you've got that culture that discourages it, and nobody's allowed one-on-one time to talk through it with anybody, it just seems like those two things might play off on each other to discourage people. You're not gonna raise your hand in a room full of people and be like, "Yeah, I think I've got some of those symptoms!" But you get one-on-one with somebody who's counseling you about this stuff, you might be like, "Well, you mean like this?" and you might actually find out something. You'd realize that maybe you have PTSD and you've just been compartmentalizing it, and trying to bottle it up.

Editor's Note: The interviewer asked if Malachi had ever received any kind of screening for PTSD.

There's a questionnaire thing and I filled mine out. It was maybe 50 to 100 questions. They passed around this little electronic gizmo, you checked boxes. Stuff like, "On a scale of one to ten, this or that," and "Strongly agree, disagree" or whatever. It was a questionnaire. Another mash training, sort of thing.

I think it takes a while to notice [PTSD symptoms]. And I think it can take a while to notice them for what they are. It's a process, dealing with them. And it takes time to notice that you've got



Malachi holding his recent batch of combat paper - handmade paper made of military uniforms.

them. It takes time to become more aware of them, and it takes time to sort of diminish them as well. Time is a good thing, I think. Time, and being able to talk to folks, and bounce stuff off of folks.

When I came back, I couldn't drive. 'Cause I was a truck driver in Iraq. A lot of that was PTSD-related. And sleep problems, I still get those. And the alertness, the hyper-alertness, and the short fuse, and stuff like that. I think over time, you either find help, or you find coping mechanisms.

'Cause I joined really early, it's sort of hard to say what the baseline was [for my life]. Maybe if I never joined the military, I still wouldn't have been able to hold a job. Who knows, 'cause I joined practically right after I joined the workforce. So I don't know what a normal work-life actually looks like. And who knows, with this economy, maybe it's the economy that's the reason I can't fucking find a job or hold a job, or whatever. But I definitely think at least part of that, of my employability problems, are related to the PTSD, some.

And I think it's certainly affected my ability to have meaningful interpersonal relationships. I have a sort of hard time attaching to folks. My wife says I'm detached, and my daughter well, I don't know what she thinks, 'cause life's just sort of crazy. But yeah, I feel detached, and I think it shows to a lot of folks...sometimes I have to do that to keep myself from losing them. I have to detach.

I had a rough time getting treatment for the PTSD. For example the VA, they told me they have to treat the Bipolar before they can treat the PTSD. And I'm not really satisfied with the treatment methods for Bipolar. I'm not sure there are any out there that I'm satisfied with. So it's a little bit tough for me to say to the VA, or anybody for that matter, "Hey, I want to try to deal with this

PTSD thing, without focusing on the Bipolar thing first," because I guess they have to take care of the one before they have to take care of the other, or something.

For me, to treat the PTSD, personally, I think anything that you can use to sort of express things, and expel them and let them out, sort of relive them on your own terms. Share them, if you can express yourself in a way that you feel somebody understands your experiences better, you're not alone anymore. And being alone is the worst I think for any mental illness. Realizing that you're in your head, and this stuff is all in your head, and everything's in your head, and you're all alone, because nobody else is in your head, and nobody else ever WILL EVER UNDERSTAND YOU! And you're alone!

So just anything you can do to express yourself. And group settings, talking with groups, or art, or really any expressive, creative means, sort of to acknowledge your experience, have other people acknowledge or understand your experience, better understanding through dialogue about the experiences.

...I know folks who can't leave the house. But they get along in the house pretty well. I think the worst case of PTSD in folks that I've seen are people who can't leave the house. I think TBI really fucks with people in a lot of different ways. Like, TBI'll make people act crazy in public. I guess

PTSD will too, 'cause I've sort of stripped my clothes off one time and walked out 'cause they were constricting me, I had a panic attack and walked out of a classroom that I was supposed to be working in.

I think however it affects people, the most common consequence of those is people will just lock themselves up in their house. The most common thing I see is people not wanting to deal with the world because whatever their stressors or their triggers may be, it's harder to find those when you're locked up in a place that you control. So yeah, you see a lot of angry people just punching folks out around a military town, stuff like that. Over-medicating, self-medicating with alcohol, and then that compounds it and they act stupid.

I think [multiple deployments] are bad on soldier morale. I think that it increases the likelihood that they're not being taken care of. I've already established that before a deployment you're less likely to get taken care of. So if you're deploying twice as much as you should be, it's twice as likely you're not getting taken care of. And then, not getting taken care of is gonna hurt your morale. 'Cause it's on top of family stress issues, and being away from your family, Jody's got your girl, all this stuff. The more you deploy, the more you're exposed to most of the stressors that are related to the military.

On my first deployment, I went through being exposed to IEDs or getting shot at and seeing this stuff, and the ever-present fear of that stuff is traumatizing. But even if somebody's never left the camp, on my second deployment I left the camp once, incoming mortar rounds, those happen pretty much anywhere you go. Those can be stressful. They were a little less stressful for me, because I was like, "Well, at least I'm not on the road."

By my second deployment, I thought it was pretty comfy, but watching some of the folks that that was their first deployment, and that was as bad as they'd had it, they were jarred. I think it's different from individual to individual. And I think you can be desensitized to it. But I don't think that makes it any better. But even below the common level, it's traumatic to up and move your family from Kansas to Georgia. And being a military brat as a kid, I think kids are sensitive to that, too. And that's a traumatic experience that's not necessarily related to the war, but just the military lifestyle. There's a lot of trauma-inducing events in many aspects of the military life.

I think the first and clearest sort of thing we can do to stem this [trauma] would be to stop deploying any troop that's got PTSD, TBI, or MST. Just stop. Don't deploy them. Because their conditions are gonna be aggravated by the conditions of deployment. If you want to take an honest step forward, that's the clearest and most obvious thing that will help. Stop it from progressing once you've identified somebody has one of those conditions.

...TBI sort of caught on after my second deployment, just after it, so I never really got any information on TBI.

The people I know who've had TBI, in my experiences they tend to lose more of their functions than somebody who's got PTSD. I don't know, their brain works differently. I've seen people with impaired motor skills, and stuff like that, from TBI. The worst cases of TBI I've seen seem a lot

worse than the worst case of the PTSD I've seen. A lot of behaviors even more inexplicable to me. And the memory loss can be worse too.

I didn't receive any training about MST. We got some EO briefings, and stuff. But MST wasn't—I don't even think that was a phrase [when I was in]. If it was, I didn't know about it.

We got some sort of briefings [on sexual assault and harassment]. Mostly they just tried to encourage women to have battle buddies, is what seemed to be the policy. And there were rapes on both of my deployments. And the way that those got dealt with, especially at the cultural level, was really disgusting. A lot of victim-blame. And, you know, “Liar, liar, pants on fire,” name-calling.

And at that time, commanders had a lot of discretion in dealing with those cases, and I understand that that's changed, or at least supposed to have changed. I think too much of that was handled at the commander level. I just remember thinking like, in the civilian world law enforcement would be handling this. And it would be less political... I think there's been some policy change since my experiences being around that.

There was definitely some varying levels of fraternization and coercion...and E-4 females, it seems like there's a fucking target on their back in the military.

But on my first deployment, it was an E-6 that got raped, by an E-4, which was sort of the backwards experience. So it just goes to prove that you can't pin anything down, statistically. On my second deployment, it seemed like any E-4 sort of had some NCO or officer sort of relationship going on. I don't know the specifics of that stuff, I didn't get into that.

It's not direct to your face, but you go in a port-a-john and your name's all over the fucking place, talking about how you're a whore. That's sexual harassment too. And that's like, anonymous, so to speak. It would be like, how do you hold people accountable to that? I think that's a prime example of why we need to fix the problems at a military cultural sort of level. Because if you just try to deal with it on a case-by-case basis, you're still gonna have that anonymous stuff, like it's the crowd discriminating. I think that highlights how wrong culture is there, about sexual harassment.

My first deployment, the E-6 [assailant] was very close in my chain of command, just directly over me. It was really weird, it happened in the tent next to us. And I can't speak to them a whole bunch, because that's the sort of shit where the mentality is like, I don't want to fill out a fucking statement. The mentality was, “I don't know and I don't want to educate myself about it, because I don't want to fill out a fucking statement. I don't want to get called in.” And “I don't know! I don't know!” And I think the same was true the second deployment. Nobody wants to deal with it, everybody wants to pretend like, “Ohh, let's just not mention that.” And on my second [tour], the victim lived in the trailer right across from me. But she got raped in the tower.

After both incidents there was a response. After the first one, we no longer had co-ed tents after that one. And for the second one, we no longer had co-ed towers after that one. And I don't

know really specifics, other than what I've said, about the cases... Because I didn't want to put my nose into that.

I was supposed to be medically chaptered for some of my head shit, before my second deployment. I threw a temper tantrum, tore up a barracks room, smashed up a guitar, righteous. Got the MPs called on me, and they sent me to see a shrink, and that's when I got the Bipolar diagnosis. And they said, "Yeah, you're not deployable with Bipolar." And they started Med-Boarding me out. My unit deployed, and I was left back on medical, waiting to be chaptered out. And the master sergeants who were overseeing said, "Well, there's no signature on your paperwork. We're gonna have to start over from day one, and you're gonna be here for another three months before the next step in the process. Are you sure you don't want to just deploy?" And I said, "Yeah, fucking deploy me."

I'm not sure what's the technical like, designation of what I was on, but I was being held for probably four months, because I got on it about a month before the unit left. And then I was here at Fort Hood. I'd say [access to care then] was fair. I think there was a person that was on Rear-D, I felt like it was her prerogative to try to get me on the plane, even after the unit had left. But I wasn't denied any appointments or anything like that. In fact, they didn't even care what the fuck I did, so long as I made my appointments. I didn't have to show up to formations, there was no accountability for me. It was sort of nice, at the time. But yeah, I'd have to make my own appointments and show up when I wanted to, and I didn't have to do anything else, really. And then she was like, "Eh, your paperwork's messed up."

Editor's Note: Malachi was asked if he had seen anyone chaptered out for issues that could have been related to symptoms of PTSD or TBI.

Definitely, a handful. Some on that drug shit at the end of the deployment. And the fact that so few



Malachi outside Under the Hood in 2014.

folks popped hot during the first piss test before the deployment, and so many more popped during the deployment, while they were deployed, there's probably a logical fallacy or something. If they weren't doing drugs before the deployment, and they were doing them during and after the deployment. I mean, maybe at least look in and see if something happened during the deployment, to sort of lead them to this place where they're now doing drugs. But no, they just treated it like, "No. They're just doing drugs. Get 'em out."

During my military career, one of my main motivators was to get out with a clean slate. Like, not get kicked out, not get put out any other way than honorable. And the prospect of it seemed very frightening. Not because I had any real status, but just because that's just sort of what you're conditioned to believe.

[Job prospects] are probably worse for folks that get dishonorables, and other than honorables. Then again, though, there are organizations out there I know who help with specific cases. I don't think they do much dent in the numbers, but I know there are folks who are sympathetic out there in the world. Like, if I were to go through the process again, I might not be so afraid of it, just because I know there's people who do care.

It took about a year for my first try [for VA benefits]. I think the military has a tendency of making people distasteful of bureaucracy. And the VA's full of that, it's like a big paper avalanche. And you're just sort of swept up in it. It wasn't a pleasant experience, but I'd say mine is pretty good. It took about a year for me to get 30%. And then, at the request of my family, I got somebody to represent me, and it took another year for him to take care of that. But I did get my percentage up, and I think I'm at where I belong right now. At or around the appropriate percentage...

My best advice I could say to anybody though, would be get that representative. Get somebody else that will do the paperwork, and send it to you, and have you sign it. And then, you send it back, and you go for your appointment. Because managing time is tough for somebody to do, especially when they're dealing with these issues. Especially when the period is over months. If you're having memory problems within the day or within the week, how are you gonna remember your appointments and all these paperwork processes, and shit like that, months out?

I don't think that [the VA] will ever be able to really fully prepare. But I do think that it's gotten better since, I'd say around '05-'06. So I think they're trying, but I don't think they're there. And I don't think they can ever really actually get there. I think it's important to always challenge the level of care that folks are receiving. Because the fact is that people are gonna always fall through the cracks, so you always have to challenge that. I don't think they were prepared for the folks who came back during the surge time. I think they do better now.

[Adjusting to civilian life] is difficult. And often times, lonely. It's hard to find a lot of folks who will relate to those experiences. If I didn't work close to the coffeehouse here, if I was down in an actual civilian population, like when I'm down where I went to college, I don't feel like there's a lot of people who relate. Around here though, I think there's more people who get it, around Fort Hood. Just 'cause there's so many people who's all dealing with these issues around here.

Editor's Note: In closing the interview, Malachi reflected on what it will take to get soldiers and veterans the care they deserve, and win the right to heal.

Lots of counseling. I think we should be prepared to sit down one-on-one with folks, and counsel them individually, on a personal level, on a regular basis. I think that's probably the most important expectation. And a willingness to try alternative things.

I think it's honestly an eternal struggle. I don't think it's something that'll ever be fully realized. And to sort of echo [what I said] earlier, I think the first thing that it'll take is stopping when people are diagnosed with these things, stopping any subsequent deployments. I think that's where the biggest impact is to be made in combating these things. Unless you're gonna stop subjecting people to the experiences that caused these conditions. Unless you're gonna end the war. You need to stop deploying troops that already have these diagnoses.

21 Allen and Carissa Dunajs*

Editor's Note: Allen* is a white Infantry veteran in his mid-thirties who completed three deployments, including one during an overseas engagement before 2001, and two deployments during the Iraq War. At the time of his interview, he was working as a civilian contractor, training soldiers at Fort Hood. He and his wife Carissa* have been together throughout his military career, and she testified with him.

Grew up in Kentucky, but I spent the last 12 years stationed in South Dakota at Fort Meade. And then I got out of the Army about six years ago, so I've been bouncing around since then.

Probably well before I remember actually deciding to join the military, my dad was in the Army. I was born at Fort Lee. Both my grandfathers were in the military—one Army, one Army Air Corps. And it's just something I always wanted to do. I had originally planned on going to college and becoming an officer, but that didn't work out. I enlisted instead.

I wasn't really looking to get anything out of it, or I didn't really think of it in those terms. I know some people will enlist to get college money, or to get job training. I wasn't really thinking that far ahead. I was planning on doing 20 and retiring.

It was just something I always wanted to do. And I also grew up liking the military toys, the vehicles and weapons. Not necessarily their intended use, but fixing them, taking them apart, putting them together, designing them. So, I wanted to go play with the cool toys.

I don't know how it is now, because a lot of stuff has changed in the last six years, but while I was in, it was difficult to get mental health care, at least for me. Not because anybody was really against it, but because our schedule and everything else was such that I didn't have enough downtime really, to go do anything on my own. I was in a tank platoon, and we had 16 people, total. To take care of four Abrams tanks. And that's it. If one person is missing, then you've only got four people on a tank crew, and one of them's always missing for something. It just doesn't leave you a whole lot of free time. I mean, you can ask for time off, but then your command wants to know where you're going, and what's the appointment for, and you may or may not be comfortable sharing that with them.

I was fortunately blessed, with a fairly good NCO corps above me. When I did go get some mental health treatment while I was still active, of course, I had to tell my platoon sergeant where I was going and why, but not necessarily all the details. And he was the type of person that was

able to tell the rest of the platoon, “Hey, he's got an appointment. Y'all don't need to know anything more.” But I know there's a lot of soldiers that are not that fortunate.

But once you get to the health care people, the active duty medical world is geared heavily toward return to duty. So in order to get any appointment up at the hospital, I have to go through my PA, who at the time was a complete jerk. He was under the impression that he was a doctor, and could diagnose and treat everything in-house, and didn't like to give referrals. So you had to convince him first, and he was hard to convince. And the only way to get around that was to go outside the system, which eventually gets back to him, and then he gets mad at you, and makes it even harder to get more appointments later.

But, once you get up to the mental health guys—I got screened by a specialist, who was maybe 22 years old. They sit down with a questionnaire, and they check the boxes, and then it goes up to somebody who may or may not have any training, and they screen it and go, “Oh yeah, they need help,” or, “Nah, they're fine.” Maybe they talked to me, maybe they didn't. At the time, it was just a very broken system.

From pretty much the beginning of my Army career, my knees were shot. Jumping up and down off of tanks, running on concrete—very, very bad for knees. Humans are not designed for the stuff we do to each other. I'd go into the PA, because every time I'd go run, my knees would swell up. I'd sit in the waiting room, waiting to be seen, the swelling would go down. Then, he finally takes a look at me and says, “Oh, there's nothing wrong. Have a nice day.” I couldn't even get a profile out of him for the longest time. When I finally went in and he actually saw my knees swelled up for once, he told me it was normal. So I simply suggested to him that the other 75 guys in my company needed to make appointments with him. And he said, “Why?” And I said, “Their knees don't swell up. Something's wrong.”

I've got two inches worth of medical records, of showing me going in there for “My knees hurt,” or “My back hurts,” or “My knees hurt and my back hurts.” I tore my back muscles the first day of Basic Training, and they still haven't healed right. That was 1998. Their whole gearing was return to duty. If they can't prove something is actually wrong, they won't send you to a specialist to find out, they'll just send you back to duty. They give me some Motrin, tell me to have a nice day. And now I've gotten to the point where morphine doesn't affect me at all. That makes surgeries really interesting.

I got a bunch of Motrin, I got some x-rays shot of my knees. And cartilage doesn't show up on x-rays, so they looked at the bones, and went, “Oh, there's nothing wrong with the bones.” They did the same thing with my back. I got diagnosed with torn back muscles. And then I had an x-ray, and a bone scan, and found [nothing].

Editor's Note: Allen's wife Carissa also gave testimony during the interview—her remarks are indicated by the initials of her alias, CD, and are included in the indented text.*

CD: There was one time when he came down with the flu. And of course we lived off-post, because we're married. We lived almost an hour away from post. And he

came down with the flu overnight. He wasn't feeling so well at work the night before, but literally, he slept through his alarm. I tried to get him up, because his alarm woke me up, and wasn't really able to get him up. And I was like, "He really needs to sleep, he's really sick." You know, there's no way I'm gonna just throw him in the car and tell him to drive an hour to work. He was already a sergeant at this time, he was already trusted.

Even living an hour from post, I was very rarely late to work, through my own fault. You know, if the road's snowed in, there's nothing much I can do about it. But other than that, I rarely sleep through the alarm, I'm in there before most of the rest of the platoon, even living an hour away. My alarm was set to go off at four o'clock in the morning. I had to be at work by 6:30am.

CD: ...Both of us were very aware of medical stuff. And I'm like, he needs to stay home, he needs to sleep. Have some chicken soup, keep him hydrated...And he'll be fine, and he'll be back at work the next day if we just let him rest, right? So I actually called...ended up talking to his sergeant, and his sergeant was like, "I know, I totally believe you, that he's just sick. But he has to go to sick call."

...I [had] to wake him up, put him in a car, and make him drive an hour so that he can go to sick call, so they can tell us what we already know, which is he has the flu, and he should stay home and rest...

Allen continued to testify about his other experiences with health care during his active duty years.

...I [was also] diagnosed with depression... My platoon sergeant, I think I actually told him. He was just like, "Okay. So, we'll keep an eye on you if we deploy." And sure as hell, we deployed. He was really cool. He made sure that I was okay. He made sure that nothing was really affecting me. During my first deployment, my grandmother died. And I had already been slated to take leave around that time. He tried like hell to get me on the next thing smoking out of dodge.

...After talking to my parents and everyone else involved, I finally went to him and said, "You know what? Sergeant, just don't." 'Cause at the time it was taking between five and nine days for someone to get from Iraq to actual home. And I told him, "You know, I don't want to yank somebody off of their leave so that I can go to a funeral. 'Cause honestly, I don't really like funerals. They pretty much suck." ...And he actually pulled me off of missions for a couple of days to make sure I was cool, and could sit there and talk to my parents and my wife, and figure out what we were trying to do. So he shuffled people around in the platoon. He said we could still get the missions done... But I've also met other soldiers that didn't have that kind of support from their NCOs.

If he called me today and said, "Hey, I'm deploying and I need you on my crew," I'd probably go shave and suit up, and go over there. I would go back to war with him, in a heartbeat. Some of the other people I served with, maybe not.

[For my knees, I was diagnosed with] Retropatellar Knee Pain...which means 'pain behind my kneecaps.' They told me, "Don't run as much." Which, in the Army, is like, "Pretty much ignore

this profile, because you're gonna be running.”

It wasn't bad enough [back then] for me to need a profile though. It took almost four years for me to convince him [my PA] there was something wrong in the first place. And then we started deploying.

...For my knees, I think I had a five-day profile once. And that was about it. Most of the time I just ran with the slow group. That was where my run times ended up. I was trying to get profiles. But the PA at the time was convinced that he was right and no one else could be.

[I did have profiles for my back] in Basic, where they're a lot more willing to give you profiles, but they're a lot shorter-term ones. 'Cause, of course, you're in Basic Training, if you can't do the PT there, then you need to get back out of the Army. And it's in the period called Initial Entry Training, where you can come in, and if something's wrong, like you can't do the PT, they chapter you out, but it's not really like getting kicked out of the Army or discharged.

... What initially happened [to my back] was, we were lifting railroad ties, and cleaning up the PT pit. And I lifted incorrectly, with my knees and not my back. And something popped in my back. And I'm like, "Okay, drill sergeant, I'm done." ...It's the first day of Basic Training. Literally, like they picked us up that morning, we went to the barracks, changed into PTs, and went to clean up the pit.

...And he's like, "Alright, that's cool, We'll pick it back up tomorrow." And the next morning, I missed formation. Because I was laying on my bunk, and I could not move my legs. Literally, they did not feel like they were responding to signals from my brain. And I hear everybody outside the barracks, you know, everybody forms up, and yells, "Where the hell is Dunajs?!" "Oh, drill sergeant, he's still on his rack, he says he can't move."

...He comes stompin' in, and he's like, "What the hell is your problem!?" And I said, "Drill sergeant, I am not screwing around, I cannot move my legs." And he softened up a little bit, 'cause he had already gotten to know me in just two day's time, and I am not the kind of guy that just complains. You know, I actually wanted to be there, I actually wanted to do this. So he's like, "All right, roll over, let me take a look." And he lifts up the back of my shirt, and he goes white. And he grabs two guys, he's like, "You. You. Carry him to sick call."

So they carried me over there, and apparently from what the guys were describing...it was a solid 10-inch by 4-inch bruise. So they carried me over to sick call, and by the time I was done waiting in the waiting room, my leg started working again, which was awesome. Because I thought I was looking at a wheelchair. They diagnosed me with torn muscles. Five day profile. That's the most they're legally allowed to give you in Initial Entry Training. Anything over that, we start chapter paperwork.

My back cleared up as much as it can in five days. And it was right back to PT. Well, the next month, you know, my back's torn up again by now, 'cause we're carrying rucksacks, we're doing road marches, carrying weapons, all kinds of stupid things that we do in Basic. And I went back

to sick call. “My back's hurting again. Like, a lot.” And they give me another profile. Five days, torn back muscles. Saw the same doctor... 'cause that's all she can do. The fourth time I went back, in as many months, I got a different doctor. He ordered an x-ray and a bone scan, told me there's nothing wrong with my back, and if he sees me in there again he's gonna kick me out, I'm malingering. Which is not an honorable discharge.

So I quit going to sick call for my back.

...I haven't been to sick call for my back since. 'Cause that's already in my records, and I didn't want to get kicked out... And so, I'm not gonna give them any ammunition. They say my back's fine, okay, fine. [But] it's not fine.

...It depends on your NCOs, and it depends on your command. I stayed in the same company, in the same unit, for seven and a half years. I got to see a lot of different leadership come and go, under the same framework. So it's not like I switched units, where things are different, and got different command... And, you know, everybody'd be out there running unless they have an iron-clad, profile—a cast on their leg type of profile. If you can run, you will run.

And I've also seen the guys that're like, “Okay, you've got a profile, cool. You're over in—” and we call it the 'Broke Dick Platoon.' ...And we would go off and do the PT that we could do. As much as we could do. We're not trying to get out of it. We're not trying to be lazy, although people looked at us like we were trying to be lazy, sometimes. But for the most part, we're trying to get better. The point of a profile is to give you time to heal without screwing it up more. And the vast majority of the time, the profiles were followed.

The times that I saw people break their profiles, it wasn't command making them do it. It was them trying to push themselves. Because a lot of people... don't realize that if it's not healed, you're just gonna do more damage. They think, “Okay, well, it's been three days, and it doesn't hurt right now”—because you haven't run on it in three days, “I should be good.” And then they go out and try to run, and end up destroying their knees. The majority of the time, it's their own stupid fault, at least in that unit. I've also heard of people, like in Ranger and Infantry units, where profiles are pretty much meaningless to their command. It depends on the command... and whether or not the leadership there takes profiles seriously or not.

I started off in another Armor unit, and couldn't pass the PT test to save my life. 'Cause I've never been good at running... I stayed an E-2 for a little over a year. Because I couldn't pass a PT test. And they also had a very big good-old-boy system going on there, and I was the new guy. And they didn't particularly care for me. But then I switched units, and the first thing my new tank manager did was looked at me and says, “You're an E-2.” I said, “Yeah, sergeant.” He said, “How long have you been in the army?” I said, “A little over a year.” “So why in the HELL are you still E-2?”

And I said, “Because I have a hard time passing a PT test up here. I haven't passed one yet.” And he says, “Alright. We got two months [left in] that training. By the end of that, you will be E-3... You will pass a PT test, and I will promote you to E-3 as soon as you do.” And he was true to his

word, we went out jogging and running every other day. 'Cause...he knew that running every day actually makes your run times worse. So I'd go run one day, and then we'd do push-ups and sit-ups the next day, and flop back and forth. And sure as shit, by the end of that two months, I passed the PT test, and two days later, he pinned me with E-3.

[Profile violation is] not nearly as much as people think. Most soldiers, they get a profile, they'll follow it. Honestly, lower enlisted soldiers are inherently lazy. They will try to get out of work as much as they can. No matter how motivated they are... For the most part. Some of them, you know, get really high-speed, and they want to push themselves. They wanna get back into it. They want to prove themselves... Nine times out of 10, they end up hurting themselves worse.

That was actually a big problem [for me], because I don't feel right sitting off to the side while everybody else is doing PT. But at the same time, I'm not here to get hurt. I picked heavy armor [as a job] because there's three and a half feet of steel between me and anybody else that wants me dead. Why the hell would I hurt myself?

So I took those five-day profiles, and I'd go off to the side, because in Basic Training they are adamant about profiles. If you have a profile, they won't let you do anything. But that's Initial Entry Training, and it's kind of like a whole different world. Because the drill sergeants will get strung up if they violate someone's profile... They will cease to be a drill sergeant. And that looks worse on a resume than not having been a drill sergeant looks. In Basic Training, they're really careful about profiles.

"Oh, you have a profile? Oh, you're off to the side." And I would sit over there and do stretches, and you know, an hour of stretching will still wear you out. And it'll still make your muscles hurt. But having been a student athletic trainer in high school, I know what stretching does to muscles, and it helps build them back up. So I was over there stretching myself until I was about to cry. 'Cause it flippin' hurt. But I was still trying to get better. I couldn't do the push-ups, I couldn't do the sit-ups, whatever. But I can at least try to better myself either way. For a lot of the soldiers, it's just a point of pride. Not only do you not want to be seen as lazy, you don't want to be lazy. You know, you didn't join the army to sit behind a desk and push paper. Those that did, do. But you don't join Combat Arms so that you can take it easy.

Between my two tours in Iraq... I came down on orders for recruiting. I only had a year left on my contract. Recruiting is a three-year stint. They said, "You have to re-enlist... You're on orders for recruiting. You don't have enough time. You must re-enlist." I said, "You're going to have to delete the orders, 'cause I'm not re-enlisting." So we went back and forth like that for a little while, and they said, "Okay, well, we're making you go recruiting anyway. And we're going to involuntarily extend you for two years." And I was like, "Oh, this oughta be a cute trick. So you're going to stop-loss me two years so that I can recruit? Yeah, I'm gonna get kicked out in the first week. I guarantee you." 'Cause right now I'm the last person you want recruiting people. And one of the steps to be qualified for a recruiter is you have to go through a mental health eval. I already had my diagnosis for depression.

So I went up to [the hospital], where the mental health people hang out, and I had to go get their

little health eval questionnaire filled out. Yay. So I sit down in the office, and this little E-4 comes in, and sits down in front of me with the questionnaire already filled out and signed. And she's like, "Well, this is pretty much just a formality, you know, if you came down on orders for recruiting, then all of these answers should be correct. Are you under any treatment for mental health?" And I said, "Yes." She went, "Uh oh...It's marked 'No' here."

I'm like, "Well, that's not mine... Yes, I'm under treatment. In THAT office right there across the hall...every other Thursday I come up here, and go to that office and get treated, so your questionnaire's wrong." She said, "But, if you answer 'Yes' to this, you don't qualify for recruiting." And I'm like, "Then you better change that damn answer, 'cause I'm not re-enlisting either." So she had to go get a blank form and actually fill in the correct answers. 'Cause the way the system was set up, generally if you come down on recruiting, you're qualified for it. And you know, at that point, yeah, the questionnaire is pretty much a formality. Well, I was different. And it kind of bugged me that she sat down with one that's already filled out and signed and stamped and sealed and, I'm like, "Your answers are wrong." ...And I haven't been a recruiter.

CD: [And they also] tried to tell [him], "Well, if you don't go recruiting, you're just gonna get stop-lossed and get sent back to Iraq." And he's like, "That's fine, and it's still not two years extra."

I'd rather go drive a tank than go sit in an office... I told them straight out, if you send me to recruiting, I'm gonna be honest." And they're like, "Good, you should be honest!" And I'm like, "No, you don't understand me. I'm going to tell them the truth about being in the Army." They said, "Don't do that."

They didn't know about [my treatment], because mental health is confidential. It doesn't go into your medical records. It stays in your mental health records, they are a separate file. At least at the time when we were still dealing with paper. I don't know how it is now, with all the electronic stuff. But my PA had no idea that I was going to mental health. It didn't go through him. It went around him.

My command structure knew that I had an appointment at the hospital. My platoon sergeant knew more details, 'cause I trusted him. But my first sergeant, he's like, "Hey, I need you to do something Thursday afternoon." And I said, "I can't, first sergeant, I got an appointment." He's like, "Oh, that's right, you got that recurring appointment." He knows damn well where I'm going! Recurring appointment at the hospital on Thursday afternoon at three to four. And I'm not coming back with bandages or x-ray films. It's for mental health. It doesn't take a genius. But he knows better than to blab it all over the place. You know, whatever's wrong with me, I'm getting help for it. So, he's happy. He'll live without me for an hour a week, so that I don't go postal and shoot somebody with a damn tank.

There wasn't a profile. I was under treatment, which automatically disqualified me for recruiting. The reason it disqualifies you from recruiting is because if the Army's taking care of you, and you're receiving treatment for something, you're supposed to be seen at a Tri-Care facility. If you go recruiting, there's no guarantee that you will be within three hundred miles of a Tri-Care

facility...since I'm already being treated for it, they're not allowed to stop that care to move me around.

CD: And that was one of the concerns they had with [his] deployment. What they were telling him was, "We have no power, even though you're under the mental health care, to stop you from getting deployed. I mean, we could write stuff up all day, but..." The rules weren't in place.

Depression was not a sickness that would put you on non-deployable status. Simple depression. Depression with threats of suicide? Definitely Rear-D. You get stuck on rear detachment, you don't deploy.

I said, "I'm deploying, what do I do about my meds?" They said, "Go down to the pharmacy." And I go down to the pharmacy, and I shit you not, they gave me a six-month supply of Wellbutrin. That's a huge bottle.

And I'm like, "What happens after six months?" They said, "As soon as you hit ground in Kuwait... The first person you need to see is this doctor that runs the hospital there. The mental health guy." And they gave me his name and his rank and his office phone number, in Kuwait. They said, "As soon as you hit ground, go talk to him."

And I did. I hit ground, I told my platoon sergeant, I said, "Hey, I need to go talk to this dude about, you know, my appointments." And he went, "Okay! Have a nice time." You know, try not to get blown up on the way. And I walked across camp, talked to this doctor. I said, "I was given your name because I'm on Wellbutrin and being treated for this." He said, "Oh yeah, no problem." Reached in the cabinet behind his desk, and gave me another six-month supply. Without even signing for it. He was just like, "Oh, yeah. You got your six-month supply, you brought that over?" I said, "Yeah, it's in my duffel bag." He goes, "Okay, here's enough for the other six months. If you get extended past that year, call me." And, "Here's my phone number, here's my radio frequency." You could actually call him on the radio, from anywhere in-country. He had a satellite phone number.

CD: Personally, I see a huge problem with that. Because now you're unsupervised on the medication. And even in the civilian world, the minimum after you've been on it for a while, you will have a med supervision appointment every six months, which he's not getting. And not to mention, with depression, most of the time antidepressants are a great way to kill yourself. So if he does become suicidal now, he has a whole year's worth of pills to take to kill himself with.

The reason they were able to do that is because I had been stabilized on the Wellbutrin for over eight months before the deployment. And had been going to the monthly appointments, and was supposed to go to our mental health provider once we settled down to the camp. The only catch was, the camp that I settled down at didn't have one. Because it wasn't big enough. Big enough for two battalion's worth of tanks; not big enough for mental health provider.

Honestly, the appointments [before deployment] were just for the medication. I wasn't getting counseling appointments at that point. 'Cause the psychiatrist who was prescribing the meds is not a counselor. And the counselors at the hospital were so backlogged that there was no way I was getting in before I made General. I asked them for a counseling appointment, and they tried to schedule me a year and a half out. And I was just like, "You know what, I'll come back."

Generally, [for mental health needs, you see a psychiatrist first]. The one that prescribes meds. Because the Army figures if they give you a pill and make the problem go away, then we don't even have to talk to your ass.

[The only counseling I had was between tours], through Army OneSource. Three appointments for free, and then you could extend it from there. And I think we ended up going until 12 or 15 total.

[My depression] had been going on, in all honesty, probably before I was even in the Army. I didn't notice any difference. One of the questions they asked was, "What is your mood like most of the time?" And I said, "Flat." And they just look at me and they say, "That wasn't one of your choices." And I'm like, "You asked me a question. I gave you the answer." And like, "No. Happy or Sad?" ... "Neither. In the middle. Just...there." And they're like "But...but that's not one of the choices. That doesn't make you manic or depressive."

I'm like, "Well, then, you're screwed. You need to figure something else out." You know, what do you want me to do, make up an answer? Fine, I'm happy. Can I go now? ...Dysthymic depression screwed up all their questionnaires. Because most of the time they're looking for someone who got depressed [recently]. I'm like, "No, this has been going on for eight years..." So they come back with, "Oh, then you're not depressed." Like, okay. Should I go back to the motor pool now?

The person had no training...they wouldn't have known the difference. They were just doing a questionnaire.

That was when I got the diagnosis of depression through the Army OneSource [between tours]. It wasn't even the hospital that did that... So I went to OneSource, and I talked to the lady for what, all of 30 minutes. And she's like, "You have dysthymic depression. Take that [diagnosis] back to the hospital." ...So I walked back into the doctor at the hospital and said, "Apparently I'm depressed." And he says, "Take Wellbutrin. Go back to work."

Okay. Drive by the pharmacy, get Wellbutrin, go back to work. Wellbutrin didn't work worth a crap, by the way... I bounced around to a couple other [medications], and they all had pretty much the same effect.

...So I told the doctor, "I don't want to keep taking this." And he said, "Okay." Like, "You're not going to ask my WHY?" He goes, "Oh yeah, why?" I'm like, "Because the side effects are screwing with me." And he says, "Oh. Try this one." "What's the side effects on that one?" And he says, "Pretty much the same shit. It's just a different drug."

One of them made me get the shakes, which is crappy. You know, try gunning on a tank when

you're [shaking and jerking]...Right. Ain't nothing safe on that range but the targets. One gave me the shakes, one gave me lack of libido, I suppose would be the technical term for that. One made me want cigarettes like nobody's business.

So I was smoking like a pack and a half of cigarettes a day. No shit, I can't sleep. You know, I'm fried out on nicotine all day, and I get like an hour and a half of sleep, and now I'm exhausted. Need more cigarettes. 'Cause I won't drink energy drinks...I actually tried energy drinks for a while. Those just make my blood pressure skyrocket. So I just couldn't win. I eventually just quit taking the meds.

I was an NCO for the better part of four years. While I was in, brain injuries pretty much didn't exist yet. I mean, believe me, they existed, but they weren't something that was looked for or treated. Because the Army medical system as a whole didn't see them as a disorder yet. In '03, we were one of the first units in Iraq... We were sitting down in Kuwait loading ammo onto the tanks when George Bush said, "Major combat operations are over!" And we said, "Shit, can we put this shit back on the racks?" And they said, "No."

...In fact, we were so early in the current conflict in Iraq that we didn't even have IBAs²⁰⁸ yet. They didn't exist yet. They were ordering them, and Point Blank was making them by the thousands, but they didn't get to us until about halfway through that first tour. So the nice, thick body armor, we didn't have. Not because the Army funding wasn't there, or because our unit was getting screwed, but simply because they didn't exist yet. And we were in tanks. What the hell do we need body armor for? And then they started giving us humvees, which was dumb. And they're like, "Oh yeah, y'all might want body armor." And I'm like, "No shit." You know, this canvas wall isn't really gonna do much. We were able to run around in un-armored humvees. Because that was all we had.

We had what I like to call "lamine cellulose granulated silicon armor." That would be plywood and sandbags. It sounds really high tech. It's actually just plywood and sandbags.

...We started getting IEDs, and they went, "Dude, this crap ain't workin'. We need to figure something out quick." That was a response to what we went through in 2003.

...Here and there, most of the time you get PTSD, but you get diagnosed as depression. Because even the DSM-IV hadn't caught up yet. You know, they're still running off of late-'70s, early-'80s technology as far as diagnosis. So they look at what problems you're having, and it fits into this list, and "Okay, you are diagnosed with [this]."

CD: That's assuming you even sought treatment...a lot of times, if you're at a small camp or whatever, the medics aren't trained on anything psych, for sure, and TBI looks a lot like psych... The regional care manager for DVBC, Defense and Veterans Brain Injury Coalition, she runs the hospital care in Texas, and she does the whole Western region. And basically, [she said] they were finding that they were treating people for blast injuries, and then a couple years later going back and realizing that the physical injuries they treated, there was also a TBI there and they

have to go back and treat the TBI.

If you got blown up, you know, they were treating your blown up arm, and fitting you with a prosthetic and doing physical therapy, and sending you home. And not even treating the TBI in these patients who were unconscious for two weeks. So the guy in the field, who's unconscious for 30 seconds, it wasn't diagnosed, there was no structure to do that.

...I had been through EMT class... And I had my Combat Lifesaver. But none of that [TBI information] was in the training. It didn't exist yet. I mean, obviously the injuries existed, but we didn't know about it. You [treated] it as a concussion. You watch it for 48 hours, make sure they don't fall asleep.

That was just common knowledge. When I landed in Kuwait in 2003, there was one psychiatrist in theater...to my knowledge. There may have been more, but there was only one I had access to. And that was the doctor in Kuwait. More than 2,000 miles from where I was based.

[The Chaplain Corps] were our mental health guys... They're not a qualified psychologist, but they are trained in counseling, to a certain extent. Like going to your pastor for counseling. And, to be totally honest, our Chaplain Corps does the best that they can. I'm not saying they're doing great, because they're not. But they're not trained for it. It's not their job. And they are winging it the best they can. And they are really trying hard.

But our regiment²⁰⁹ has a Chaplain. For 6,000 people. How much time you honestly gonna get with it?

[People talked about PTSD] a little bit, on the second tour. 'Cause we got the new ACHs,²¹⁰ we got the new helmets and body armor because they had figured out that the blast injuries were screwing us up. The whole first tour and in between tours, the Army R&D was going haywire. We've had the same helmet since mid-'80s, the old Kevlar with the suspension straps. And they figured out rather quickly that that helmet [was] not protecting us from brain injuries.

...And now I've seen research from, I believe it was the Australian army, that there is absolutely nothing you can put on your head that will protect you from blast injury. It's just not gonna happen. But God bless 'em, the Army was trying. And they tried like hell, they were developing stuff and pushing it out to the troops as fast as they could, without even testing half of it. They're just like, "It might work. Here. Wear this, and let us know how it does."

It started to [get better] a tiny bit, right at the end of my second tour. Because the unit that came in and replaced us, their medics had had the training. But it was very miniscule, at the time. It has expanded since then. They were just getting the beginnings of, "This is what you look for, and write it up as a TBI, so that when they get back, they can get treated for it."

[PTSD came up] a little bit. At least, our second tour, the policy was if somebody died in your company...the company would get 24 hours, no missions. Everybody else would just have to

cover for them for 24 hours. You know, deal with it. If you were on maintenance day, tough shit, you're not on maintenance day anymore. And we had to cover for other units that lost guys. And it worked both ways, and nobody had a problem with it. But you would get 24 hours of downtime. Where you could sit back, you don't have to worry about going out on missions, you don't have to worry about prepping vehicles, going on guard, nothing. 'Cause companies are pretty close-knit... And that really helped, I think, alleviate some of the PTSD. But it only goes so far.

Pretty much [that was the only PTSD treatment in theater]. I mean, you still gotta go back on a mission. You can't have everybody down until they feel better. Because, you know, you still got a mission to accomplish.

If the mission can support it [you get time off]. You know, our company only had 72 people. And we had two tanks out on the route 24 hours a day. We were working 12-on 12-off missions. So you lose one person, you're screwed! You have to have three people to operate that vehicle! It's not like we roll out there with one dude asleep in the seat. You have a driver, you have a commander, you have a gunner. We're already stripped down as low as we can go, 'cause we've eliminated the loader. And so, you lose a person for two or three weeks? You're done. You don't have enough people to accomplish the mission.

If you go out there even more short-handed, somebody's gonna get hurt. 'Cause you don't have enough pairs of eyes. Our second tour, our whole job was protecting this one section of road, one of the main supply routes... I watched almost every one of those convoys roll by me. Fuel, every day. Thousands and thousands of gallons every day. Trucks full of food, and stuff for the PXs.²¹¹ And ammunition, and you name it, it was going through our area. We were tasked with, "Keep this road open. Don't let them put IEDs out there." "Okay, roger." Well, you got three pairs of eyes out there on one vehicle, so six total—with two tanks you've got six pairs of eyes, on a six mile stretch of road. And you lose one person? How much is gonna get past you?

When we took [that road] over from the Marines, they were getting over a hundred IED hits a day, on that one five-mile stretch of road. In less than two months, we had that reduced to one a week. Because we were watching that close. Even with just six pair of eyes. We would roll the tanks up and down the road. If a car stopped for more than two seconds, we'd be on them like white on rice. With a tank, going, "What're you doing?" Half the time, they just drive off. Go plant their IED somewhere else, or whatever. It got to the point where, instead of burying them, the best they could do was to drive down the road at 60 miles an hour, open the back door, and kick it out the door. Because they knew if they stopped for more than two seconds, we would drive a tank up on top of them, and ask them what they're doing. And even if they detonate it, it's not gonna do anything to the tank.

CD: His second tour, they had two big focuses, for mental health, basically. And it was, "Don't drive tired," and make sure no one else is suicidal... So you're supposed to run around asking everybody if they had a plan.

That was hilarious. Their whole suicide prevention was, "Ask them if they have a plan." And my

only thought at that time was, "I am required, by policy, to carry a loaded 9mm pistol, at ALL TIMES. Okay, if I am ever more than arms length from one of my weapons, I am in deep shit. How much planning is this gonna take?" ...Although, in the one year [in Iraq]... I don't remember anyone from our squadron committing suicide...out of that whole year. We lost plenty of people out on routes and stuff. But, you know, it's combat. That's what happens in combat... I think there was one or two over in [another squadron].

...After we got back, you know, it kind of goes to the wind.

CD: We were hearing it almost weekly in the papers, about soldiers committing suicide, after he got out.

But there were also what, over 500,000 troops over there. So, you come back, and every week one or two commit suicide. And you're just like, "I didn't know him." And, as callous as it sounds, we went through the same thing with the phone centers over there. You come back from a mission and it's like, "Hey, the phone center's shut down." And you're like, "Dammit, who died?" "I don't know, somebody from [the other squadron]." "Well then, I don't give a fuck." And it's not that you don't care that an American soldier died. But it's like, I didn't know him. I just want to call my family, and let them know I'm okay... And that wears hard on you, when you come back off of 12 hours of sheer terror, and you just want to talk to somebody. Preferably not somebody you just spend the last 12 hours with. And you can't, because somebody else 50 miles away, had the rudeness to die on you. It's like, "Quit dying, I want to call my wife."

So it wasn't really pressure to ignore the injuries. We didn't know they were there...

CD: what makes me mad is when I was researching what could be wrong with him. I found scientific papers that had been published more than 10 years before the war, talking about this kind of injury, that there have been studies done in Northern Ireland, about blast type injuries. And that it had been pointed out to the Senate and to our military leaders before any of this happened, that if we have this type of war, and this type of thing occurring, with the IEDs, and everything else, that we're gonna see a lot of injuries like this. So, it was known in the higher levels. It wasn't known to the medics, it wasn't known to the average soldier.

The higher levels weren't expecting us to get hit that much... They were under the impression that, just like in '91, when we went into Iraq, it was gonna be a quick in-and-out, crush them, and let's move on. They weren't expecting a long, drawn-out war. My first tour, I got hit with maybe three IEDs over the whole year. My second tour, I got more than 300.

It escalated that fast. My tours were 11 months apart. So in less than a year, it went from one blast every four months to one blast every five minutes. It escalated that fast. Mostly it escalated when Al Zarqawi came into power, as it were, which happened between my two tours... We came back a year later, and tried to un-fuck it. And it didn't work.

It just kept escalating. We were expecting our heavy armor to protect us, we were expecting the

body armor and helmets to protect us, and they found out rapidly that it wasn't doing the job. Because it's not designed for stuff like that. I've really got to hand it to the R&D guys, they tried like hell to protect us. It didn't work, because there's nothing you can do about it. But they tried. They really did... And consequently, they didn't know about the injuries, so they tried to protect us from them. When they found out that didn't work, then the treatments came in...

Having more mental health professionals and people trained in such things, in theater [would help]. Like I said, we were going to the Chaplains. And they're not trained for it.

CD: And having the ability to give you time off, so that you could see the help.

...[Maybe] train the medics on it, because the medics are with every unit. And I know they're not gonna be fully qualified or anything like that, but you know, more training than they usually get. Maybe the PAs. Maybe one mental health aid station, even. 'Cause I can always get to my Battalion Aid Station. Even if you put one psych nurse at each aid station, that would probably help quite a bit.

They didn't have enough psych nurses. There was maybe a few hundred in the Army, total. You know, you can't push those down to every unit, there just aren't enough of them. And it's not like you can go down to some civilian clinic, grab a random psychiatrist or psychologist, and say hey, "You wanna deploy to Iraq?!" They'll diagnose you as Fucking Crazy.

CD: And you gotta remember, what kind of treatment did he get when he went to the Army hospital at the time, in between his two tours? ...And that was this side. Forget deployed.

Deployed, they look at you and go, "Go out to the rifle range and shoot shit?" "Fuck it, alright."

CD: Or, "Let's go lift weights." You get a lot of that.

Well, that's how each individual person handles it. Some people have a rough day and they want to go lift weights. Some of them go over to the coffeeshop, get fried out on caffeine. Some kick back with porn. Well, whatever works. Some of them just go to the phone center, and talk to somebody that cares, or talk to somebody that doesn't care! Whichever they call!

We [helped] each other out. You know, with this unit, especially our second tour, when most of the injuries and PTSD were happening—one thing you got to understand: the company, we all got together right before first tour. Some of us had still been together since [we deployed] in 2000. We were a pretty close-knit group. And, through the entire first tour, only one person from our company got evac-ed out of country. And, he did it to himself. In fact, the commander refused his Purple Heart, for getting injured in combat, because the way he got injured was by being stupid.

Our second tour, within four months of landing in country, we lost our commander—he's still alive, but he got evac-ed; a platoon leader; the commander's humvee got hit, and tore up a damn fine

sergeant, who didn't make it, and then severely injured three others who were evac-ed out immediately. And it was a big shock to us. You know, we're tankers. We're in tanks. These are the most impregnable vehicle on the battlefield. And all of a sudden, we're riding around in coke cans. You know, something just ripped through the side of it, and we're just like, "What the fuck." What the hell happened in the last 11 months, since we were here last? But most of us had all still been together. So you knew the guys you were with.

I had to tell one of my good friends, Langley,* that Glover,* the E-5 driver of that humvee that got vaporized, wasn't making it home. And we sat down, he started crying on my shoulder, and I pulled him into my barracks room, and basically tossed his ass down on the bed. And I'm just like, "Alright, Langley, hang on a second." I told my roommate, "Hey, run over to the chow hall, and get me a case of Mountain Dew." He's like, "You don't even like Mountain Dew." I said, "Just go get the case of Mountain Dew! What the hell is wrong with you." He's like, "Why would you want that?" I said, "'Cause we don't have beer."

You know, 'cause that's what normally guys would do, we'd go out and get fucking shit-faced. Except, in country you can't do that. So I'm like, "Go get me some sodas. We're gonna be up all night. Fuck it." And we sat there for the next about 36 hours, just talking. Told him old war stories, 'cause Glover and I were together [overseas before 2001]. So we'd been in the same company for four years at that point. So it was cool to be able to help each other. But for my unit, there wasn't a whole lot of stigma attached to going to seek help. And like I said, we had a really cool NCO corps above us, that if you needed help with something, "Go get it. We will do whatever we can to help that happen." When the help isn't there, there's nothing you can do about it. But, I told my platoon sergeant, "Hey, I need to go to the hospital for appointments." And he said, "Okay, go."

CD: But it was a huge deal when [he was] trying to decide to go. He was afraid that it could hurt his career... We had heard stories about soldiers in other units being teased, by basically, up to and including the commander, for getting treatment for something mental. I mean, that's why he knew the name, it was Three West. And then it became like, Four North, or whatever. But that wing that was the 'crazy ward.' That's the psych ward. And you didn't even want to be seen going there.

And yes, that's individual people, and that has to do with society's stigma. His command turned out to be cool, but it was a huge decision for him to even decide to seek treatment in the first place.

"He's a Three West ranger..." The Army culture as a whole...doesn't see getting mental help as a good thing...while it may not be detrimental to your career, it's definitely not something you're gonna put on your resume. What it boils down to, though, is individual people and individual commanders. You know, some commanders are cool about it, and they're great. And some commanders are dicks. And it's honestly luck of the draw which one you get.

[The stigma comes from] the United States as a whole. I've met commanders from California, who have no problem with people seeking mental help. You meet somebody from Georgia, it's a

problem. Because in Georgia or even New England, to some extent, you don't go get mental help. You fix it yourself, dammit. But out in California, dude, everybody sees a therapist.

I think [the military] tries hard not to promote either, but it fails miserably. It still boils down to individual people and their prejudices against it. You can make a policy that no one will be teased about it all day. Is it gonna change their way of thinking? No.

CD: ...When he was in, the big thing was the sexual harassment trainings. So, does that stop soldiers from like, checking out, you know, another girl's butt? Hell no. But it does make them more cautious about how they do it, and maybe not do it so openly. And even having those kind of trainings in place for mental health issues, which definitely weren't there at the time—that would've helped. It just wasn't there.

And then when we'd ask people about it, they're like, "Well, we're afraid that if we make it okay, then everybody will want to go." Like, so they can get a mental health profile and get out of stuff.

Yeah, I mean, if you think about it, if I were to make a policy right now that said, "If you are under mental health treatment, you can't be deployed," there would be a line out the door, down the block, and around the building, for mental health, because people don't want to deploy.

When we went to Sierra Leone, there was an MP unit that went with us. Three out of five of their female soldiers popped up pregnant within a month of deployment [notification]. Now, one of those three had been actually trying to have a baby... So I don't fault her. So out of four female soldiers, two of them are pregnant. The unit deploys. Within a month of that deployment, those two girls were no longer pregnant... They'd got pregnant so they could get out of deployment. And admitted as much. And then went and had abortions, actually, on both of them. And when their command found out that they were no longer pregnant, they were on the first thing smoking to Africa. Said, "Oh, you're no longer pregnant? Pack your gear." And the command is afraid that if you make it okay to go seek mental help, you get any mental health profile that says, "Okay, now you can't be deployed, because you're depressive, or PTSD, or whatever."

Then, where's your force gonna go? You have an awful lot of soldiers that will do anything and everything to get out of a deployment. You know, before Don't Ask Don't Tell, there were people saying that they were gay. Just to get out of going overseas, or getting out of the military. Whether they were gay or not is not my decision or my judgment. But I met more than one that was like, "I'll just tell them I'm gay, and then they'll kick me out."

They need the trained people that they have in. You can always sit back and say, "Well, if they lose this soldier they can replace him." Do you have any idea how much it takes to train a soldier through Basic Training? It's almost two million dollars. Per soldier. To get them through Basic and AIT, depending on their MOS.

"Stand in line..." that's all I remember about SRPs. "Quick, quick, back of the line, back of the line." There's long lines to get through all these stations that are essentially meaningless. We

check your dental records, we make sure you have glasses, make sure you have dog tags, make sure your SGLI²¹² is updated, and then we send you away. There's more stations than that, but you get the point. It's making sure that all the paperwork is straight, and you're done.

Our commander was pretty good about identifying people that weren't going to be deployed, and they were on Rear-D. And they got put on Rear-D before everyone else SRP-ed. With the exception of, "Oh crap" problems, and then you get quickly shifted to Rear-D.

Maybe [I deployed with] depression [when I shouldn't have]. But at the time it wasn't considered that bad. I was being treated with medication, and they had the capability to give me enough medication to last me through it. So, they did.

Anyone that I saw that had started having problems [in Iraq], the command was pretty quick to jump in to take their weapon and their ammo away. And then get them the best help we had at the time. Which was not anywhere near adequate, but I saw people get escorted over to the Chaplain, over to the medics, more than once.

...While we were in Iraq the first tour, they caught some of our medics breaking open the auto-injectors for nerve gas defense. There's two different auto-injectors, one's Atropine, one's Diazepam. Diazepam is a severe depressant. And they were breaking apart the Diazepam injectors and shooting that up. So they came down and took away all of our auto-injectors. Put them in a huge box up at headquarters. And we're like, "Just out of curiosity, what happens if we get hit with nerve gas?" I think [the limit] is up to five minutes to take your auto-injectors. They said, "If you get hit with nerve gas, we'll pass them back out."

...After we come back...you basically sign back in. You pick up your linens, and sign for your room key, get your shit out of storage. You go to the "Welcome home, how you doing?" ceremony.

[Screenings for PTSD or TBI] didn't happen until about 48 hours later, and they just had the one sheet of paper, both sides. It's like, "In the last month, has any of this changed?" It's like, dude, 48 hours ago I was in Iraq. So I don't even know yet.

And there was no follow-up screener after that, yet. It was literally one screener, as soon as possible after redeployment,²¹³ which usually meant in the next 48 hours, before you went on leave. They'd give you this one sheet questionnaire.

CD: They'd give it to you, like before you could see the wives. So everybody's like, "Oh, I'm fine. I wanna go see my wife! She's in that room right over there! Let me go!"

"If I say no to this, they keep me here, right?" "That's correct." "Yes, yes, yes, yes. Can I go home now? I wanna get laid."

[We were briefed] a little bit on the anti-suicide stuff. You know, you check if they have a plan. The PTSD, no [briefings]. [It] was actually in the medic book, that I managed to snag a copy of and

read, but I wasn't a medic... Our medics, part of their tasking and training is to deal with combat fatigued soldiers. Which is the very old term for PTSD. They don't call it PTSD yet, even in the books. It [was] woefully incomplete. It's just, "Try to keep him happy, and make sure that they don't have any ammunition near them, and then take away anything sharp and pointy."

I am diagnosed with PTSD now. [Describing how that has affected my personal life] would actually be more her department, 'cause I really couldn't tell you.

CD: It pretty much destroyed his personal life. He lost all his friends, and our relationship was really tough, when he was not doing so hot. And actually, work, for him, was kind of better because of it. Because everything was rigid and structured. Except for when the guys wanted to be a jackass and like, somebody brought fireworks to work one day.

I started work as a military vehicle mechanic. As a civilian contractor, to work on military vehicles. And it was vehicles that I knew forwards and backwards and inside out...very structured, step-by-step type of stuff. And then one day, some of the geniuses decided to throw fireworks out of one of the trucks. Which is really not a good idea with a bunch of combat veterans... I swore to them and the supervisor that if they did that again, I would beat them with a pipe.

EMDR helps a lot for the PTSD. I personally don't really believe that you can actually cure PTSD. I may very well be wrong on that, and I hope I am. But right now, I don't see it happening. So treatment and the cure for it is to learn how to cope with it, and EMDR is a big help... I think I'll always have it, and it's always kind of this specter sitting there on your shoulder. But I've learned to kind of ignore it now—better now.

Multiple deployments, God, it tears us apart. Some of the soldiers that I teach now as a contractor, they've had three and four deployments, and they don't want to go back. And some of them are all gung-ho and they'd love to go back...that's cool. If they want to do that, then by all means, go for it. But, you know, three and four deployments, they've missed their kid's first, second, and third birthdays, they've missed all the first steps, they've missed this, they've missed that. All in favor of these deployments. Some are happy about it, some are not. You know, the single guys, they come back and buy a new car. You know, it's like, "Dude, I've been deployed like three times in the last six years, I own my freakin' Escalade outright." Awesome! ...If that's what makes you happy, go for it. But the guys with families are really sucking it up...

What I think actually caused my PTSD, wasn't so much of what I saw or what I did. Because, to be totally honest, we didn't do a whole lot. Mostly we sat on the side of the road and watched for people to do something stupid. What really affected me was the fact that I spent an entire year, one, outside of my life. My life stopped, and was put on pause for a year. But it kept going around me. You know, I get back home and it's not when I left. I don't think I've changed. I put my life on pause for a year, but nobody else did.

And that's rough. And you're sitting in situations in a whole different world while you're deployed, where normal rules don't apply. And nothing makes sense. And it just screws with your head the

whole time.

For one example—I finally got it explained to me later by one of the translators—I can point a tank gun or a machine gun at somebody in Iraq, and they won't care. They'll just keep walking. If I hold up a nine millimeter pistol, the car that's 200 yards out will stop dead in its tracks. At 200 yards I can't hit him with this pistol. It won't fire that far. I can point the tank gun at him, a gun that's capable of vaporizing the car and leaving nothing more than gravel, and he won't care. If I hold up a pistol, he'll stop dead. And I watched this for a year and a half, and I'm just like "WHAT THE FUCK is this?" He knows damn well I can't even hit him from here.

So I finally asked one of the translators, and he says, "Oh, it goes back to the times when Saddam was in power." ...He said, "Most of the men around here have been in the military. They had mandatory conscription. And the 1999 Gulf War, everybody was involved. They all know machine guns. Hell, most of them carry AK-47s in their car for personal protection." We consider that an assault weapon. They consider it a personal weapon. "Machine guns don't bother them, they know what those are. They carry them, they operate them. When Saddam was in power, the only people that carried pistols were his personal death squads. His execution squads. You hold up a pistol, it means someone's getting executed. You hold up a machine gun, it's just another soldier." And I'm like, "Okay, well, that makes more sense." But after a year and a half of it not making sense, not really helpful.

CD: Honestly, just the whole climate, they never really had any place where they could feel safe. Even on base, the round came through the bathroom.

I mean, even on camp, in our barracks, where we're supposedly safe and we can take off our flak vests, we had a mortar round come in and blast through two floors. Didn't detonate, hit the bathroom, and there was a guy next to it on the toilet, in the next stall over. It completely destroyed the porcelain.

...It's just like, even where you're safe, you're not safe. Mortar rounds...and our first tour, we got really jaded to it. Initially, a round would land in our camp. There were these two guys that liked to fire rockets at us. Two rockets, between nine and ten-thirty, every night, for three months. Literally. Like clockwork, between nine and ten-thirty, there would be two rockets, and that's it. And they'd drop away. And the first couple of times, the rockets land right outside the camp, and we jump on the tanks, and we try to find these guys. But we never could find them. 'Cause it takes a good half hour to get a tank started up. These dudes were long gone by then. So after a while, we'd be kicked back watching a movie—[a mortar hits] and like, pause. "Did it hit inside the berm?" "Nope." ...Okay, fuck it... We ended up catching them later on a checkpoint. Found the big semi truck, with two rocket tubes bolted in the bed. We were not gentle with them.

[This trauma] is the nature of war. My grandfather dealt with the same thing in Europe in 1940s. My dad missed Vietnam, but he knew people that were in Vietnam, and Vietnam was the same way. You're never safe. There is no downtime.

CD: [It would help to have] enough people so that you could actually get enough

sleep. They're doing all this stuff about, "Don't drive in convoys tired," because it was killing people. And then they have them working 12-on, 12-off. And then they get into a fire fight, and they're all dehydrated, and they're still out there 24 hours later. You know, they've been on shift for like, 36 hours...you get back in and you're thinking, "Oh, it's my 12 off now," and somebody else's died and you gotta cover for them.

And when they say '12-on, 12-off'—I was in a tank unit. It was a 48 minute drive from camp to our route, in a tank. It's actually only about 20 miles. But tanks don't go fast. Especially not through a city. So we'd work either the 7am to 7pm shift, or the 7pm to 7am shift. So say the 7pm to 7am shift, the overnight shift. I have to be out on the route by 6:50pm, to relieve that unit at 7pm. So if we do backwards planning from that, it's a 45 minute drive, which means I have to leave camp at 6:05 or 6:10pm. It takes us about an hour to eat dinner, prep the vehicles, get all the gear on, get radio checks, get the weapons mounted, and all of that. So now we're back to five o'clock. It takes about an hour before that to get your personal gear ready, and you know, your flak vest ready, and water filled, and anything you're gonna take with you, ready. So by four o'clock in the afternoon, I'm starting to prep for my shift. To get all our convoy briefs, and everything else out of the way, so we can be out on the route by seven.

Well, I get off of work at 7am. I don't get back to camp 'til eight. I have at least an hour of maintenance on the vehicle. My time is not my own until about 9am. So the only downtime I have is actually 9am to 4pm. I've got to eat, sleep, do any paperwork on my soldiers—'cause I was the NCO—any maintenance issues that weren't covered in that hour to get fixed. If I've got to go over to Finance, or PSB,²¹⁴ or want to watch a movie, or want to go to the coffeeshop, or go to the PX and get my hair cut, take a shower—I've got eight hours to do it. And then back into prep for the next 12-hour mission.

CD: So they were constantly short of sleep... And that's assuming they don't have a debrief because they had some kind of action.

Editor's Note: While wrapping up the interview, Allen and Carissa discussed other traumatic injuries, including TBI and military sexual trauma.

I came out of [the Army] with a TBI, but I was diagnosed after the fact...

CD: ...He didn't take an ANAM test because that was something that we screamed about—they had no...pre-test to find out if there had been changes. He wasn't actually blown up, but he was exposed to over 300 IED blasts, specifically the blast pressure wave. And he was also in a tank roll-over in training, between his first and second tour. He didn't get any TBI screenings after those incidents, unless they did one at the hospital after the tank roll-over.

Yes, he has experienced all those symptoms [of TBI]. They've completely changed his whole personal life and work, and even his personality. What type of treatment? We did it ourselves, because we couldn't get help from the VA, and he was already

out of the Army. And yes, many other soldiers we know have been affected by TBI, but most of them were out too, and part of the support network that we were involved in.

...In about 2000, was when sexual harassment became the huge thing in the military. When I was a private and PFC and a specialist, it was supposed to be annual training. We went through it like six times in two years. Because they changed all the rules—before I came in, the rules were basically, “Sexual harassment doesn’t exist, we’re not gonna deal with it.” Which obviously went well.

The sexual harassment then switched, because of stuff that was happening up in Washington, with Clarence Thomas, and a bunch of other things going on in the country. They changed the rules on sexual harassment, and it actually switched too far the other way. To where, basically, all the woman had to say was she was harassed, and the guy was screwed. It was her word against his, and her word was going to win... He could lose rank, get kicked out of the Army, get thrown in jail. In a heartbeat, just because she said so. No evidence was required.

...And then about three or four years later, they went back and said, “You know what? This is bullshit.” And actually, at this point now, it’s more evened out to where the woman has to provide evidence that she’s actually being sexually harassed, not just her word. Because there were an awful lot of people that were like, “Well, I’ll just scream sexual harassment.”

Editor’s Note: The conversation turned to Allen’s discharge from the Army, and looking ahead at what could be done to protect soldier well-being.

CD: His outpatient purposefully left any question that could have required him to be Med Boarded blank.

Because of [my] unique situation—I was stop-lossed and my unit was moving. So there was legally nowhere they could put me except out immediately. If I had answered “Yes,” and they’d actually put it down, they would have had to keep me in. Which means they’d have to PCS somebody who’s already stop-lossed. Or switch me to another unit, already stop-lossed. And since neither can legally happen, because I’m stop-lossed, there was really nothing they could do for it... And I was past the re-enlistment window. I couldn’t even re-enlist. Stop-loss actually extends before your actual ETS date. But once you’re passed your ETS date, you can’t re-enlist... The best they could have done was hospitalize me.

CD: Yeah, they said, basically, “We can look at you for Med Board, but then you’re gonna have to go with your unit, and then another stop-loss is gonna come down. So you’re gonna miss your chance to ETS, with the possibility of being Med Boarded. But because another stop-loss will come down, if you’re not Med Boarded, you’re going back [to Iraq].”

And I would’ve been looking at the unit in question. If I had stayed with them, less than a year and a half after I got out, they were back in Iraq. With new tanks, but they were back there.

[To protect soldier well-being] for the active guys, you're gonna need a lot more mental health professionals, in uniform, deploying with them, embedded with the units.

CD: And you're gonna need, honestly, a lot more troops than you think you need, in general, so that they can have the off-time to go see them.

Like, when they do the surges overseas and double the troop concentration for a few months. You're gonna need to send in twice as many troops as you think you need, because half of them are gonna be hopefully seeking that medical care. And they may only be out of the loop for two or three days. Or maybe a week or two at the outside, and then they are good enough to go back out on the route. And that's fine. But for that couple of weeks, they're gone. So, a lot more mental health people, and more down-time for the troops. I'm talking like, R&R trips.

When we were in Iraq, supposedly you could go down to Dubai or UAE, or whatever the hell base that was. But you only get one R&R leave per tour. Supposedly there's a policy in my company now that if I'm deployed or away from home for more than 45 days, I'm supposed to get a weekend home. If you have the extra troops there on the ground, and you can afford to have the guy gone for a couple of days. Send him out of country for a couple of days.

Even if it's, you know, a weekend in Kuwait, where he can take off the flak vest, and not worry about a rocket or mortar landing. Where he knows for a fact that he's not gonna get blown up. I could come back to camp in Iraq, and take off my flak vest in my room, but I happen to know there's a bunker three feet outside my door, in case a round lands. I need to go to some place like Kuwait, where we take off our flak vest, and put it in the duffel bag, because we know we don't need it. Even if it's for 24 or 48 hours, it may be enough.

I would've killed for the chance to take off my vest and not mess with it—when we went on leave, you have to wear the flack vest all the way down to Kuwait, because you're flying over obviously hostile territory. But it was so nice to get down to Kuwait, and they have these big Connex inserts, where you stack your gear and tag it, and all this other shit, because you're not gonna take it back to the States with you. And it was so nice to take that flak vest off, and set it in there with your name on it, and go, “I don't have to fuck with this for two weeks. This is gonna be so nice.” But it was the only chance I got, over a full year. Two weeks, in a year? That I'm actually able to feel safe? It's not enough.

22 Reese Stewart*

Editor's Note: Reese* is a white active duty service-member at Fort Hood. As a team chief NCO in a combat arms unit, he currently sees many soldiers struggling both physically and psychologically, many of them very reluctant to seek any care. He spoke at length about a soldier in his unit who is suffering with mental health issues. The soldier has been deployed four times, is an NCO and served as the team chief of his unit prior to his instability. Reese respects him highly and shared that he has always been a top-notch soldier and a "genius at his job." However, even with this track record, Reese says his command is just trying to chapter the soldier out any way they can, without fully disclosing this to him. Reese has also deployed twice to Iraq. He has a foot condition for which he has occasionally been on profile. Reese describes times when he was made to take Record PT tests while on profile, and testifies to the culture of stigma which keeps soldiers at Fort Hood from standing up for their health care needs.

I'm from Texas. Job market was going down in San Antonio and I decided, "Hey, why not join the Army?" I joined when I was 25, so kind of late in the game. It was pretty tough. Being old enough to know better and getting yelled at like I was a kid was a pretty drastic change.

[I wanted] a solid routine. We're always going to be doing PT, okay, cool, always gonna get a paycheck. Don't really know where I'm gonna be at, but at least I'll know my family's taken care of if anything happens.

If I'm hurt, I'll go, if I'm not, I won't. But I've had soldiers who you could really tell that there was something bugging them, and they didn't want to go seek help, because they thought it's gonna make them seem crazy, or less of a person, for getting that kind of help.

We do have one soldier that was handed to me, who actually went to seek help, and he got the help that he was needing. But now they're looking at trying to chapter him out because of the help that he had to get, and the things that happened to make him finally turn around and say, "Hey, I need help."

He was a Team Chief in our section, and his performance started going down. I wasn't really tracking who he was, I just knew he's a specialist over here. [The guy who] was running that show, section sergeant, was E-5, a friend of mine. He was telling me something's not right with this guy. Before deployment it wasn't really too bad. The guy went on his fourth deployment with us, and he was doing his jobs real good. But some things were slipping, like his counselings were

not getting done on time, and he was getting wiggled out by the sirens really bad. They ended up yanking him off his team, took his Team Chief spot away. And then he thought, “Hey, I’m not a Team Chief anymore, so I might as well just be a shitbag.” So, that’s what he went through, and when we came back [home], he was on several different medications for sleeping, because he couldn’t sleep very well. He had a bad back, and he aggravated it while we were deployed. It was a bunch of different issues.

He hasn’t really opened up to me on everything, but what he has opened up to me about, I’m not at liberty to really talk about. Some of the things that he’s seen, he was having trouble dealing with those, and he finally talked to his Team Chief, which was our section sergeant, and he finally said, “Hey, I need help.” They took him to the Emergency Room and got him admitted, and he ended up going for about 45 days, getting counseling, and getting his meds straight.

When he came back he was doing pretty good, after his meds were all good, and he wasn’t sleeping at work or zombified, here but not here... Now he’s trying to get his stuff straight. He got command referred,²¹⁵ because the command wasn’t happy that we couldn’t find anything else out about why he is the way he is. Actually, last week I had to go and find out from one of his doctors if we could chapter him for any of his counseling that he was getting. The doctor they had him go to, however, was a biofeedback specialist, and they only teach relaxation exercises.

They had him go to that [civilian] doctor, but his escort fell asleep and didn’t ask the questions that they wanted, so it was pushed back on me to go and find out what’s going on, because right now I’m the acting section sergeant. The idea was, “Hey, we need to find out if we can go ahead and start getting him out because of whatever.”

I walked in there and said, “Look, I need to find this out.” And they said, “We only teach relaxation exercises.” So my command’s not happy about not having a good answer, but he knows his job really well. Getting rid of him because he’s got an issue is not really the right way to go, is how I see it. So I’m kind of pissed off about that. He’s an ace, a friggin’ genius at his job.

I’m not privy to all the information that [command] has gotten, but from what the doctors were saying in Denton—one doctor was saying, “Oh, he’s got an alcohol problem.” Well, this guy doesn’t have an alcohol problem. He was just on pills so much that he was not really coherent most of the day. But they said he had an alcohol problem because he had a drink with his pills, once or twice. Okay. Crap happens, sometimes you pop a pill, you don’t think about it, have a beer. But they said he had an alcohol problem. He’s adamant that he doesn’t. People that are around him that I’ve talked to say he doesn’t have an alcohol problem.

But that’s what the doctor was saying, so they command referred him to ASAP, and they said, “I don’t know what the hell’s going on. Why are you here? Why are you wasting my time?” ...At the emergency room I believe [he saw] a medical doctor, and then a psychiatrist, and then up in Denton it was mostly psychiatrists up there.

The only things I’ve talked to him about was why he went, and he was telling me he saw bodies, he saw kids getting shot, or he saw pieces of people. And I understand that would freak somebody out, cause some scars. But like everything, time heals, so usually, everybody thinks, “Oh, I won’t think about it for a while, or whatever, it’ll go away.”

That's what he tried to do. And that's not working, so then he actually went and got help for it. Not to mention the strain of change of command or change of responsibilities. We got a new first sergeant who's quite a bit more strict than our last one, which pushed a lot of buttons, and it's still pushing buttons.

...He doesn't really know that they're trying to chapter him. When he came back, I was his only piece of leadership that they gave him, because our second sergeant had been on leave for a couple weeks. And then he actually talked to me and told me what was going on. He said, "It's too much, I can't be here, I need to go somewhere." So we take him out. Take him somewhere, get him away from everybody, take him to R&R, take him over there.

Since our second sergeant came back I've been out of the loop on a bunch of stuff. I do know he's had marriage problems. He's got kids that he's not allowed to see, which probably adds to a lot of crap. He's having financial issues. He doesn't really have a place to stay because his wife left, but he's still getting paid as being married, so he can't stay in the barracks. So he's living with other people off and on. Can't afford gas right now so he's carpooling with somebody. He's taking it pretty hard. He came to me and said, "Hey, I feel like I'm under the microscope. I feel like they're trying to push me out the door." But he doesn't have anything solid.

He's been late 12 times, so they're trying to Article 15 him for that, and then they're gonna try and chapter him on Patterned Misconduct or something. So I thought, "Okay." But then he came to me the other day and said, "I think they're gonna try and chapter me for being late so many times, but I've got a profile for sleeping." And I never knew it.

He didn't know either. But he went to a doctor and found out that actually he's got a profile for oversleeping. I was like, "Oh, that's weird. I've never heard of it, but whatever. If you can provide that profile, then you should be in the clear."

Editor's Note: Reese went on to clarify that his soldier's profile was from a medical doctor, but he did not know who, because the doctor had not informed the soldier he was being put on profile at the time.

...Right now, they're going through a whole thing where profiles that you get are pushed into the system, and you can log in and print out your profile, but I know a lot of doctors aren't giving actual physical profiles out. They're putting it on the soldier to go out and print it out and give a copy, which is weird.

I know a couple other people that have a profile but can't print it out. So they're like, "Where do I print it out?" And they were given a list, how to log in and print it out, but then they can't. And then they're having to run when they're not supposed to run, or lift when they're not supposed to lift.

[These are soldiers] in my unit. Because I get soldiers, "Hey sergeant, I've got a profile, but I can't get to it." Well, if you don't have it on you, it doesn't exist according to our command, so if it's not on you, then you don't have it. So find a way to log in and get it. Otherwise you're going to be doing what the command wants. I know when I went through [myself] only a few months ago, they said, "Here's your profile. We're gonna put it into the system. Thank you." And I went back

and I made several copies of it, so if I lost it I always had another one. But they apparently do not hand them out anymore.

I know I was in there in April of this year, and I got a hard copy of the profile, so some time after April, [is when it started to change].

Mine was no running, no jumping, walk at own pace and distance. I have plantar fasciitis, so it's bad for running.

So they said, "Okay, one month, no run, no jump." And then, "Hey, you've got a PT test."

I was like, "You can't do that." And my platoon sergeant, while I was sitting there, after my pushups and sit-ups, and I was getting ready to go do the run, they said, "No, you go stand over there and make sure people don't cut the corner." So I wasn't able to finish. Then I got flagged for PT failure. Okay, cool. They always had a copy of my profile, and I said, "Look, I can walk, but that's it." And on a temporary profile you can't take a Record PT test.²¹⁶

...The next month I was on profile recovery, and came up on another PT test. And I said, "Okay, fine, cool." I went and did it, and I finished it. I did all three events, and I ran in, and it was all good. I said, "Hey look, I passed." That was in May.

I failed [the one before]. It was a flag stating that I was a PT failure and I would have no positive actions, that anything good that came along, I wasn't gonna get. So they did that, and then the next month, I passed, because I saw it on the DTMS.²¹⁷ It's a little thing that pops up in your AKO²¹⁸ that says all the trainings you've done, and it told me I was a PT failure, and I thought, "Wow, that sucks." I checked my promotion point worksheet through HRC,²¹⁹ and they said, "Nope. PT failure." So I was like, "Okay, so I'm not promotable now because I'm a PT failure."

Editor's Note: Reese clarified that his profile was setting work restrictions pursuant to his plantar fascia.

It got aggravated during a run, and I had to sprint to catch up, and then I hurt myself. The ankle popped, and I went in. And I didn't go in for the plantar fasciitis in the first place. But when I told them what the symptoms were on the one foot, and what happened on the other foot, they said, "Here's a brace for the one foot, and here's a one month profile for the other foot." And I said, "Oh, wow, okay." But everything straightened itself out.

Editor's Note: Reese testified that he did not receive a medical evaluation before his month-long profile ended. The profile simply ended and was supposed to be replaced by 'profile recovery,' although with no paper profile documenting the specifics of that. The only treatment he received was what he had outlined thus far.

...It just expired. It expired and I went on profile recovery, which is supposed to be two times the profile length, where you're supposed to just walk it, or try and run a little bit. They gave me inserts for my shoes, but that doesn't really do anything.

I just had my profile that ended on a certain day, and they said, "Okay, you got two months." But that never happened. They just said, "Hey, PT test." Okay. Cool. Let's go.

I said, "I'm on profile recovery, but I'm gonna take it because I know they're gonna take my score either way, so it doesn't really matter." I just bit the bullet and did it. There wasn't much to it. I said, "I don't want to be flagged anymore," and had awards coming that I should have gotten, so I wanted to make sure I was straight.

Editor's Note: When asked, Reese said that taking this PT test definitely put him at risk of re-injury.

Because I didn't think it was 100%. It's probably still not 100%, but if it starts aggravating again, then I'll just go back and get it checked out again. See if they can do anything else.

But I've been in nine years, and I'm used to it.

There's a female [in my unit] that has the same profile I have, running at own pace and distance. She falls out with the rest of the profiles and does her profile walk. Guys that can't lift, can't do anything. One of my soldiers is on profile for a torn rotator cuff, and his surgery is scheduled next week, so I've got him not trying to do anything that will aggravate it. But you tell him, "Hey, no pull ups," and then he's over there trying to do pull ups. It's like, "No man, stop. I'm not gonna be the one that gets hammered if you hurt yourself any worse, so just stop."

Another guy has a chest muscle that he pulled, and we get pretty good leeway, when it's PT time. The platoon goes, and they do their own thing. We're not under the first sergeant's eye all the time, but when we are, they ask, "Why are these guys standing over here? Why are they just stretching?" "Well, he's on profile, he's on profile." "Well, they need to be doing something." So do abs, or do sit-ups. Or do the dying cockroach, just put your arms and legs up in the air." They can't do anything else. We try and keep everybody that's on profile covered.

Since I've been in, there's a stigma with being on profile. It's that you're a shitbag. You don't want to do the work, so you're gonna go get on profile, and sham out of doing anything. But I've noticed a lot of our guys, they say, "Hey, I don't want to be a shitbag. I don't want to be called a shitbag, so I know I'm on profile and I'm getting looked at, but I'm still gonna do the work." And we say, "No man, you can't do that." It's not that we don't need the help, which we do, because we've got 15 people, at least, on profile.

So I say, "You can't lift. You can't run, but can you lift?" "Yeah." "Okay, cool. Help me." But they say, "No man, we got it." Alright, cool. I'm not looking. You go and do the work, but I'm not gonna look. Job gets done. It's not the right thing to do, I don't think, but job's gotta get done one way or the other.

It's not right to have them on profile and actually do the job, even though they think they can. But it's not right to have them out there lifting and picking up the 300, 400lb things that we have to pick up and move. Here's the job. I'm gonna go over here, make it happen. Roger. Moving on. Job's done. I come back and say, "Okay. I know y'all lifted and you're not supposed to, but I figure if they've got enough people to help lift, then it shouldn't be too much of a strain." And one guy with a bad shoulder, he's got a good shoulder on the other side, so he can lift with that one, so he did. But I just don't like doing that.

Editor's Note: The conversation turned to the Fort Hood policies on profile violation and stigma. Reese testified that he did not think most soldiers in his unit were aware of MEDCEN-01 or SURG-01. He also stated he had never been briefed on either policy.

If it's not posted up in the company, on our bulletin boards, they're probably not aware of anything.

I just read the handout that I was given three months ago from [Under the Hood]. I thought, "Wow, that's pretty good." It's in my leader's book, actually. To somebody with a profile, I say, "Hey, take a read of this."

My guys, I've showed them. The other guys in the section, I haven't showed them yet.

[My first sergeant] is pretty adamant that if you don't have it on you, it doesn't count. Even if he knows a guy is broke, limping around, if he doesn't have his profile on the giant run day, if it's not on him, he's gonna be out there running with us, whether the first sergeant knows that he's got a profile or not. That's the only thing. He's pretty strict on, "Have it on you. If you don't want to do it, have it on you."

I don't think [the printing issue] has been brought up to him. Everything is dealt with to try to keep it at the lowest level, fix it before it goes up that high.

Or he'll tell them to go back to the TMC²²⁰ and get and print one out so you can have one, which is the answer I've been giving to most of my people. And if you can't get it, go back and tell them, "Hey, I can't get it. Can you help me?" If they can't, then I don't know what to tell you.

Editor's Note: Reese went on to describe what could be done to enforce these policies at Fort Hood.

...Like anything, it'd have to be put out by higher. The only time we get to do anything, or get told not to do anything, is because they actually come out and they say, "Hey, don't do this," or, "Hey, go by this." General Campbell, or especially Sergeant Major Coleman, he gets a bone and starts tearing it up, and it's what happens.

We've had a couple of deaths in our unit already this year. Three, I think. They were actually motorcycle deaths, and because we've had so many of those, he's gotten up in our kool aid a lot more about, "I want to know this, I want to know that," talking about putting restrictions on. Like a curfew for motorcycle riding, so if he gets wind of something, or is told to put something out, he might actually do it, which would actually put it down to our first sergeant, and make us have to do it.

The only thing that I noticed that they really cared about was when the rumor was going around that Sergeant Major Coleman had a DUI. They blasted out on their Facebook with General Campbell saying, "No, this didn't happen." Somebody starts a rumor, and you come out and squash it really hard. Maybe something like that. Blasting it on the Facebook, blasting it on whatever comment site they have for the PA, the Public Affairs officer. I worked in that area for a while. In their meetings, they are going to say, "Hey sir, this is what's going on. We should probably talk about this." "Okay, cool." Their news people, inside Corps. That might work.

There has been a person [in my unit] that was hurt, but didn't go to get any help because of thinking, "I don't want to be a shitbag. I'm just gonna do my job. Look, boss, this is what's going on. If you can just spare me some leeway, so I can get some recovery on my own, it should be good." And a lot of times, it works out, for me anyways. If somebody's hurting, we try and make sure they go and see somebody. And if they won't, then that's on them. We can't really say, "Hey, you're hobbling around. Go." That was actually done to me by my first sergeant. In our runs, I was hobbling too bad, and I made the formation look like crap, so he said, "You're going to sick call." "Roger. Got it."

But as far as actually saying, "Hey, you should probably go get it checked out." "Roger, sir. I'm good, I'm good. No, no problems." And they're still struggling. That's up on the person themselves. We can't really say, "Hey, go. Go get checked out." But we will if we see somebody hurting, we'll advise them strongly to go. Probably order them to go, I'm not sure.

...The thing I hear most from other people is, "I don't want to be like so-and-so, who's riding their profile for..." Somebody hurt their back, and back profiles are really tricky. Back injuries are tricky in themselves, but you can't really tell if somebody's faking, so they'll go get a back profile. "Oh, I can't lift. I can't walk. I can't run. I can't do this. I can't do that. I can't wear my gear. I can't wear a helmet." "What the hell can you do, man?" "Nothing, sergeant." Okay, then go in the corner. Blink in cadence, do something. But a lot of soldiers, they don't want to look like that guy over there that's, "One, two, three, one, two, three." It looks stupid. It is stupid, but you can't do anything if you're on a dead man profile.

...I've thought about how do we get more people to actually say, "Hey, I know this is gonna sound like crap, but I need to go [get help]." ...I can see it. Lots of my buddies can see it. But we're pretty lenient with it. We say, "Hey man, there's no harm in going to get your back, your leg, your head, whatever, to go get it checked out." But it's still there, everybody still jokes about it, no matter what it is. "Oh, look, your knee's jacked up, you're spending too much time on it."

The Army's always gonna be full of jokers. It's not gonna change, probably not even if there was a disciplinary action for it. It's like the Don't Ask, Don't Tell thing. "Oh, my God, now We're gonna have gays in the military, or they can actually say, 'I'm gay.'" Who cares, man? Who really cares? I don't care. But there's still the jokes. People are gonna see things the way they want to see them.

You can try and open it up and say, "Hey, you can go do this if you need to. There's not gonna be any repercussions for it, no one's gonna think differently of you." And there's still gonna be your handful of people that do it. So, I wouldn't know how to change anybody's mind...

I know that when people come to me, and they say, "Hey, I've just had it, I've tried everything I know, I don't know what else to do." Then I say, "Hey man. Check this out. Did you know that they have this? They've got the resiliency campus. I've got this brochure here. Check it out." They say, "Oh wow, cool. I think I'll go and try that." I don't hear anything back from them. It's not that I push it, but I'm so busy, I really don't remember who asked for anything, or who said they were gonna go somewhere. If it's not on paper, and I haven't made a note of it, I don't remember who went anywhere. So as far as making somebody try and find their point, it's all up to the person.

...I know a lot of guys who have our slight PTSD. And everybody does. Slight—it's certain things. Loud noises. Since we've been back, since November, I've gotten a lot better, and I can't believe that used to bug me. Like, dump trucks: on the first deployment, bad ju-ju. I've gotten a lot better now. I can deal with being next to a dump truck and not freak out. Other people I've talked to, especially 4th of July, just yesterday sitting out in my backyard. Pop pop! Then, pop pop pop pop! The initial [snaps] is like, "Oh God!" Unless it was right outside my gate, and then I would be looking, "Who's doing that?" Grab my gun and chase them down.

But there's a lot of people that claim PTSD but don't have it, or don't have it as bad as they say they do. And there's people that don't claim they have it at all, and you can tell, by just watching them any time of day that they've got it. But as far as them getting treatment, and how it's treated, I don't know.

Editor's Note: The conversation turned back to the soldier Reese is concerned about in his unit, and whether he felt he had the power to do anything to help him.

I'm just the Team Chief. Given the acting section sergeant title for a little bit, there's not really much I can say to anybody higher that's gonna change anything. I could talk to him and try and get him to see things a certain way, and see how the command sees him, so he can try and change a little bit, if he can change. I can't say whether he can or not. But that's the only benefit I got, is that soldiers actually look at me like, "Hey, you're a human. You talk to us like we're human. Can this happen?" But I actually get more people to get the job that we need done, and they all come to me, "Hey, sergeant, worried about this. Hey, what about this? Hey, can you help me with this? Can you give me an idea on this?" "Yeah, man, yeah."

I know it's a big issue and it's been hammered into us that, "You gotta watch people, you gotta watch your butt, you gotta watch your soldier, you gotta watch this, you gotta watch that, you gotta watch your spouse." Okay, got it. So a lot of us, we still joke about it, but we still do it, because it's been put down to us that, "Hey, this is your job. You watch out, you take care of these kids." Okay, cool. If I don't see something, and somebody else sees something, and they bring it to me, then alright, cool, I didn't notice. Thanks. I'll keep an eye on it.

And that happens more times than not that somebody says, "Hey sergeant, he's being pretty anal over here." We gotta go check him out. We talk to him. Find out this guy's grandpa died two days ago and he's stuck here. He's about to start clearing, so he can't really leave to come back, so he's just a depressed kid. So we do what we can to help him, and try and fix things. Can't really fix things with a dead relative, but we try and make him as happy as possible. That's on and off duty. I've had guys come over to the house. Hey, let's cook. You know, We're gonna have burgers, dogs, We're gonna watch a movie. We're gonna go to the range. A lot of my buddies, a lot of soldiers at work love to go and just shoot. It's awesome. Yeah. Steel. Target. "Pow! Pow!" It's fun.

...Ever since I came in, I've been married, so I haven't been into the barracks and been with the guys a lot, but I know there's rarely NCOs that come in and say, "Hey, what'cha doing?" It's been mandated to us that we're gonna go, every weekend we're gonna find out what our soldiers are doing that weekend, what they plan on doing. But when it's mandated down to you, and you

don't do it, and you don't make it seem genuine, it's just yeah whatever, "Man, We're gonna go do this." Okay, cool.

Come around the next Monday and you're like, so how was this? "Oh, we didn't do that. We went and got drunk in Austin." Dude, I asked you what you were gonna do. They say, "Oh well, we had a plan for this and..." You're feeding me bullshit. I want what you're really gonna do. A lot of guys care, a lot of guys don't. But it's just how you interact with the soldier, and I've got a lot of soldiers out here that don't care. Like, "Here, take my pistol. Go over there, and end it. Because I don't want to see you any more."

I don't tell them that. I did once. He didn't. But the real bad soldiers, the ones that don't give a crap about being in the Army, you get the, "I don't give a crap about you because you don't give a crap about me or your job, so you go over here." That happens a lot. But still you talk to them. Like, "Hey, what are you doing?" "Okay, cool." "How's life?" "Yeah, that's good." You could tell I really couldn't care less. But check the box. And if that's what they give off to their NCOs, their NCOs gonna give it right back to them. So they have to change their attitude towards the work, then their NCO will change attitude towards them and actually probably give concern about what's going on. Instead of being mandated to, "Care about your soldier. Talk to them. Find out what's going on. Hug him."

Editor's Note: Reese also spoke about his experience in SRP over the course of his deployments.

The first time was in Germany. It wasn't the easiest or most pleasant thing to do. It was, "Everybody get over here, get your shots." "Alright, you done over here? Go over here and get your gear." Okay. We got our gear. "Now sit here and wait, and make sure all this paper is done." Okay.

Here it's the same way. Except it's more confined, and it's all done in one day, basically. It's not reinventing the wheel, they just got it more consolidated. Two, three days, then you're done. Questions they ask, through SRP and Reverse-SRP, is basically the same things. They ask, "Did you have any accidents or incidents or injuries while you were there?" No. "Okay. How close were you to any mortar blast? Or rocket blast?" Too damn close. Well, I'm not gonna say that, because I want to get out of SRP, because I've been sitting in here for 3 hours, so I'm gonna be like, "Hey, I'm good. I dip a lot. I drink a lot. I smoke a lot." "You want help?" "Nope." "Okay." "Bye."

I don't really know [who I saw in SRP]. It was some colonel. Coming through on the Reverse-SRP, there was this lieutenant colonel. She asked me questions... No, that was the 90 days after she asked me about my drinking and my smoking and my dipping, and whatever. "No." Asked me about blasts. "Nope, I'm good. I got back."

I'd hurt my back while we were down there, so they gave me Flexeril.²²¹ But the guy that checked me in for the first Reverse-SRP said, "It says here that you were given Flexeril." "Yup. Hurt my back." "Still hurt?" "Yup." "Let me write you a prescription." "Cool. Thanks." I've still got them. They make me stupid. I only take them on worst case scenarios. But I haven't seen a doctor about my back in a year now.

But, the process is you tell a doctor what they want to hear. So you get out of there, because you don't want to be there. Which is not really the best thing. I think it's because you're herded in a

line throughout the entire thing. You get sent in front of a doctor, which you finally get to see, or a counselor, or whatever they're called, after waiting for two and a half hours in a stance, making your cycle. All you want to do is get out because it's already two o'clock. I've missed lunch. I just want to get done. So you tell them what they want to hear. I don't know if making it a more one-on-one process, which is not the only way, would be better. Then people would actually say, "Hey, yeah, doc, this rocket blew up, right there, man. And it freaked me out." Or, whatever the case is, they'd actually feel a bit more honest, instead of, "Okay, I'm here, check the box, check the box, check the box." The SRP process sucks.

I don't know who [the SRP providers] were. But I never brought up any issues. They never wrote any kind of issue down. So it's, "Whoosh," out the other end.

Since we came, and before we left, they gave us the cognitive test, whatever that is. Sit there at the computer and click buttons. Before I came in, I was a bull-rider, so I'd already had a lot of concussions. So it really didn't make any difference to me, but I scored the same as guys that were fresh out of high school.

Editor's Note: Reese confirmed that the test he had received was the ANAM, which he was tested with before his second deployment. He was never given a post-test.

When I got to Fort Benning after my first deployment, anybody 26 and over had to go to a TBI class, and then we fill out the questionnaire. Then you sit there and you do little computer clicks. And the math problem. Still, I thought it was kind of funny. I suck at math anyway. So I take a while to answer the questions, and there is no change between my first one and my second one. But if we did it afterwards, I don't know how that would have been—because we didn't do the little clicky-clicky afterwards.

[TBI testing] was just during in-processing, when we first got there, to the base itself. You had all your people that had to go through all the in-processing briefings, and then if you're 26 and over, you're going over here. So they made all of us old people got in formation, went over there, did our thing, and went back, and completed in-processing.

We've also had to do [a TBI training] on a computer. It gives you a certificate. Can't remember what it was, but we had to sit, and we had to log in, and do this training, that we know what it looks like, we know how to treat it. That we know that we need to get them to a doctor if certain things have happened. We all go through, and we click the thing, get the test, print out our certificates, return to the platoon, and they're like, "Alright, cool, you're good to go." At least in my unit, I know everybody had to go and do it. That's the only real training we've had.

July 5th of last year, we had a massive amount of rockets hit our file. I think it was 17 in total. They actually caught some that were still on rails. It would have been worse. The one that almost took us out was within 50 feet. But we were inside a building. It wasn't really a hardened building. It was like an adobe. But we had a generator and a T-wall. It hit at the base of the T-wall that was separating our place and another place. It was actually concrete reinforced. Everything in our shack, the door swung open, the shrapnel hit the door, things fell off the walls and all the dust that was in the ceiling rafters just decided to come down. That was pretty awesome. Scared shitless, but it was pretty intense.

I got run over, actually, by a soldier coming in after the alarm started going off. The guy stepped on my ankle and just ran right for the stairs. Luckily I was in boots, so it didn't really hurt. But yeah, we had ten people on duty that night. We had eight people on duty, but two others were there to play X-Box with us, so that was the worst night we had. That was as close as I got to a blast.

Editor's Note: Reese clarified that he did not think he had a brain injury from that blast exposure.

Probably not. We were pretty insulated from any blast. It's not like being there at ground zero, with the pressure. There was something to push the pressure away from us. The only thing that happened was, like I said, a door swung open, crap falls down from the rafters, and things fell off the wall. But still, it was really close, you could smell that smell really bad. That blast was really bad. Everything went out the window.

...My wife might be able to tell you [if I have any symptoms], but irritability, yeah, I think so. Forgetfulness, definitely. If I don't write it down, I forget anything... For short term, definitely.

Me and a buddy, we were talking about something, and he said, "My give-a-fuck is busted." ...I was like, "Man, I'm the same way since we got back, it's just been blah." And he was like, "Yeah, man. It's right on." So we started hanging out more because we could associate with each other better, and we've both gotten a lot better as far as I can tell, but it's still just, "Hey man, this is whatever." And it's like, "Yeah."

Personal life, probably [has been affected]. I know I wasn't the easiest person to get along with when I first got back, but thankfully, the unit did send me on a marriage retreat, and we were actually able to talk and do a bunch of stuff that. Sitting down and talking was the main thing, like, "Hey, look, I just went through this." "Okay." "I've been through this, this and this. This is why I'm like this." And once it's understood, then it's, "Oh, okay, cool." Or, "Now I know where you're coming from." The thing just kind of went from butting heads to meshing really good. It was weird.

Editor's Note: Reese also knew of suicides and high-risk behavior at Fort Hood, and shared his reflections on the effects of multiple deployments.

I think there was a guy that tried to kill himself in another company. I don't know who he was. This most recent guy rode his motorcycle without all his protective gear. And that's pretty stupid, pretty suicidal, if you ask me. But as far as actual suicide attempts, no. People talk about it. People joke about it, but nobody that I know has actually tried. Some of our soldiers have had family members that did commit suicide, but those people don't really joke about it that much with the rest of us. If they bring it up, "Oh, my aunt committed suicide," or, "my brother or sister," then we say, "Okay, man. Sorry." We'll go joke about it over here, but we're still gonna joke about it.

I know guys that were [deployed] back to back. You go in, you come back, maybe not even for a whole year. Then you turn around and go back again. I know that wore on them. It wore on their families. They divorced, actually, over it. She cheated, he cheated. Split. I know some people that, it was just one deployment, and she cheated, and he said, "I hate your face. See ya."

But multiple deployments, definitely. Morale really sucks. Like, “Oh my God, I’ve been here before, and I’m gonna be back.” Especially if you’re going to the same place. I’ve been to Iraq twice. I know people that have been there four times. I was kind of pissed off, because I wanted to go to Afghanistan. Get the other ribbon. People aren’t very happy to keep having to go back and do it over and over. It’s not a happy thing to be doing anyways. But at least you get paid for it.

...It’s mandatory we get [MST training] every quarter, or something like that. It’s about the same as everything else in the Army. We make jokes about it, and I think that now they’re doing an actual play. They get people to come out and do acting things, and they go out and show us the wrong answer, and they show us the right answer, and they get help from the audience to find out what the right answer would be, and those are pretty good. Pretty helpful. Because it gets people actually talking about it, not being afraid of it. Afraid to speak against it if it happens. And not to commit it... Those are pretty helpful.

I know [soldiers] that have claimed assault and rape, but none that has ever been substantiated. So, nobody really knows. So I just...one ear and out the other.

They went through all the process to say, “I was raped by this person.” And they get people to try and back up their story, and the person that they’re trying to get to back up the story is like, “That’s not the way I remember it. I remember you were drunk as hell and you were like, hey.” But as far as what actually happened, I don’t know. The person that talked to me about it couldn’t really give a straight answer, because there was too much alcohol involved.

Editor’s Note: In wrapping up the interview, Reese shared his reflections on what kinds of care his soldier needs.

I think he needs to continue his counseling, definitely. He’s got a group session that he goes to every week, at least once a week. He’s getting that over at the R&R Center. He’s still got his ASAP appointments to make, and he does that every week. He needs to keep doing that, definitely, because he’s shown to be a lot better, especially coming out of group. When he comes out, he’s easier to be around, he’s a little bit more smiley. Just from my standpoint, the dude is really good at what he does. As an NCO, I’d hate to lose him from a team. But if he’s gonna be not fully there, then he can be a genius at what he does and he can still hinder the team. So I’d rather have somebody who’s got their head in the game instead of halfway out.

But I don’t know if he wants to stay in. If giving him what he wants would be the best thing, or getting him out so he can spend more time getting help. But then he’s gonna have no money, so he might not go. So I really don’t know. But personally I think he needs to keep getting the help. And stay in the Army. He can, for one, keep getting the help, and for two, so we can keep people learning from him. That way helps us more.

23 Shauna Dione*

Editor's Note: Shauna* is the spouse of an active duty service-member at Fort Hood. She is white, in her early twenties, and from the US South. At the time of her interview in 2012, her husband Jay* was currently on deployment in Kuwait, and was anticipating being medically retired after the deployment. Jay is from a small town in Texas and enlisted in 2006, serving in an Infantry unit. He had already been on two deployments to Iraq prior to his current tour, and continued to struggle with post-traumatic stress and a possible TBI which remained undiagnosed at the time of the interview.

I wasn't a big fan of the military, I never have been, but I really liked Jay* and when we first started dating he said, "It's okay, I only have like, a few more months of this and then I'll be out and then we can do whatever." He said in May that he was gonna be out in November. And once we started seeing each other, it turns out that it wasn't that November, he would get out in a year. Like, next November. And then, I think it was once I moved in with him, it was somewhere along the lines that he still had 2 years and some-odd months. After we'd gotten serious and probably after we'd gotten married he told me, "Okay, well, I have two and a half years. Instead of just a few more months." So I was pretty much tricked into it.

I was like, "Whoa-whoa-whoa-whoa." I can handle a few months of like, I'm gonna be gone and then I can do whatever. But no, he was just like, "This is what I have."

I don't know what his hopes or expectations were [in enlisting]. I don't think he really had a plan of what he was gonna do after high school... I'm not sure what he thought the military was gonna be. It was just like a job to him.

He grew up in this tiny little town. And it was that stereotypical thing, he played football, he was from a small town, and his older brother had joined the military and was probably telling him all sorts of good things. So he's like, "Oh, well, I guess I'll just join the military too."

I've talked to him about different screenings and stuff like that. He said that it really wasn't anything. Like, it was basically check off a box.

Editor's Note: Shauna was asked if she, as a military spouse, had received any training or briefing on the warning signs of PTSD or TBI.

Absolutely not. I've received nothing.

If [Jay's unit] did they probably didn't really give a shit. Because there's a certain mentality in the military, but there's especially a certain mentality in infantry and special forces. All the other military they're like, "Hoo-ah, I'm a badass." But in infantry and special forces they're even more like, just rub some dirt on it and move on. They're even worse about it so they just don't talk about it, they don't deal with it.

There's really a stigma of 'broke dick' stuff. That was the first time I've ever encountered it was at Fort Hood. We were at Ben's,* the medic, for a barbecue, it was right after Jay went AWOL and had to go back...right after we moved down to Fort Hood.

One of the neighbors came over and he had some kind of leg injury but he was still current military. And he's like, "Don't worry, I'm not a broke dick. I actually have a legitimate injury." And I was just like, "What the hell is a broke dick?" And apparently a broke dick is someone who has sustained some kind of injury, but they're too much of a wimp to actually get over it, they use it as a crutch, they're like, "Oh no, I have a profile. Oh, poor me." They call them 'broke dicks.'

[The stigma comes from] the military itself. The military literally cannot sustain itself if the soldiers keep getting injured and being chaptered out, so they just encourage them to move on and just get over it, just be a man, just tough it out. You have to tough it out for the sake of the mission.

[Jay] doesn't really give a shit about the mission anymore, the military has worn him down enough that he doesn't give a shit about either one. He doesn't give a crap about the mission, but then if something happens, he gets injured, then he's not gonna do anything about it because he feels that nothing's going to be done about it. He's not gonna go to the doctor's 'cause they're just gonna be like, "Oh well, just have the ibuprofen and move on." It's just a waste of time to him.

There's just been too many times... I don't know any specific examples because Jay can't remember anything anymore, which is probably the result of a TBI that he got in his first deployment. But, they've just worn him down to the point, from what I feel, that he doesn't care about his job, at all, he doesn't care about the military, he doesn't even really care about politics, he just wants to be out and free.

...He doesn't talk about it. Jay is not a loquacious person, he does not talk. The only information I've gotten are from bits and pieces that he happens to remember over the past two years. Just random little bits. But he doesn't really remember much of anything.

Before we got married, I probably saw him for a total of two weeks in person. And then I went and saw him in October of the same year and that's when we got married, so I probably saw him for about a total of about two and a half weeks before we got married, and then he moved down to Fort Hood, that December and I moved down to Texas but I was in San Antonio. I moved in with him at Fort Hood, or Killeen, about six months after that, and that's when he went AWOL.

He just really hated the military, and he was like, "They're not gonna notice if I go missing, if I just don't show up, because they're stupid like that." And then once his mind frame was like, "I'll just

not go to work until someone notices and then I'll just start going again or whatever," whenever he first started, when he decided he was just going to skip a day, of course I didn't know anything about the military. I don't know how it works, I don't know accountability, so I just kinda let him do what he wanted to.

He was just gone for a couple days, and a couple days turned into a couple weeks, and a couple weeks turned into a couple months and then I became really uncomfortable with it. I got to a point where I was like, "You need to go to work, this isn't even ethical, who just stops going to their job and expects to get paid and stuff like that? That's just ludicrous." So I was pressuring him about that and then one day I got a knock on the door, he was probably an E-3 or an E-4, he's like, "Is Specialist Dione* here?" And I was like, "Yeah he's in the backyard." And Jay had this beard and long hair and he was just dirty and he was digging in the garden and he came inside and looked at the dude and the dude is like, "You need to get ready and report in an hour. You're in deep shit."

And then I didn't see him all day until 11 o'clock that night and I was scared shitless and I didn't get a phone call, I didn't know if they were gonna arrest him. I had no idea what the consequences would be, because I don't know anything about the military. And then he came home and he's like, "Oh everything's fine, you know, nothing's gonna happen." I think this was a Monday or a Tuesday but he had to ship out to the National Training Center in California, NTC, Friday, and he'd be gone for a month. So he had to get all of his stuff ready and he just left all of a sudden, for a month. And I didn't handle that well, because we had no money, I was alone, in Texas, where I literally had no friends to go to, there was no way for me to go out and do anything because we were broke. I just stayed inside all day, week after week, and I literally talked to no one, there were weeks where all I could do was talk to our dog.

It was rather traumatic. There were several times, or at least a couple times, where I called him up and I was just so angry at him. Plus, I wasn't on his insurance because once we got married in Alaska they told him that he would just have to do all that paperwork at Fort Hood since that was his next permanent station, and then he went AWOL, so I had no insurance, I had no medication for my depression, and I was alone in Texas with no money and no way to do anything. I was completely isolated.

He ended up calling me and I fucking snapped, I snapped on him, in the worst of all ways, like screaming, and I had a voice that not even my mom would recognize, it was ridiculous, just screaming at him because I was so angry. I'm still angry, I'm still angry, it's been over a year and I'm still angry at him for going AWOL and leaving me like that. And then, next thing I know I get a phone call, and he's trying to get out of NTC because I'm freaking out and then he tells a couple of people, he tells his Chaplain and I don't know what's going on exactly, but Jay tried to use my depression as a reason to get out of the military. He tried to use me as a scapegoat. He literally took advantage of my illness for his benefit of getting out.

He wanted to come be with me, but at the same time he wanted to get out more. All he saw was an opportunity to get out of the military. And, of course, he saw it as him getting out of the military and then us being together and living happily ever after. But, I just saw it as he wanted to get out

and he was going to use any means necessary, including taking advantage of me. Which I'm also angry about—still lugging it around.

I don't know what he could have done [differently]. I know that a lot of soldiers go AWOL and that's fine, they do it for really good reasons...

I feel like I'm the one who singlehandedly caught all of the shit from it, because after that they made us pay back every single cent that he got whenever he was AWOL. So, there were times where, I was sitting there, I had to go to a food pantry because we literally had no money. And who would I go to and be like, "Yeah, my husband fucked up, can you help me?" He was gone from five o'clock in the morning until midnight, so he was only even around for five hours between midnight and five. After they caught him [AWOL] they were like, "Okay, we're gonna punish you with an Article 15," they gave him 40 or 45 days of extra duty, which ends at midnight. And he still had to show up for PT the next morning.

...A lot of the military wives are scapegoated, where they say that's the reason why the military's so fucked up, because of the military wives... I've heard that the suicide rate isn't because of the mental health, it's because when soldiers come home they find out that their wives are cheating on them and they kill themselves. I hear that a lot.

I think...some of it [is true]. I think there's some women out there that, they make mistakes or do terrible things. You know, wait until the soldier's deployed and then end up taking the kids and all of his money and everything, and he comes back and he has absolutely nothing, after he's experienced all of this. I think that would definitely make someone commit suicide.

But at the same time, it's really hard being an army wife. It's really hard to put up with a lot of the shit we have to put up with from the military. And we don't get enough credit, I mean, especially for the ones that do try. There's a lot of military wives that are pieces of shit, but there's also a lot of military dudes that are pieces of shit. You never hear about the military members that can't keep it together, they have PTSD and TBI and they end up beating their wives and they drink too much and they spend all the money. And she's stuck there without having a partner, because her partner's fucked up, and then she's gotta take care of the kids, and she can't just leave, she can't just move. I mean, puts you in a hard situation. And then half the time he's not even around.

You've got these kids to take care of, you've got your husband to take care of, and then he's deployed, and he's gone, and you need a partner. You can't really blame them all that much for being like, "I have to hold up this entire household, I just want someone that I can lean on, just a little bit."

I don't know if there is anything that can be done, because nothing's gonna change the fact that you're separated from your partner and that you both miss each other. The military is all for, "Yeah, we appreciate the family," but the family's always second. It's always second place to the mission. And I mean, a marriage may suffer because you get a phone call once a week and that's all you get. And they're literally not around and they don't exist in your life. You can't really blame a relationship, you can't blame either person in a relationship for a relationship disappearing when

there literally is no relationship.

Editor's Note: The interviewer asked Shauna if she thought there were pressures on spouses to act as de facto mental health care providers.

Of course they are. The soldier's mental health is usually his responsibility, but if he can't remember to take care of any of his shit, then it's gonna be up to the wife. I think that war affects the soldier very much, I have no doubt about that. But I think it equally affects the family. Equally, because I could not even describe to you the pain in the wife's point of view or the child's point of view, when the soldier acts out. Like when he gets triggered, or just the irritability, the mood swings, all that kinda stuff. Yes, the soldier is angry but they're, in turn, taking their hurt and moving it to their family.

[The military] tries, they do their briefings every Friday, "Don't beat your dog, don't beat your wife, don't drink too much, whatever." But there's not really anything that can be done, when you're triggered, you're triggered. There's nothing you can do about it. I've been triggered before, and all you can do is just stand back and not get hit. That's really all you can do, is just let them work it out, and be there when they're done.

I have probably two Army wife friends, I wanna say. Jean* and Carrie.* Jean is at Fort Campbell, she's the wife of Drew*...Jay's best friend. I don't think Drew, Jean's husband, has a whole lot of problems. I think Jean would've said something. I think Carrie has had a little bit more problems, 'cause Brad* was deployed with Jay the first time. He was in the same company, but not the same unit. They didn't meet until after they had both gotten back. But from what I've gathered with Carrie, Brad has problems. From what I understand. But I mean, we haven't spent a whole lot of time talking about it.

I've had a really positive experience with the MFLCs. It stands for Military Family Life Consultant. I was fortunate enough that after Jay turned me in for my mental instability, trying to get out, we met up with an amazing, amazing woman. But she was basically a counselor. And I never could have picked a more wonderful woman to have as my counselor. She started counseling I think in the 80s, and she started with Vietnam veterans. And has worked with veterans since then, for probably over 30 years. So she was excellent.

But the only problem is, we were going to counseling with the MLFC lady for me, and I don't feel that that should've been the case. I definitely think we should've been going for Jay. Because I can go get help. I can go and do my own thing, and that's fine. 'Cause the only real problem was the fact that I didn't have any medication. I don't need counseling. I've been counseled for forever. But he's the one who's never really talked about any of his issues.

We were both going, we were going as a couple, and the problem is that, if we were going for him, that would've been a totally different issue. He would've gone to a different counselor, it wouldn't have been an MFLC lady. He probably would've gotten a lot of shit for it. Because he's not allowed to have any kind of mental illness. I can be crazy as fuck! I'm allowed to be crazy as fuck. For some reason, as a military wife, I'm supposed to be crazy as fuck. He is supposed to be

the sane one, with the crazy wife.

Go to family counseling, and pretty much scapegoat your problems onto your wife. It's pretty much a backdoor. 'Cause he could've gone to counseling with me all he wanted. He did. Like, he just, "Hey, I have to go with my wife, we're getting couples counseling, for our marriage, or for her psycho-ness, or whatever." They're like, "Oh, yeah! Take care of your wife! Bleh, it's fine!" But if he was like, "Hey, I need to go talk some issues out," they'd be like, "Whoa, whoa, whoa. Hold up."

...Once he gets back [from Iraq], he automatically has to start his paperwork to get out of the military. 'Cause he gets back in three months, and he gets out of the military four months after that. And he should've [already] started his paperwork for getting out.

The only time I've ever pressured him into getting counseling is after he came back for mid-tour R&R this Christmas. And he was fucking weird, is what he was. Like, staring at things that weren't there, he was talking to people that just weren't there. He got angry for no reason, just fucking angry! And I had no idea what his problem was. And, for the random anger he has, I can handle that. But when he starts seeing people, and talking to people, it has got to stop. So I waited until he got back [to Iraq], and I was like, "Okay, you need to go talk to someone." And he's like, "Okay, well, I'll go talk to someone." And then, he lied to me, and told me he was getting help, and he actually wasn't. And that really, really upset me.

He said he was afraid of something actually being wrong with him. So his mindset was, "If I just ignore it, it'll go away." But the thing with schizophrenia or anything like that is, it never goes away, it only gets worse. So I really pressured him. I pretty much told him, "If you don't get this done, that's it. I'm done fighting for you if you won't even fight for yourself. You gotta give me something." And so, he went to the mental health building over in Kuwait. And they got back to his Commanding Officer, and he took Jay and some of the other people in his unit that also sought mental health, or had profiles, and pretty much talked down to them like they were pieces of shit. Like, "How dare you seek mental health? You bastard."

I'm not sure what his rank was. He has to be up there, probably an O-5, O-6, something like that. I want to remember him, because I want to wait until Jay gets back, and I want to call that dude a douche-bag to his face. I just really don't like him.

[Jay] did end up talking to a counselor, before that. And he said that there wasn't actually anything wrong with him. That he was totally fine, and all that kind of stuff. So we haven't really gone past that. I mean, it's to the point now where I can't really make him do anything, because I'm 5,000 miles away. I mean, I know the problems still exist. My focus right now is making sure that he's happy, so he doesn't snap and end up fucking killing someone. 'Cause he does have anger issues.

Editor's Note: Shauna was asked if she thought Jay killing someone was a real possibility.

Yeah, I totally believe it. And he's had extreme tendencies to violence. Which is the other reason I like to keep him happy, because I don't want to become anything in that line of fire. I mean, he's

never physically assaulted me, but it's come damn close. Damn close.

...He was really irritable... He's never been really able to sleep. There's been several instances where it'll be like, four o'clock in the morning, and he'll just get up and walk around, and stare out the window. I didn't even know it existed until like, a month ago, but I'm pretty sure he has it. He has sex-somnia. Sex-somnia, where he will be sleeping, and then he will become sexually violent in his sleep... And then he doesn't remember anything. Like, anytime that he has some kind of sleep episode, where he gets up and he walks around, or he talks, or he does stuff, or gets sexually violent, he doesn't remember anything.

It [worries me]. Because...I don't know how violent he's gonna get. I don't know if it's gonna get worse. I know it's gonna get worse after this deployment, 'cause I know he saw more action. I mean, at least before he went to Kuwait. But I don't know how bad it's gonna get.

I don't know what can be done about it. I honestly, I really don't know. I mean, I'm not any kind of counselor or anything, I don't know what can be done about it. I know he needs therapy. I know he needs someone that is able to take care of him. And I know that I'm not that person. And that's something that's really, really hard to face, is the fact that I still love him. But I also realize that I'm not the right person for him. Because I've been through so much in my life that I'm unable to be a caretaker. I need someone to protect me, and take care of me, and to be a support system. But I've never gotten that from him. There's been very few instances where he's actually able to step up and be a partner.

It's been for the past two years, that I've had to take care of him. And I have this image that he's this man-child, and I am this mother figure. And it drives him crazy, and it drives me crazy. But I don't know how to handle it any other way. Just to take care of every single aspect of his life, to make sure that he's okay. But I can't do that. It's not fair to me to be an advocate and take care of every little mood swing, and stuff like that. It's too hard.

...He does have forgetfulness. I don't know. I didn't know him before. I don't know if it's just like, pure stubbornness, or stupidity, or a TBI, or what. But just everything he does, I have to go up behind him and make sure that it was done right. Most of the time it isn't. I don't know. I'm trying to think of some kind of specific instance. But I mean, he's been gone for so long. The worst thing is, is that I remember when he left, right after he left, probably a week after, I was sad because he was gone, but at the same time I was so relieved. That was probably the biggest relief I've ever had in my life, because after he was gone I didn't have anything to worry about. It was just me, and the apartment, and if I set something down, it was gonna be there whenever I came back.

[Jay's history] is the part where I have the most difficulties, because what I know about Jay is things that I have observed. Like, one percent of it is from stories that he's told me. Because he doesn't remember anyone who he's dated before me. He doesn't remember friends from high school. He doesn't remember things that happened in his first deployment. He doesn't remember anything. He just doesn't remember.

Like with the ex-girlfriends, he doesn't remember any of their names. He has to think about instances in his last deployment. I'd ask him something like, "Were you ever blown up?" And he's like, "Yeah." And I'm like, "What happened?" And he's like, "I don't know. I don't remember."

...He saw a lot of action on his first tour. He's killed people. He doesn't remember how many. He didn't keep track. I've never asked him if he's lost any friends. I've never asked him a lot of things. Now that I think about it, I think that it'd be really beneficial if he talked to another vet about it, because maybe he's just not comfortable with me.

He's switched command so many times. The commanding officers never know their actual soldiers. Like, they realize, "I have 12 pawns!" Like, "What do I do with these pawns." And they never see them as people. Like, "This person is acting outrageous. Why is he acting outrageous?" Well, the dude's been in for six years, and gone through three deployments, and must be really fucked up. The commanding officers don't connect that.

Editor's Note: Shauna continued by reflecting on whether she thought anyone in Jay's command has been tracking his symptoms, or how many times he has been exposed to blast pressure. She also shared that Jay is not currently receiving any treatment for TBI or other symptoms.

I doubt it. And if they do have those kind of records, they'd be in Alaska, and they wouldn't have been transferred down to Fort Hood, 'cause no one knows and no one gives a shit. But as for Jay and his forgetfulness, he realizes he's really forgetful. I don't think he remembers if he was forgetful before the deployment or not. He doesn't remember—which is part of the problem. But he does realize, he's aware that he's forgetful. He just doesn't know what to do about it. He's bought memory books on how to improve your memory, and stuff like that. But it doesn't work.

I don't know [if he's been screened for TBI]. I don't think he's had an MRI, or a CAT scan or anything like that, not that I know of. He hasn't told me anything about it.

...I've asked him several, several times, like, "What kind of action have you seen?" All I know is that he's been blown up. That's it. That's all he tells me. He doesn't tell me anything else. Which is really hard on our marriage, because how am I supposed to trust someone I don't know anything about? I love him, because I see the person that he is. But I don't know anything about him before I met him. There's 22 years of his life that I don't know about at all. Because he can't remember, and I think part of it is 'cause he refuses to tell me.

Editor's Note: The interviewer asked whether Shauna thought Jay should have been deployed a second time.

No. They should've just let him go when he got the Article 15. And he got the Article 15 'cause he went AWOL. They should've just chaptered him out, but they needed the numbers. They needed quota.

They just saw him as a delinquent. He was just a shit-head delinquent.

I don't think [his going AWOL] had anything to do with his TBI. I think it had to do with the fact that he was tired of picking up candy wrappers off the sidewalk. He was tired of just sitting around and not doing anything. It's like, "Why would I want to just sit around a desk, and just sit there and literally do nothing for hours and hours, when I can just do that at home?"

The only time he's ever been on profile that I know of, was when he got a skin infection. And it was a combination of cellulitis and impetigo, which is a nasty combination. He was literally unable to go out in the sun, for probably a week. And he was hospitalized for it. Which ironically enough, the military didn't even want to deal with him. I was forcing him to go to the ER, to Darnall, to seek help. Because his skin infection was so bad that I couldn't even recognize who he was.

It was all over. It covered everything, it was all over. His face was swollen from the puss, and he was leaking it out of his ears, and just out of every pore of his skin. And he was red, and puffy, and leaking this yellow stuff... We went to the ER, and they're like, "Okay, it's just a sunburn, it's okay. Just don't go out in the sun." And we came back, and he went to some 24-hour duty thing. And I went and I picked him up—it was eight o'clock in the morning. He walked up to my window, and I looked at him and I was like, "I don't know who you are." And he's like, "Jay." And I'm like, "Shit, we're going to the ER now." And that's when they finally took him—it was probably the third time, I think, we went to Darnall, and I was finally just like, "This is not normal. You can look at him, you can look at his ID. That is not the same person." And that's when they admitted him into the hospital. But it took probably two or three times of going to Darnall before he actually was able get help.

He wasn't on profile for very long. They pretty much hooked him up to some IVs and the infection went away really fast. Probably just as fast as it set on. But get this, even though the doctors gave him a profile, and were like, "Hey, this guy's really fucked up," because he was on extra duty, his commanding officer was like, "Oh no, this dude's faking it. He's full of shit. He's going to the ER."

So he went to his company, and walked in, and his first sergeant looked at him and was like, "Oh my God. You are fucked up." And he told him, he's like, "Benji,* don't you ever go out in the sun." Jay's white, he's white as hell. So it was probably the reason why he ended up getting the disease in the first place. But his first sergeant went to the commanding officer, and said, "I've seen this dude, he is not faking it. I don't know how you even think something like that. "So he's good."

...I wouldn't have let him go on back to extra duty. I would've gone back to his office and bitched him out, and been like, "You're full of shit. And he's gonna stay home. If you don't like it, you can fuck off." I have pictures of him, and it was just ridiculous. But yeah, the commanding officer was gonna make him go back on duty, 'cause he was thinking he was faking it. But it was 'cause the first sergeant went to him, and was like, "That dude's not faking it at all," that he was actually allowed to have the time off that he was allowed in his profile.

I doubt if [his unit] is really aware of [MEDCEN-01]. And if they are really aware of it, they don't care. They're just like, "Well, fuck that, I'm gonna do what I want." So...I think Jay's a little bit

different though, 'cause his first sergeant, who's usually supposed to be an asshole—in military terms, 'cause he's the one who gets shit done—this is his last deployment. He's retiring after this. So he doesn't really give a shit. So when Jay went AWOL, he actually kind of viewed that as admirable. He's like, "I wish I could go AWOL, I wish I actually had the balls to do that. But I'm career, so I'm gonna live vicariously through this Joe."

So he's kind of a celebrity in his own little company. 'Cause everybody wants to go AWOL, but no one really has the balls to do it, so he did it. They call him "AWOL Bob." That's his nickname, AWOL Bob. No one knew his name when he got back. He was supposed to be in that unit for several months, and no one knew him. So he was AWOL Bob.

...When he was on extra duty, he with a lot of other dudes that I don't know if they had a prescription medication problem, but he was Alpha Company, and all the dudes in Alpha Company, they were the AWOL guys. And Charlie Company, he said, was all the dudes with the cocaine abuse. But I don't think he knows anything of guys with prescription medication problems. He might, it's just another one of those things that he might know, he just forgot to tell me.

...I think multiple deployments is really harsh. 'Cause you're not the same person when you come back the first time. So you're gonna be even less of yourself when you come back the second time. It's like you sell yourself a little bit, every time you get on that plane.

It's really harsh. It's really hard on people. You can always tell a soldier who's never been deployed, over one who has been deployed. Because you get one of those fresh-faced privates, straight out of boot camp, they're like, "Yeah! I'm in the Army! We're the greatest army in the world! I'm gonna kick some ass! It's gonna be like Call of Duty, I'm gonna kill people! Ahhh!" And they're like, "I can't wait to be deployed."

And then, once they come back, they're like, "Dude, this sucks. I hate this. I never want to go back again." And then they're gonna send them back again. You can just always tell the ones that have already been, 'cause they're like, "Fuck. I don't want to go back. I know this is gonna suck balls. And there's no way around it."

The charm, the glamor, it wears off. Once you get over there, and you realize it's not like Call of Duty, it's mostly just picking up trash, or patrolling and not doing shit all day, or just like the sad jobs. Or, even worse, going over there and doing things like dealing with the villagers, and things like that, and realizing that these are some sad people. And they need help. And they don't need to be governed over the way the military's doing. And that they're actual people. It's even worse, 'cause it's like, "Wow, this war is pointless. It's absolutely pointless." I think it's once you see the pointlessness on your first deployment, you really don't want to go back for the second one. 'Cause you know exactly what's gonna happen.

I'm surprised there hasn't been an uprising among the Joes over there right now. Because they're all just sitting around in Kuwait, not doing anything, when they could be home. But instead, they're just sitting and waiting, and bored out of their minds. I don't even know what he does over

there. They do stuff like go to the range, and stuff like that. But it's nothing they couldn't do on garrison, on base. From what he told me, they're pretty much trying to get battle-ready—they're talking about deploying his unit to Afghanistan in 2014. So I guess that's what they're getting ready for. Jay's gonna be out by then. But there'll still be so many people still in.

Jay wants to get out. He would definitely be medically chaptered out, that'd be fine with him. A lot of the problem is, is that soldiers might want to get chaptered out, and they would be medically chaptered out, but then they have no job after. That's a very key thing. A lot of soldiers put up with what they do because that's a job. And they have the skills for that job. And if they leave that job, they have shit. You can end up going to some kind of government-related job that will take military members.

Jay's already got a job lined up. But that was only because he was a military member, and he is going to have that veteran status. His mom just asked around, and was like, "Hey, my son's getting out, he's a veteran, anybody want him?" And there was just people, like manual laborers, were just like, "Hey, yeah, we'll hire him." I mean, he'll make good money. I don't know if his plan's still to go to college, but he basically wants to operate a solar farm. He really likes solar power, for some odd reason.

I've heard stuff about sexual assault in the military. I would say Jay doesn't have a problem with that in his unit, 'cause it's all males. But even if it was guy-on-guy, I don't think that's happened to his knowledge.

I've been to the FRG once, maybe twice. I think just once. That was right when he was deploying. I showed up, and his CO was there. And he was like, "Okay, we're gonna deploy. This is what's up." I was pissed. And...I didn't go to the FRG because I had rumors circulating about me before I even showed up at the first meeting.

I went because it was that barbecue, over at the doctor's house. I thought I was being friendly, Jay thought I was being friendly, like there was no kind of jealousy thing. But I was talking to one of his friends, Benji, just really friendly, just talking, everything's fine. And next thing I know, you know—'cause Jay was trying to get me friends. Like, I had no friends, I might as well make friends with the military wives, maybe that'd be a plus. Which is pretty much how I met Alma,* is 'cause soldiers set their wives up on dates with other wives, so they can get friends. But yeah, Jay asked about Benji's wife, to Benji later. And he's like, "Ah, my wife doesn't want to have anything to do with your wife," because she said that I was flirting with him. And it was ridiculous.

Which is even funnier, because he had been telling Jay that he knows that his wife sleeps around. And he wants to leave her and divorce her, and stuff like that. And yet, she gets angry because I was just talking to him at a barbecue. And Benji's wife is one of those—she was already in the in-crowd for the FRG. She already went drinking with the FRG leader, like the CO's wife, and they get all chummy and shit like that. So I'm like, "I'm not dealing with this." I'm not gonna show up at a meeting with a bunch of women that are just gonna shit-talk about me, and not even help me with any of my issues, and if I do have an issue, and I bring it up to them, the entire unit is gonna know. Because they're gonna tell each other, they're all gonna tell their husbands, and just this

ridiculous rumor mill. Nothing stays confidential.

...While Jay was in the hospital on base, for his cellulitis and impetigo, I went driving around on base, which is the first time I'd ever really just kind of did my own thing. And I think I was going to a Burger King or something, to get him something to eat. And I went by the gym, which is right by the hospital. And I was like, "Oh sweet, there's a gym," went inside, I got information, and found out that all their classes, all their exercise classes are free. So I started going to yoga at the Fitness Center. And that's where I met Chris. He was the only non-creepy guy in yoga class...

And he came up to me afterwards, and he's like, "Hey, I'm going to this place called Under the Hood. They're having an art show. Maybe you could enter some of your photos." I'm like, "Okay, that's cool." And he was also talking about painting it too. They were gonna do like, murals. So that was the actual reason I was pulled in for the first time, 'cause they wanted me to do a mural for Under the Hood. And I came here, the first time, I met Kyle, Chris was there, and Aaron. And we just sat and chatted, we didn't talk about military stuff. And they made fun of me for being a hipster.

...But I still came back. And yeah, I kind of just came here, just chilling. And it was definitely different, because I come from a small town in Missouri. And I'm damn liberal for being from Missouri. But I looked at these guys, and I was listening to what they said, and how they said it, and I was like, "Wow." Like, they're politically correct, and there's a certain way about all of them...It's really hard to make observations on myself. Because I can see that I've changed. But I can't name specific instances on how I've changed. I know that I've started doing things differently, and I'm more politically correct, and I stopped shaving my legs. But you'd probably have to ask somebody like Jared,* who's my bestie from Missouri, who's definitely gonna know some changes, once I get back.

...But as long as we all acknowledge that the military is not perfect, and there is problems that need to be fixed, I think that's like, the common denominator [at Under the Hood]. It doesn't matter if you like or do not like the military, you cannot argue that the military is perfect, and that there's nothing to change. Because I know veterans that were in the military for 30 years, and are all sorts of fucked up. And they would still fight tooth and nail, and say that the military is good, and that everyone should join the military, and it's a good thing. But at the same time, they are fucked up, and they need to start taking care of their soldiers more, because there's all sorts of these problems that are being swept under the rug.

So we should be able to agree on that much. And I think the only people that would disagree with the military, and be like, "No, the military's awesome, and if you don't like it, you can just fuck off," are the people straight out of boot camp, that have no idea what they're dealing with. I think anyone who has actually ever seen action in the military will agree that there's something wrong with the health care, and the treatment, and stuff like that.

What do I want to see...I don't know. I don't know what would be possible. I would like to see more screening. I want the security of knowing that if you are deployed, when you leave and when you get back, you will be thoroughly examined, to make sure that you are mentally stable

and physically stable, and emotionally stable.

I want to have the ability to say without a doubt in my mind, the soldiers are being taken care of. Without a doubt. From the moment that they entered boot camp, to the day that they died, you know, once you're a vet you're always a vet. I do think that there's some people that think that military should get benefits for the rest of forever. I think there's certain kind of logistics we have to work out. Like, financing. I know a lot of people have problems with the military right now, 'cause like, "Oh, well, so many people are going undiagnosed for PTSD."

They also have to stop and think about the doctors and the qualifications that you have to have to be diagnosed PTSD... The government gives so much money for the VA each year for disabled vets. And of that money, there are more people injured than money that can cover all of these injuries. So the doctors have to take the worst case scenarios and give them the adequate amount of disability, so they can get funding. So it's hard to get disability from the VA, 'cause frankly they don't have the money to give everyone... So the doctors have to go through and pick and choose who's more fucked up than the other person, because person A may have TBI, but person B is missing both of his legs. Who do you think is gonna get the funding? The guy with no legs. 'Cause he's the one that they're gonna wheel onto football stadiums, homecoming, and you know, be like, "Oh, he's a hero! He lost both his legs!" But they're gonna look at the TBI guy, like, "It doesn't look like there's anything wrong with you." It's the visual that they need... I think there's frankly not enough funding for the VA.

...I think the people that need the disability the most are the people that can't advocate for themselves.

The VA is back-logged claims by like, \$900,000. And it's the fact that there's not enough funding... The government doesn't have money to be spending on the military. The nation's deficit is trillions of dollars, and yet we're still pouring money into the military, which is not profitable. If we were gonna be charging stuff on our credit cards, it's better to buy food than a TV. I mean, that's kind of how I feel at this point. It's all just fucked up. It's all just fucked up.

24 Josue Gomez*

Editor's Note: Josue* is a Latino infantryman in his late twenties with two previous deployments. He is from a large city in the Northeast. His wife is also in the military. At the time of his interview, he was on profile and entering the med board process. He discussed issues of stigma encountered by injured soldiers.

I'm going to talk about the way things have been going for people that are in the med platoon or getting out of the military. I know the army changes, but still, it doesn't mean it's okay for it to treat its soldiers like crap. Some people are hurt. And you already have issues within your own self, because you'll get hurt you don't want to do the job. You can't do it.

Your medical reasons for it stress you out. On top of that, the NCOs make you out to look like a shitbag when you really are hurt. What you want to do is get all of your medical proceedings to get out. But it's hard over here. It's either that you're stressed out, or the way they lump stuff together, the medications you are taking make you feel like crap and tired.

They make you do stuff at the unit that devalues your profile. It's not like you always want to get out of the work. But you have to break your profile. Literally, it's like 24/7.

They say to carry your profile with you, but sometimes it doesn't even matter to have it on you. The reason why I'm on profile is for my lower back. I have chronic lower back pain. I have a bad left shoulder. I can only have certain movements in my left shoulder. Sleep disorder from some PTSD. They say it's severe.

They said I have severe anxiety. Whatever the hell that meant. I'm doing this program for people that they want to say what problems are going on, but they can't, either because they're scared, or they're scared that they're going to get in trouble for saying what they have on their minds. Because of the way the NCOs treat them, or the way the Army is, or this unit is. One of the other reasons is the way they make you violate your profile—Especially me, because I have my bad back and stuff. They will make me crawl. They will make me work on vehicles. I'm not supposed to be jumping or crawling, or any of that stuff.

If because of everything that is happening to me, I were to get worse, I'm pretty sure they won't help me. The Army is already saying they can't help me. It's kind of weird, because how in the hell are you going to say to me that you can't help me, when I gave you all of my fricking youth?

They ask me to break my profile 24/7. Sometimes it's at PT. Some people can't do PT, so it's either pick up trash and bend over a thousand times, or pick up cigarette butts and trash here and there. Whenever they want us to do PT, they want us to force ourselves to strain and do something we can't do.

The NCOs order us to break profile. They just don't give a shit. You're hurt, but you want to do it just so you can get them off your back.

They're aware of what's wrong with me, oh yeah. They're aware and they'll call you names. Because you'll tell them your reasons—that you have medical reasons—whatever it is that's bothering you. You tell them, “Look, my back hurts.” And they'll be like, “That's bullshit. You know you can bend down and do this and that.” I was like, “Yeah, I could do it, but I'm not going to bend down a million times to pick up cigarette butts. I'm not even a smoker and I have to pick it up.” It's ridiculous stuff like that. Or they'll tell me, “Go to the depot and pick up pants that weigh 50 pounds,” when I'm not supposed to pick up more than 20 pounds.

I got my injuries in combat, in my first tour, 2004. I was in another unit. That was a hard tour. I guess over time, it took a toll on my body. My back started giving out. That was another reason we didn't have enough manpower to do missions, and we were screwed. If you had something wrong with you, they told you to go to the sick call, but they gave you ibuprofen and some bullshit pain pills that didn't help. And you still had to go on missions with a jacked up back and expect that hopefully you don't get fucking ambushed or some shit like that.

Over the second tour with my unit here at Fort Hood, that definitely put the icing on the cake and my back just started going out. I put it on standby because I just I didn't want to let my friends out there do all the work, because that's just not me. When I came back, we were doing training in squad tactics. We did that for a week or so. That is when I started realizing that my back was giving out. I was trying to get up and my back was just screwed up.

I was like, I can't do this no more. I've got to go to sick call. I found out that my back was really bad and I couldn't do my job anymore.

I have chronic lower back pain. The discs, the fourth and fifth, are swollen. The part where the bone rests—that cushiony part is swollen. So that's pushing the bone and it's hitting the nerve, to the point where it's now pinched my nerve. And it's gotten worse, to where it's spread down my leg and sometimes my leg goes numb. Sometimes I'll pick up my kid and my back will go out. I have to tell my wife to massage my back.

Other soldiers get made to break their profiles constantly. When we have to go to the motor pool for some vehicle maintenance, sometimes we have to get inside the vehicle. We have to climb and jump and stuff like that. We can't do that. Some people just can't do that. It might seem like it's easy, but some people just can't do it, because that's how serious some people's medical problems are. Sometimes you say, “This is what's wrong with me,” or, “I can't do this,” and they just start calling you names. They just really don't give a shit about you or what is wrong with you. They just want whatever they want to get done and if it doesn't get done we can't go home, so

we have to break our profiles.

There's stigma towards soldiers who go to sick call. I think that's one of the reasons why I jacked myself up, because you always want to be strong. I think it's an infantry thing or Army thing. You don't want to be seen as a weak link, so you want to put off a lot of strains that are on your body, or any problems that might be going on with you. You blow it off. You put it on standby because you don't want people to talk shit about you, you would be screwing yourself.

With the stigma in my unit, if I have a mental health problem...I'm not going to try and get help. They always have something for us to do. Sometimes we can't even do the stuff that we have to do so that we can get the hell out of the Army—for medical reasons, appointments and stuff. Sometimes they won't let us go to our appointments unless we have appointment slips. Sometimes we can't get the appointment slips because it's done by phone. And sometimes we have to cancel our appointments, and it just prolongs our stay in the army. It just makes us more pissed off, because we don't want to be here.

I see this with a lot of soldiers, not going to sick call because of the shit they'll get. Especially most of the new guys, because they don't want to be seen as a weak link. People call somebody that's hurt in the army a pussy or fucking shitbag. It puts a strain on soldiers' minds, and makes you depressed on top of that, because you can't do your job—the job that you came to do in the Army. I came to the Army to do infantry. I love my job and I can't do it. It stresses me out, because most people are training and I'm here doing some bullshit details. It just doesn't make sense sometimes. Sometimes I can't do the stuff that I need to do to get through Med Board because I'm doing some detail.

With the sexual assault training, people don't take it seriously. They see the Army hasn't tried. They try to upgrade their videos and stuff like that. The way they give the classes, sometimes it's funny because the videos are just so ridiculous, so the soldiers don't take it seriously. And on top of that—they just do these classes at the wrong time. They do it when soldiers are not there, or they just say, out of the blue, "Oh, we have got a class right now." And a shitload of soldiers are not even there, because they didn't put out that we have this class at this time. Or you have to take somebody to an appointment or you have an appointment, and you try to come back to the class and they don't let you in. It's stressful.

25 Ian Augusto*

Editor's Note: *Ian* is an active duty soldier in his late-twenties who did not identify his race. He was in the medical retirement process at the time of his interview in 2012. Originally from the South, Ian was a Tanker/Armor Crewman, and completed three deployments to Iraq between 2003 and 2009. While technically lower enlisted, he had been serving in an NCO position, leading other soldiers, and testified to the difficulties he faced in trying to advocate for his soldiers. Ian had been diagnosed with both PTSD and TBI after his deployments.*

I was bored one day, and I was working on my truck, and a recruiter came up. He said, "What you up to?" I said, "Working on my truck." He was all like, "Well, you got a minute to talk?" I said, "Well, I'm kind of busy right now. I gotta put this transmission in." And he was all like, "Okay, well, what if I help you? Then will you have a minute?" And I was like, "Alright, sure." So he helped put this transmission in this truck. I mean, the guy was in his uniform still, got dirty as shit with me. He helped me out, so I listened to his spiel. Went up to the recruiting office one day, watched a video, saw tanks doing some cool shit, so I was like, "That's what I want to do."

The college fund and all that stuff, looked appealing, but really what I was looking for was life experiences. I was looking for something to do. Something different—everybody that graduated with me, something that they weren't thinking of doing.

What I saw is a lot of stigma thrown upon [soldiers seeking care]. There was always a lot of pressure to just kind of push forward. They tell you to not let shit bother you. Really, it was probably more stressful to find the help than to just kind of deal with the problems yourself. Just because of the fact that people would look down upon you. For some reason, they would think that you're trying to get out of work. Or trying to skate out on some kind of duty or whatever, just because they didn't understand what was going on.

A lot of people didn't really take too much time to ask, "Hey, what's wrong with you?" No, it was more like, "Hey, you need to get your head out of your ass and get back to work." It was just one of those things where there wasn't a lot of sympathy for people that were actually having legitimate issues.

I've seen a lot of good guys. Burton,* for example, nobody knew that he was having problems. He did such an amazing job at hiding it. And one day he decides he's gonna flip his car, and try to kill himself. And then, that's when everybody's like, "Whoa, hold on, he had some problems?"

Yeah he had some problems. But the reason why he didn't want to say anything to anybody was because he was getting rode so hard about his next promotion.

I went through it. For lots of years, I just kind of pushed through. Because of the problems that I was facing, I led a very destructive path in my life. But because of the fact that I'd hear people say, "I've got stuff wrong with me, but I'm not gonna go because I'm not gonna get labeled a shitbag or this or that." I fell upon that stigma, so I just kept pushing through it.

I was like, you know what? Fuck it. I'm just gonna drink myself stupid. And as long as I'm performing at my job, nothing else really matters. And for years, I just pretty much resorted to the bottle. Eventually one deployment, the last deployment, where we didn't have a lot of access to the outside areas of the camp that we were staying at, or whatever, it was really hard for me to get the alcohol needed to maintain my sanity, and so I started deteriorating. And I eventually got into a fistfight with a good friend of mine, who was also my platoon sergeant. And it wasn't something that we hadn't done before, it was just something that was escalated to a point where we usually knew when to draw the line. But that time I just kind of snapped. And that's when the red flags went up. It took something like that for people to realize that I was legitimately having issues. When before whenever I'd say, "Hey, I think I need to go talk to somebody," they'd be like, "Oh, don't be stupid. It'll ruin your career."

Essentially, I guess it kind of did because of the fact that they did retire me because I was diagnosed with PTSD. But, at the same time, now when I look back at it, it's not necessarily ruining my career, it's more giving me a second chance of life.

That was on my third deployment.

One, they disarmed me. Two, they put me under supervision. Just basically I went from being a free person to a medicated prisoner until we actually got back Stateside. And then I just kind of got lost in the system. They pretty much just wrote me off into the medical system, and didn't want anything to do with me after that. Because me seeking help and me having all of the doctor appointments and actually trying to get better would trigger a mass movement towards the mental health clinic, I guess. People would say, "Oh, well he's getting help. Why can't I?" And then next thing you know you've got 16 people out of ranks because they're all standing in line down at the mental health clinic trying to get some kind pills to cope with whatever the hell they're dealing with. So they would segregate us and they would pretty much just leave us to our own groups.

This was after they acknowledged the fact that I had an issue. Because before I didn't even attempt to contact anybody. I mean, one time they called Army OneSource and they hooked me up with a therapist in Austin. And that was like, six sessions. And it was pretty much six sessions of her telling me how messed up I am. It didn't really do a whole lot for me. It intensified my anger, more than anything.

Once they acknowledged I had a problem it still took the medical system a really long time. I was going months between appointments, when I was supposed to be getting seen on a weekly

basis for medicine adjustments and stuff like that. It would take months to get an appointment. I'd get referred to the next clinic, it would be a month before I'd get referred to the next clinic or the next level of treatment. And it really did take a really long time. And the excuse that I was always getting was that they were so understaffed and they were so overwhelmed.

Once I actually got into the system and I was able to maneuver comfortably, once all the referrals came through and stuff, the level of care was actually really good. There were still a couple of instances where they were trying to find a counselor for me, and I'd try one or I'd try another and they didn't mesh with me as far as me being able to open up to them. The comfort level still wasn't there.

But eventually, I did find one that I could open up with. And she was the one that actually helped me get into the Warrior Reset program. It was amazing. The Warrior Reset program was the best program that they probably could've had. The only problem with it was that it was very limited, and it was very selective of who got in.

Oh my God. We went through the full spectrum of antidepressants. Everything from an anti-histamine to Zoloft and Valium. And then we'd play with the dosages. And then for sleep medications, once again, they'd try everything from Benadryl to Seroquel time release 5000s or whatever. I mean, we did everything. The Ambien didn't work. It was one of those things where we'd play with the medications, just trying to see what actually worked for me.

It wasn't until I actually started getting a lot of my issues out that I was actually able to somewhat work with the medication, but for the most part it was just really hard for me to shut down, and I would fight the medication. So my day-to-day basis was some kind of gorked-out zombie-type person, just going through the motions. I probably shouldn't have been driving under so much medication.

I had the typical nine to five profile that they give the psych patients that are on the sleep medications and the antidepressants; no carrying a weapon, no operating military vehicles. It was actually followed to the T, to the point where it prevented my wife and I at the time from going to marriage retreats that we could've possibly benefited from while we were going through some issues. Because, once again, you're going through the system, you're opening up new cans of worms and it's hitting home... It kept me from going to these marriage retreats because of the fact that the bus for these marriage retreats left at 6:45 in the morning.

The profile was assisting my recovery by giving me a certain level of independence, by being able to tell them when I was going to be able to show up to work, gave me that foothold on recovery because the independence part was the recovery. Me being able to separate myself from that uniform and take a step back and look at it at third-person point of view.

I did get a lot of flak for it. I did have a hard time with it, because people would look down on you. Because, "Oh, well, we can't use this guy, 'cause he's all drugged up and he's got a nine to five, he's gotta leave at a certain time." ...It was good, but at the same time it singled you out for a lot of discrimination.

[Command was] very aware of everything. I don't know exactly what they do now, but at the time what they were doing is they were recording how many appointments you had. They would send out a list down to the units, "This individual has this appointment this day," or whatever. And if you missed an appointment, they'd find out about it. It was more of an accountability thing, and making sure you weren't just trying to abuse the system. As far as them actually being proactive, as far as trying to help you out, as long as you were making your appointments they could give two shifts of what you were doing. For the most part they would sit me in the orderly room and I would just sit there, kind of zoned out and staring at the coffee pot most of the day when I didn't have an appointment.

The stigma was that I was broken and that they could only use me so often. And so for the most part they didn't even attempt to put me to work... It was a give and take, sort of double-edged sword. Because I got that independence where I could say, "Okay, it's time for me to go home," or, "I'm not coming in until this time, regardless of what you say." But at the same time, I did get a lot of stigma because of it.

They made sure that they adhered to every single step of that profile. But at the same time, they ensured that you adhered to every step of that profile, and as soon as you stepped outside of the rules of that profile, then you would get punished for whatever reason. Like, let's say I show up five minutes earlier than nine o'clock, they would say, "You're not supposed to be here 'til nine or after. What are you doing" It's like, really? It's five minutes, dude. Chill the fuck out...seriously.

The first profile was issued by a PA, a major in the behavioral health wing over at Darnall. It was at the third floor. He was down at the Combat Stress. He's a cool guy, but at the same time, he was more about making sure that my profile was up to date, and "Let's play with your medications a little bit more. You seem like you're still a little high-strung."

Once I started the Med Board process, they re-evaluated [the profile], and they figured, "It's what we're gonna keep it at." That's what they said.

There was always pressure to do by the profile, to abide by the profile, because you would get the full force of whatever punishment you would receive for breaking that profile. Because they were watching you like a hawk. They were making sure that you didn't break it. 'Cause as soon as you broke it, they were gonna burn you.

Every time that I would have one of my guys come up to me with an issue, I would help them resolve it to the best of my ability. A lot of times, I would get a lot of flak for helping out, and pretty much obtaining resources for them, as far as who to contact, where to go, stuff like that. Our chain of command saw it that that information was more than adequately posted, and the way they would put it was that I "baby my soldiers, and walk them by the hand to mental health. If they really had a problem, they would do it themselves." And that's where I had a really hard time with it, because I lived with this stuff for seven years, and I didn't walk down there by myself. It seriously took a life-changing event, for me to actually say, "I have a problem."

As a leader, I felt that I needed to circumvent that. I needed to nip it and basically get it before it got them. Whether it be an issue like, "Oh, I'm having problems with my wife," or it'd be an issue where somebody'd come to me and say like, "I've been having a lot of really, really dark thoughts, and I'm in a bad place." I would always find a way to find them the help. Because that's the leadership style that I was brought up with.

[There was not pressure for] overriding medical profiles, but just to find loopholes, find a way around it. Not necessarily break the profile, but just to find the loophole. You know, "Okay, so this person can't lift over 35 pounds. Let's have him do something different." Just basically circumvent the limitations on the profile.

We had to do a ruck march once, and one of our guys couldn't carry a pack over 35 pounds, or whatever. So instead of making him carry a pack, they made him carry something else. The profile stated you couldn't carry a backpack, but it didn't say anything about you couldn't drag something. Situations like that.

The quotas for combat readiness, basically whenever we would start doing SRP and stuff like that, or just have even the mundane PT tests that we would usually have, it would usually start with some sort of corrective action, and eventually lead to separation. There was a very short fuse when it came to people not being up to the standards. Especially in the later years. It was one of those things where the standard became more important than the actual well-being of the person.

...It stems from higher-up. Because the higher-ups would set a standard, and in the Army you can always add to a standard, but you can never take away from. So because there was always somebody trying to obtain that higher-up position, they would add to the standard, to make sure that they were in somebody's good graces.

I don't necessarily think it affected anybody's medical care. But it affected their willingness to receive medical care.

They would always promote getting your guys out of the barracks and doing fun stuff, and basically breaking the monotony of it. And then, they also had the equal opportunity guy, for each company. And basically he was the sexual harassment guy, or the equal opportunity rights guy. You're getting discriminated against, that's who you go to to file. And then you had your IG.

They had a number of things going that you could run to, to find some kind of assistance with whatever your problem was. The only issue was, those were always not exactly primary duties. Those are usually secondary or third duties that they would just be assigned. And nobody really followed up on them. They were pretty much to just check the block, "Yes, we have an EO guy." When was the last time he gave a briefing? "Uhh, yesterday." 'Cause he stood in front of a bunch of people and was like, "You shouldn't pat each other on your butts." And that was the briefing.

Basically, they were trying to get out of work, that was the attitude towards [soldiers on profile]. It was, "There's nothing wrong with you. You're just trying to get out of doing something." Or, the

favorite one was always, "Oh, you're broken, so you're no good to us." I mean, they never actually said that, but that's pretty much how they would make it feel, because of the fact that they would segregate all of the profiles together, whenever there was anything going on.

...When I actually started getting into the system, a lot of the guys that knew me, they were more in awe of it, that I was actually having issues, than anything else. I've never actually seen anybody being ridiculed for it. I've heard of it, but as far as seeing it, no.

It stems from being in the Army. You're a soldier, you're a soldier 24-7. You're supposed to be able to shoot, move, and communicate, and that's your thing. You just do the job. Supposed to be hard-core. They don't yell at you in Basic Training for eight weeks for nothing. I mean, that's supposed to toughen you up, right?

[The stigma] makes them feel like they're not gonna advance if they do find care, or because everybody automatically assumes the worst. You know, for instance, they see a guy who didn't seem to have any problems before, and he goes to see a doctor once, and the next thing you know he's getting kicked out of the Army.

And nobody really understands that there's different levels of PTSD. There's not just full-blown, "Oh my God, I'm having nightmares and hiding under my bed every night." There's also the passive forms of PTSD, where it's like, "Okay, well, I've got some anxiety. I can't be in a crowded room full of people." Or, "I gotta change the channel whenever that Geico commercial comes on." Just something stupid.

The SRP process pretty much stayed the same the entire time. You go in, they make sure all your ducks are in a row, your medical's taken care of, your dental's good, finance, the power of attorneys, your wills, you've got everything in line before you leave. It's a big clusterfuck, how they do it, but it gets done, and apparently, it works, for the most part.

I've seen a lot of people that shouldn't have been deployed. The SRP process doesn't necessarily keep them from being deployed. The SRP process just makes sure that all the legal and the medical stuff for it is in order. They don't exactly do a psych screening on people. When you do SRP, you sit in front of a PA, and they ask if there's anything wrong with you, and you tell them your knee's hurting or your back hurts or whatever. And he'll put that down on his notes.

But as far as actual sitting you down, talking to you, like, "Hey, how do you feel about going on this deployment?" They don't actually do that, for SRP. Being able to pick out somebody from a large group and, "Oh, this person shouldn't deploy, because he's got issues," that wouldn't have came out through SRP.

Editor's Note: When asked if he thought he had deployed with conditions that should have rendered him non-deployable, Ian responded emphatically.

Absolutely. After my first deployment, every time after that was with some kind of condition that definitely would've disqualified me from going. [PTSD] is pretty much the one thing that, I would

say, would definitely disqualify somebody from deployment. I mean, really, honestly. 'Cause really, what's the point of putting them through the same shit that they just lived, and caused them problems?

I mean, I did three deployments. It took the third one to actually break. So yeah, I figured it did exasperate it. At the time, I thought I was just doing my job.

[PTSD] definitely hindered a lot of stuff. But PTSD isn't one of those wounds that you can just see on somebody. Whether that person broke down or was really good at hiding it, that was just one of those things, versus an injured person, where they actually deployed somebody with a broken arm, that's gonna be an actual visual, that person is actually broken. Whereas, somebody with PTSD, they can still participate, and not really show any signs.

...On my second deployment, because of the fact that we did a lot of in-town, lived with populations, stuff like that, with these other teams, we had access to pharmaceuticals and alcohol. And I never did any pills or anything, but I did drink. It was definitely something that I looked for so that I could function. I didn't necessarily get sloppy drunk, but I got drunk enough so that it would calm my nerves, and I was able to make decent shots, or make rational decisions...you know, just find that level.

...I don't know if they've improved on [PTSD and TBI screenings], but I know at the time, they weren't screening for that [at R-SRP].

They didn't ask about PTSD or TBI. It was something that I had to bring up to them. I had to bring my medical records from [Iraq], here and turn them in at the Reverse-SRP, so that they could find me the proper channels to go through. And even then, that file just went into my medical records, and I never received a phone call back, as far as a follow-up, or, "Hey, this is the clinic you're gonna go to." So, I had to do it myself, basically. And go down and sit in the triage, down at the Combat Stress Center, and then sit there and wait for like, eight hours, and eventually somebody'd see you. And then they're like, "What the hell's your problem?" And I've been sitting in that goddamn waiting room for eight hours, with a bunch of people that smell like ass, and now you're sitting here asking me a bunch of stupid questions. It got to the point where, I don't know if it was part of the screening process, to see how cool you could sit out there, before you stab somebody or, if it was legitimately like, "Hey, we're really this backed up."

...I at first did not feel comfortable requesting help. Because I didn't know how to ask for help. And then, once I had my coming to Jesus, going to talk to the therapist over there, and stuff like that, that's when I was like, "Okay, well, you know what? There's nothing wrong with asking for help." But really, at first, before I knew that there was actually help available, that wasn't gonna judge you or ruin your career, yeah, I had a hard time asking for it.

For the most part, the [PTSD] briefings, they'd always be accompanied by some kind of pamphlet, or some kind of video explaining what PTSD was. There was a lot of joking around in those briefings. Not a whole lot of people would take the whole PTSD, combat stress-type stuff seriously. Because you always have those guys that are always trying to cover up some kind of

traumatic experience or whatever with, "I'm tougher than that." Yeah, they would try to just push themselves up, so they pretty much ridiculed anybody in the room that felt like they actually could have legitimately had a problem.

And then also, you had the armchair warriors that had never really experienced anything, but would always talk a big game. And it's like, "Oh, you received your combat action badge, playing X-Box, because a mortar landed outside, near you." But I don't have a combat action badge, but I have awards of valor, that I received because I was out there protecting my guys. I mean, it wouldn't make any sense.

There really wasn't a screening process [for PTSD]. They would have briefings, and they would hand out little cards that would say, "Hey, these are the signs that you look out for, for your buddies, or whatever." But that was it. They didn't actually sit you down once a month, or every couple months, "Hey, what're you feeling?" There really wasn't much of a screening process. It was more, if you had an issue, you would go find help yourself.

Before I understood that I actually had legitimate PTSD, I would associate my symptoms with the stressors of doing the job, or whatever. But I never actually acknowledged the fact that I had PTSD. There was a lot of that avoidance behavior, like funeral details, and talking about stuff. Just, in general, thinking, "Well, why should I do it?" I never actually really grasped the concept that the avoidance behavior was me keeping myself from putting myself back out there and getting hurt, or whatever. Until I was actually explained what the symptoms were and somebody broke it down for me when I spoke, I had no clue. I mean, really, you just don't know. Until somebody else points it out to you.

I by no means was self-diagnosed with PTSD. I did not walk into a doctor's office and say, "Hey, I have PTSD." I walked into my PA at the time, 'cause that's all we had on our compound, and I said, "Hey, can I talk to you for a second?" And he said, "What's up?" And I said, "Well, I'm feeling very anxious lately. And that thing that happened to Sergeant Tyson* the other day, that shit was out of control. I think I need something." And then he would sit down and talk to me. And it wasn't until I actually saw an actual psychiatrist, or psychologist, that I was diagnosed with PTSD...

Looking back, if I would've known myself on a personal level, versus a professional level, I would definitely say that I was exhibiting the prime symptoms of PTSD.

It affected [my personal life] majorly. When I first deployed in 2003, I'd just gotten this girl pregnant, a girl I'd known from back home. So we got married, for the benefits, 'cause she needed it for the baby. I thought that was what you do. You get a girl pregnant, you marry her, right? I was a kid.

And so, I come back, and I'm completely different. And she's completely different, 'cause she's spent a year raising a kid. We can't see eye-to-eye on anything. We get into big fights, this and that. I didn't really acknowledge the fact that something had changed me. It was just, "It was a year, being away from this person. I get back, she's a royal bitch. I don't want to be with her,"

right. And that's pretty much what I associated it with. I didn't really think much of it.

So we got a divorce, and then after the divorce I just started doing my thing. Just kind of going out and partying, one night stands left and right, doing whatever I wanted to do, 'cause that's what I felt like I needed to do. A relationship would come along, I'd hang out with them a couple weeks, and then I'd drop them, because I didn't feel like I needed to be tied down. It was just one of those things where it was a lot of avoidance behavior, is what it boiled down to. I was avoiding getting close to anybody.

Subconsciously, I was afraid of being hurt again, because every time that I'd gotten close to somebody before, something would happen to them. And then, it was just one of those things where I would alienate friends. As soon as I started getting close to somebody, as far as either romantically, or friendship-wise, it would go south quickly, because of the fact that I just would separate myself from the situation, due to the avoidance behavior. I would drink a lot, just trying to self-medicate, trying to forget a lot of the stuff that happened. And that was also detrimental to any type of relationship that I had. My recent divorce was because of the fact that I was trying to find who I was, the new me, and through that I was just very unstable, very ugly, very rude, just was shutting myself out, wouldn't let anybody in.

I felt like, "Okay, my doctors are the only ones that are actually gonna be able to help me, I don't want you to find out what I'm doing. These people, they'll keep it confidential, it's not gonna go anywhere. I don't need you running your mouths to somebody else about what I've done, so I'm not gonna tell you." And that's how I felt. And that's why I would shut everybody out, emotionally. And then once that was actually explained to me, that that's what I was doing, then I started realizing, "Holy shit, I've been doing this entirely the wrong way. I should've actually opened up to somebody, and it actually would've helped me out, more than it would have hurt me."

I'm gonna segue here a little bit, but that's really the reason why Maya* is here. She came into my life at a kind of crucial point. I've started realizing that I'm not an asshole like everybody else thinks I am. It's just I made myself that asshole to protect myself from being hurt, or having to lose somebody, or whatever. And really, I want to start off things, like putting myself out there, and that's how relationships are really built. I felt like whether it's just friends, or if it's a romantic interest, it's something that needs to be put out there, how you feel, and whatever. If you shut yourself out emotionally, it's more like living a lie than anything else, because you're not giving yourself 100% to that relationship or that commitment, you're just kind of half-assing it and going through the motions.

Eventually it's gonna break down, where—"What's wrong with you?" "Why don't you ever talk to me about stuff?" And, "You always seem to have something on your mind, but you never want to share it." And it causes issues and fights, and people to be ugly, and just puts them out there like that. PTSD is definitely a huge contributor to the fact that I haven't had a stable relationship in the last like, nine and a half years.

[Command was] supportive, because what the marriage counseling was doing was keeping her out of their hair. Because she would come to the office on a regular basis, bitching about my

latest and greatest asshole move. And they would say, "Well, maybe y'all should seek marriage counseling." And they would bring me into the office, and they'd be like, "Look, I'm tired of her coming in to the office, you guys have to go talk to somebody about this." But as far as my relationship actually working out, they didn't give two shits. They were like, "Either divorce her, or go to marriage counseling."

...[Fort Hood has] a TBI clinic, they specialize in nothing but TBIs. And their people are very, very well-educated, as far as TBI goes. It's a small clinic... And the other big resource that was available was the Warrior Reset Center. And once again, that was a very small clinic, and a very limited number of positions for patients.

Editor's Note: Ian was asked whether soldiers he knew experienced symptoms of PTSD.

Almost every single one of them.

There was one time, when I was prescribed Zoloft. And Zoloft really made me very depressed. And I had one blow-up with my wife at the time, over the phone. And I went back to my room, and downed pretty much an entire bottle of sleeping pills. Because I wanted to sleep away the depression I was in.

Fortunately it didn't happen, I just got really, really high. When they came and found me, I was sleeping with my rifle. It was normal for me, me sleeping with my rifle was an everyday occurrence. But they got concerned when they saw the empty bottle sitting on the floor. And then they attempted to wake me up. And then eventually just dragged me into the first sergeant's office, and then he was all, "Hey, what's your problem." Of course, I'm borked out of my mind, 'cause I'm high as shit on these pills, so I can't really give him any straight answers. But because I hinted at the fact that I was to the point where I wanted to just end things, that's why they really took an interest in what was going on.

That was during the third deployment. That was when they were changing up the meds and trying to prescribe me stuff.

Editor's Note: Ian confirmed that he was on the medications while deployed, and while on guard duties with access to multiple weapons.

I was on restrictions, I wasn't on an actual profile. It was more of an unofficial thing.

I wasn't running missions, but I was pulling guard duties. We had a 240²²² up on tower, and then I had my rifle, and a 9mm pistol, and a 203 grenade launcher, and a knife. And a piece of rope.

Seriously, anything that you could possibly harm yourself or anybody else with, was within my reach while I was on medication. It was just one of those things where, they figured the dosage was low enough that it'd keep the edge off, but it wasn't gonna cause you any serious... It was prescribed through the PA. Actually, the reason why I chose to accept being on the medication was because I'd known a couple other people on the compound that were actually on lots of

prescriptions.

You notice a difference in the guys that do multiple deployments, versus the guys that have just recently completed their first deployment. There's a huge level of don't-give-a-shit-ness, I guess you could call it. The guys that have done the multiple deployments, and have seen this stuff, and have lived through it and they're still working on going through another deployment.

It was just one of those things where they were just going through the motions. We got so used to the routine, that it was really hard to shock any of us. We would do our training going through the motions, knowing that today is just training, it's not real life, real life scenarios are completely different. And then there was the fresh guys, the guys that were still going, "Oh, man! This is so realistic!" And it's like, we were playing a video game.

The major cause of trauma is the loss of your friends, your partner, your brothers. If you didn't lose anybody, that was a good day, but the moment you started losing people, that's when stuff started hanging heavy on you. And you'd start avoiding more and more situations because of the fact that that's what caused you to lose an important part of your life. To this day, I still struggle with a lot of survivor's guilt. You go through the motions, the "what-ifs," and the, "What should I have done?" "What could I have done?"

That's what it is, for me, the fact that I lost guys over there that were depending on me to bring them back, or that we were depending on each other to be there, for whatever reason. You know, kid's baptism, or you know, "Hey, I just had my twins born, I can't wait to go on leave and see them." And he gets to go on leave in a fucking box. He didn't even get to see his kids be born. And now he doesn't get to see them grow up.

It's shit like that that's really what caused a lot of my issues. The taking of lives, you're never going to forget it, and it's always going to change you. But the actual losing lives is one of the big things for me. It's definitely what's hurt me a lot more than anybody else. You get close to these guys. You live with them, you eat with them, you go out and work with them. Everything that you do in a day-to-day basis revolves around somebody else. There's always like, "Hey, man, I'm going to the showers." "Hey, hold out, I'm going with you." It's just one of those things. There wasn't any type of separation between y'all. Y'all were close. It was almost like y'all were cut from the same cloth. And especially when you worked together, and you trusted each other, and it was just a smooth working machine. The moment that one of those cogs became undone, that's when your machine broke. And it would never work the same again, even if you did get a new part. There was still that—you'd still have to break that part in. And that's always been a big, big part of my hurt. That's would be what my post-traumatic stress would be, would be the losing of people that I consider family.

The best way to actually deal with stuff is actually just by talking about it. That's what I've learned. I've learned that really just putting yourself out there and just hearing your thoughts. You start realizing, "Wow, I'm really thinking that?" Or just having a third party saying, "Okay, well, that sounds like you've got a little bit of confusion going on," and then they break it down for you. And then, it makes sense. Once you have somebody to help you to make sense of it, it works.

Also, writing stuff down, you write everything that you're thinking, from the time that your pen touches the paper, to the time it runs out of ink. You go back and read it, half the shit doesn't even make sense, 'cause you're going back and forth on yourself. And then you start thinking, "Okay, well, how can I fix this?" And being able to open up about what's eating you is really the best medication for it. I think that hindering the ability of people to actually voice what's eating them is really what's killing them.

The military that I grew up in, I can honestly say that I don't think [it wants to open that up]. It's a dialogue that weighs entirely too heavy on entirely too many people. You get one person opening up and putting themselves out there, then eventually you're going to have a multitude of people putting themselves out there. And then, by the time that it's all said and done, it's gonna be really hard to actually sit there and sift through everybody that's trying to a) get better, or b) just trying to do something so that they don't have to do the actual work.

...I was diagnosed with a TBI. They gave us briefings about the TBI stuff. Once again, it was just one of those things that we just kind of joked around about, 'cause you know, the symptoms of TBI are headache and dizziness, stupid shit. You been sitting through a presentation, you get a headache, you stand up, you get light-headed, bam. Automatic, "I got a TBI! "From sitting in this fucking presentation." You know, just people joking.

Editor's Note: Ian testified that he thinks he probably took an ANAM test, after one of his deployments. He said he had been in explosions and received a concussion while deployed, but that he had not received a memory test afterward while deployed. Ian then described the TBI symptoms he has experienced, and the treatment he received.

Just the headaches, the spotting vision, the restlessness, just the regular, run of the mill TBI symptoms. The things that you would think, "Oh, you know, I'm just seeing spots 'cause I'm a little dehydrated," or, "I got a headache 'cause I've been shooting machine guns for the last six hours at the same house," just stuff like that.

They gave me Topamax, which is a pill. And then, that's pretty much it. I mean, I'd go in for screenings. They did the CT scan to make sure that everything was growing back normally, or whatever the hell it does.

The TBI diagnosis came after I was deployed, because of some symptoms that I complained about. 'Cause I thought the symptoms that I was experiencing were something to do with the medication.

Every time we'd switch out a pill bottle, they'd say, "Okay, look. This one's gonna cause impotence." Or, "This one's gonna cause you to bleed out your asshole, or you know, dehydrate." They would go through the barrage of side effects. And then they were like, "Oh, so do you still want to take it?" "Uhh, not really. But you say it's gonna make me feel better."

...My TBI wasn't severe enough where it was causing memory loss, or any type of inability to

function. My TBI was mild enough that all it was causing me was some goddamn headaches. And some spotting of the vision, and stuff. At first they thought it was cataracts. They sent me to the optometrist to go get me some glasses, and then I was like, "I don't need glasses." The optometrist was like, "Of course you don't."

Editor's Note: The interview transitioned to address sexual assault and harassment in the military, and wrapped up by addressing Ian's experience in the Medical Evaluation Board process.

...I was in an all-male unit, every time. Every once in a while, we'd have females attached to us for female search teams, or whatever PSYOPs team was with us, or interrogators, or whatever, that were with us, were female.

I guess there's never actually been a serious, reported case of sexual harassment or anything. 'Cause, I mean, we all ran around grabbing each other's asses anyways, on the most part. You know, like telling fart jokes. So, in our unit, sexual harassment was more of one of those things where, unless if it actually legitimately made somebody feel uncomfortable, because somebody was actually legitimately 100% without a doubt violated, it was one of those things that was just brushed under the table. It was just guys joking around with guys.

...We received a lot of training [on MST]. We'd sit in a room, and they'd hit us with a PowerPoint slide, and then we'd sit here and joke about how like somebody put their wiener in somebody's face when they weren't supposed to.

...Honestly, I don't know if there's anything we can do to really avoid it. It's gonna happen. You got males and females in confined spaces, and places where there's a lack of supervision. But because I've never served in a unit with females, I wouldn't know how to [prevent MST].

[MEB] was very swift. They didn't do a lot of dragging their feet in the Med Board process. [My commander] was happy that they were gonna actually attempt to get rid of me. That was pretty much it. I mean, really, that was his response to it, "That's great that they're gonna Med Board you."

...I tried to appeal my Med Board, so that I could stay in. And they basically told me that if I appeal it, I'm probably going to lose the benefits that they're fixing to give me now, and it's only gonna buy me another two months in the army.

Once I got my profile, they discriminated against me because of the profile. They just pretty much just put my promotions on the back burner. Because of the fact that I was broken, and they couldn't use me, so why would I be rewarded for it?

26 Randal Terrell*

Editor's Note: *Randal* is an African-American active duty soldier, originally from an East Coast city, serving as a Mechanic. At the time of his interview, he had served for eleven years, and was being evaluated for medical retirement. Randal had already been struggling for two years to get treatment for a hernia after a failed surgery, along with other medical and mental health issues.*

I joined the military in May 2001. I first enlisted just to do three years, to say I've done it. After my three years, I enjoyed it, so I stayed on. My plans were to go into the warrant officer field and retire as a warrant officer.

I did initially want to join the infantry, but my mother would have had a fit. So I did mechanic, so if I decided to get out early, I could be a mechanic.

I'm currently on Med Board and I'm having problems getting them to examine my hernia surgery that I had. I'm starting to have pain and I actually take medication for it. But it seems I've been getting the run-around for the last almost two years.

I had the hernia repair done September 2010. In December I started having pain. We were on our way back to the States in January, so it was either go back to Qatar to get the surgery re-done or be stuck in Afghanistan for another two to three months with nobody that I knew. They asked me if I could tough it out and make it back to the States. When I get to SRP, everything would be good. I mean, that's a win-win. I came with my battle buddies, I leave with my battle buddies. And I get help when I get back.

But when I got back, they said they couldn't do it. Because they weren't the doctors that did the surgery, they wouldn't touch me. And they told me that I had to wait to talk to my PA. I got back in January and then I saw a doctor in March. I didn't see a surgeon until April, but they didn't do anything 'til June and then they said, "We can't do the surgery." So they sent me to pain management. That was my initial appointment with pain management in 2011.

And then in July of 2011 is when the pain doctor numbed me up in the front and told me I may have some nerve entanglements. And after that, it was a "Nope" from the Med Board, "There's nothing we can do for you." The brigade surgeon said, "Hey, you're gonna have this pain for the rest of your life." I talked to other people who've been in the same situation. This one guy told me they had to go in three different times until they seated the surgical mesh correctly. But no one

would go in to try to pull mine out. And that's all I wanted them to do. And they will not do it.

Editor's Note: Randal specified in further detail who in Afghanistan had promised him that he would be treated for his hernia upon returning stateside.

It was a PA. I don't know what unit he was with. He was actually the one who examined me before I got my hernia repaired, and then in December of 2010 he checked me out again. He told me that I probably had to get it redone. They sent me back to Kandahar and I talked to my PA, and she also asked if I could tough it out and wait 'til I got back. And said "I'll just wait, 'cause we were on the downslope, we were packing up everything at this time. I'll just wait 'til we get back, 'cause I don't want to be stuck over there with people I don't know.

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[The first PA] didn't actually do the surgery, but he's the one who wrote up that I had a hernia, and I had to go to Kandahar to get it fixed. And in December he was also the same doctor who said, "Something's wrong there, you may have another hernia."

...[The second PA] meant what she said. She'd been the PA for awhile, all the way through August of 2011. And I was mad that she left, because she actually knew my situation, and she was sending me in all the right directions. But when the brigade surgeon heard I'd been back for over six months and on profile for over six months, and nothing was getting better, then the PA said go to Med Board.

Before that happened, my PA wanted to send me to pain management and to see a neurologist. She had everything planned out for me. But since I've been in the Med Board, I have not been to pain management. They have not done anything as far my abdominal pain...nothing.

Only thing they do is, whenever my pain gets so bad, even though sometimes I take medication, they'll numb me up. But as far as trying to get me a diagnosis or trying to find out what exactly is going on, nothing. And they're still avoiding it to this day.

I've been running my head trying to figure out why. It has to be something. Maybe the [surgery] product that they use is not that good, maybe they're trying to help themselves out. But I know they are pushing for me to get out... Some kind of way, I am going to figure out why no one is helping me. Tomorrow, I'm going to go to my case manager and I'm going to ask her the same question too, 'cause I just met the case manager a couple weeks ago. At my last appointment at pain management, I was hoping to get the answer I was looking for. I had to wait two months in between going to the pain management. And when I got there it was basically, "We're gonna set up this for your back," 'cause I have back problems also. But then February was the end of my pain management for my back.

I finally got a referral that I'd been waiting on. It came in the beginning of March, saying that I had a referral to the pain clinic for my abdominal pain and knee pain. So now from March to last Monday, I had appointments at the pain clinic. And they're still talking about my back. But when I talk to the nurses, they say, "Okay, you're here for abdominal pain." But when I go in to see the actual practitioner, she's talking about my back, so they're not doing anything they're supposed

to do. Any time I bring up my abdominal pain, they keep telling me that the stuff they are doing with my back is going to help my abdominal pain. But it hasn't done anything. So they've been jerking me around.

...It was the brigade surgeon that had seen that [I was back for six months]. She only met me the one time I went in to my PA to renew my profile, and she was like, "Oh, your PA is on leave." And she pulled up my records, and she just initiated my Med Board right there. That was it.

I told her I didn't [want to be Med Boarded]. That's why I wasn't before. They told me that by June 2011 I was supposed to be placed in Med Board, because it'd been over six months that I'd been on profile, can't do any PT events. So I was supposed to be Med Boarded. I got initiated in August 2011.

And the purpose of the Medical Board is to evaluate you to get you fit, and if they can't, then you have to get out. But they have not done anything to try to get me fit. So I didn't understand the purpose or the point of them even putting me in there. I was getting more help before.

...My back pain started back in 2003, I can't actually remember exactly how it happened, but I know we used to go to the field every other month, and we used to do some rough training. It was fun, but it was rough. And I hit my back so many times, I can't remember exactly what started everything. But I used to complain about it, go into see my back surgeon, and they'd give me muscle relaxers. That was basically it.

2005, the same thing. After coming back from Korea in 2007, I got here to Fort Hood. I felt I always had a big bulge in my back. I went to our company medics and they said, "It's hard, you have a bulge there." Something is going on. So they told me to go get it checked out and put in for an MRI. But I guess on Fort Hood you can't get an MRI until you do back exercises for a couple months. Then after back exercises, you have to go to back classes. Then after back classes, then they'll say whether or not I can get an MRI. So they gave me a sheet with a whole bunch of back exercises to do.

This is in 2008. You're supposed to the exercises on your own. A couple months go by, it's not working. So they put me in for a back class. The back class is to learn how to lift and everything. And I told the nurse, "We do this for our job. They teach us how to lift with our back. I have a bulge right here, there's soreness when you push." But they basically said, "Well, we can't give you an MRI without a back class."

I was doing them on my own...and even to this day [I have pain]. A lot of bending back and forth, my back used to spazz so hard that I would hit the ground. And it would literally knock the wind out of me. I still take strong muscle relaxants now for that. And since I missed the back class, they scheduled me for another back class, and I got down to where the class is, but they said it was somewhere else. And when I finally went to the building, they had moved it. So when I got to that building, I was supposed to sign up 15 minutes prior, but I hadn't. And they told me I had to wait, and that's a six-month wait.

That's how long it takes to get in the class. Back then. I don't know how it goes now. So by me not going to the back class and my back spasming, the only thing they'd give me was, "Here take these and practice, take some flexor ribbon, take that." Well, I need an MRI. And my PA would push for me to get an MRI, but I can't get an MRI without that back class in my records. What was so crazy was when I got back in 2011, I saw my pain doctor in June, filled out some paperwork, and then he sent me to Scott & White.²²³ Scott & White did an MRI on my back to make sure my back wasn't causing my abdominal pain. And he saw what was going on with my spine and he asked me how long was all this pain going on. And I told him from 2003. And he said all of this could have been avoided if they would've just went ahead and did my MRI when I asked them to.

He told me this in June 2011. And then once my Med Board initiated, I got sent to another pain management doctor in October, who's right across the street. And when they got the MRI on my back that I got from the other doctor, he said the same thing. He said, "It makes no sense." He said all of this could have been avoided if they would have just gave me an MRI. But they make it tough just to get an MRI.

They were both civilian doctors, and both pain doctors. And they both tell me that my back has nothing to do with my abdominal pain. It's just weird.

My PA [referred to the civilian doctors]. I told her General Surgery on post denied me surgery three times as far as my abdominal pain. They denied me every time because they can't find any abnormalities in my MRIs. They did everything, ultrasounds, they can't find any abnormalities, so I guess it's all in my head. But every time I ask for a second opinion. I went back to Scott & White... The surgeon says it's probably the mesh. But everybody has a boss and this boss is not authorizing the surgery. That's the problem, no one is authorizing the surgeries because they need to find something abnormal going on in there before anything.

[The civilian doctor] said there obviously is something going on. But he can't do the surgery. And it's just crazy. And then, I talked to this other provider, and she even asked me why haven't I been referred to a neurologist yet. And I told her that's what I've been trying to get, but they sent me to pain management. I was trying to go to see a neurologist because of the nerve pain that I was having. I take pills for that, and a patch for my just everyday pain. So I put in a referral to go see a neurologist and that got denied. TriCare, they denied that.

...And then I got a referral to get a nerve stem stimulator put in to make you just feel tingling instead of pain. And from my understanding, a lot of people who've had it done, they get back to their normal life. So I was, "Cool, that's an easy way out of it." At that point I was ready to try anything.

Nope, got denied. That was a couple months ago. It got denied in March, 2012.

My pain doctor that I have now, he put in the referral for me to get the nerve stem stimulator. I see all civilian doctors. I'm not dealing with army doctors any more.

[The Army] denied the nerve stem stimulator. And my pain doctor also put in for me to see a chiropractor off-post, but the Army overtook that and said no, they have room on-post, so they're sending me to an on-post chiropractor. And then after all of this time, they're going to send me to a chiropractor and they're trying to get me to all these other places. But I'm not dealing with any on-post doctors.

I can deny that request. I don't care. I want to see somebody off-post. That's just for my back, and everything has been for my back since October 'til now. But I'm in the Med Board for my abdominal pain.

My pain just gets worse, so I'm taking extra pills to boost my pain medication because my pain doctor doesn't want to give me any more medication. Which I totally understand, I'm actually tired of taking all this stuff. I hate taking medication. I'm on a lot.

I started [meds] in 2011 when I got back. I had my pain in December of 2010 and we got back in January. I saw my PA once or twice a week, I would have to get a shot of Tordal every week. Or if not, they would have to send me home, they would put me on quarters. That's how bad my pain gets. Then I went on block leave, and had to go to the emergency room. I told a doctor what happened, she didn't know exactly what was going on, but she knew what to give me. She gave me Tramadol when I finally got initiated in MEB, in August 2011. In September, they switched my Tramadol to Vicodin.

After two or three months taking the Vicodin, they switched me to Norco. But Norco was too strong. They switched me to Norco in late November, but I couldn't handle the highs of it, so they put me on BuTrans patch. That's what I take right now. They started on fives in December, now I'm sitting on twenties, 20mg now. And that stopped working over a month ago. I've been taking Motrin, 'cause I went online and they said if you take Motrin with it, it will help with the inflammation. And then that stopped working, so now I take Atarax, which is an allergy medication. But it helps boost the pain med—my PA found that out. The PA I have now is good. He tries to do whatever he can do at his level. Because, you know, they get shut off at a certain level. My pain doctor is who issues me all my narcotics.

Everything stopped working. I got a tolerance for everything, but the Norco. The Norco, I would take one and I'd be drowsy. And then the medication would wear off, but the high doesn't. So when I take another pill to help with the pain after that, they have to try to wake me up if I'm at work. I sleep with my head on the desk. So I had to get taken off that stuff, I couldn't handle it, couldn't drive, couldn't function.

...This one pill I've been taking for probably going on three weeks to go with the patch. And I usually take one at night and then I can go on with my day the next day. But now I take one at night and I get up. And if I take one tonight, I know I'm going to have to take another one tomorrow. But they make me drowsy also.

And then I have a muscle relaxant. If I don't take that, I get real bad back spasms. And they just switched that out Thursday. And the one I took yesterday is no joke. So I actually don't know

what I'm gonna do 'cause I can't take it at work, or take it and drive, so we'll see what happens.

...They always [give information on the side effects]. And they gave me a big sheet of paper that says what it is... It's too much. And I'm on sleep medication too. Ambien.

...When I first got initiated to the Med Board in 2011, I went in and told them that I was having trouble sleeping. As soon as I told them I had trouble sleeping, they gave me some Celexa. So I went home and I looked it up. I saw all the warnings, and it was for PTSD, depression, anxiety, all that stuff. So I went back to the doctor, I asked him why he gave me this pill, it doesn't say anything about sleep. And he told me that it'd help me sleep. So I took it the first day and I actually took it for awhile, because it didn't knock you out or anything. But after a month of taking it, a buddy of mine called me, and he was like, "Man, don't take that stuff, 'cause you won't care what's going on." And my car was a mess, my house was a mess, for that whole month. And I'm a pretty neat person. So I stopped taking it.

It didn't help me sleep. It never helped me sleep. So I went back and told them that. They took me off of that. Then they gave me Remeron. It was another for PTSD, anxiety. They told me only take it at night. It knocked me out for about five hours and my roommate was trying to wake me up. I was comatose, out of it. But once I woke up, I ate up everything in the house. I did that for three days in a row. So I went back to them and told them, "I can't take that." Then they gave me Trazodone, after that. Which was another for anxiety and depression. It would knock me out for only a couple hours. I'd get up, do my laundry. While everybody is asleep, I'm up. But I didn't go back in, I just took the Trazodone, I just left it at that. And they sent me to a psychologist in March or April, this year. He diagnosed me with PTSD in April or May. And I thought that was kind of funny, because now I don't take any PTSD medication.

Now I just take Ambien. I got prescribed the Ambien in May of this year. After I had been on all the other stuff, they put me on the Ambien.

...I wasn't seeing anybody for PTSD [before]. They were just giving me all these pills. It was my MEB doctor prescribing them. And they kept saying, "It'll help you sleep." The Remeron and the Trazodone, I think I took those for three days each. And I was like, I'm not taking that stuff no more.

Editor's Note: Randal confirmed that upon writing his prescription for Celexa, the MEB provider did not specifically instruct him not to stop taking the medication abruptly on his own.

They just wrote me up a prescription, and "Here, try this for sleep." That was it. But actually I had a breakdown in March of 2012. I woke up in the middle of the night like I always used to. I used to wake up full of energy, sometimes shaking, sometimes just feeling down, and sometimes I'd wake up like not from a dream. I would wake up and I would be sweating and crying. And usually I just go back to sleep, but that night, I couldn't go back to sleep. So I went to the emergency room and after that I've been seeing a psychologist.

I remember I got into an argument with my roommate [that night]. I told him he had to leave,

'cause he kept disrespecting my place. And I come to find out I had a whole bunch of complaints against me, and I was about to get kicked out of my place. Break the lease, breach of contract. So I told my roommate he had to leave. I had been at a friend of mine's house when my girlfriend sent me a picture of my house, and my roommate had a big flowerpot in the middle of the carpet, and had a whole bunch of people in there smoking cigarettes. I don't smoke. He already knew to smoke outside, he just had all these people, music blaring. Just very disrespectful. So I told him he had to go. I actually was yelling for him to leave. And I woke up later in the middle of the night, just woke up on my girlfriend's bed, shaking. And that's when I went to the emergency room.

I didn't see [a psychologist] 'til like a month after. That night, I went on post, and this civilian lady talked to me. I guess she was an around-the-clock social worker. And she was talking with me for a little bit and trying to get information about what happened... My sleep had been messed up since I got back in 2011. I used to go see the MFLACs, every unit has an MFLAC, a Military Family Life Consultant. And every time I'd tell them I had sleep issues, they'd tell me to go see my PA and get some medication...

[The psychologist diagnosed] the PTSD and depression. I see him every week, once a week. That lets me let out a lot of frustrations. My main frustration is them not helping.

We have a new commander, he's aware of [my] situation also. So he sent everything up the chain that was going on with me to the Colonel. They all know my situation. I just come into work, deal with it everyday...

As far as the doctors, I do not know why they just push me to the side whenever I bring up my abdominal pain. Every time. And last Monday was proof. They had me in the system as coming to see them for abdominal pain and all they talk about is my back. I told her that my referral expired for my back pain, but they still keep sending me in. And they keep using the excuse that maybe when they cauterize the nerves in my back, it will help with my abdominal pain. But they told me, it's not in writing, it's in their doctor's notes, but they told me to my face that my back has nothing to do with my abdominal pain.

And the same providers Monday told me that maybe when they do the cauterizing of the nerves in my back, it will help with my abdominal pain. So they just contradicted themselves. So I'm moving to another provider. Next week I have to let my providers I have now know that I'm leaving them. But I gotta wait until I get my MRI next Wednesday. After my MRI, I'm going to go to their office and tell them that's it.

Since December 3, 2010, I've been on profile... It said, "Hernia." When I finally got evaluated, my profile changed in March or April and they changed it to "Abdominal groin pain." Actually changed it to that instead of hernia, because they couldn't find a hernia. All the tests they ran, they still couldn't find one. But now I have two permanent profiles, one for my abdominal pain and one for my back.

The one for my back says that I can't sit or stand for a certain amount of time. Sitting like this, leaning forward. I can sit down longer, if I sit straight. If I'm on my medication, a half hour sitting at

the most. And that's driving also. Off my medication it says 15 minutes, but I can't sit up for 15 minutes straight. I can't do PT, I can't lift, push, or pull or carry anything over 10 pounds. March at my own pace and distance. Basically what we call a 'dead man's profile,' can't do anything.

Editor's Note: Randal testified that he has not experienced pressure to violate his profile at Fort Hood. He also said that he and others in his unit were generally aware of MEDCEN-01 and SURG-01's regulations against profile violation and stigma.

They actually have to tell me to stop. To put stuff down. I don't lift up stuff real heavy, but when I do, they're like, "Alright, put that down."

...Soldiers look up everything on the computer. Plus we have a policy letter wall. All III-Corps policies, it's mandatory to have them posted.

When I got my first profile in December 2010, I didn't get another profile done again until March. So I went the whole month of February without a profile. But no one made me violate it.

Some soldiers do try to ride their profiles out. Every time theirs gets done, they go get another one so they won't have to do certain jobs. It's been like that since I first came in. For people who ride their profile, [they get made fun of]. 'Cause some soldiers hate to run, so they'll get a profile saying they can't run. But on sports day they're out there playing football, basketball, soccer. Soon as the next day is a run day, they can't do it. They'll basically just tell them, "You know you faking it."

As far as mental health, I don't know too many who has that, except for myself. I'm on Rear D, so there's only between 14 and 20 of us...

There was a soldier that I deployed with. Probably about a month ago, we were all sitting around talking about all the missions that we went on, people who didn't make it back, people who got blown up. And he actually came out and said that he was scared the whole time, and that some nights he finds himself awake. And I tell him, "Hey, you know, go get help. I went and got it. I honestly did not think I needed, but that one night..." [He hadn't gotten help] 'cause the soldier still wants to stay in and still wants to be able to deploy.

Editor's Note: Randal went on to reflect about where stigma against mental health concerns comes from, and described his own experience in post-deployment processing.

It comes from the highest to the lowest. That's in my opinion. 'Cause leaders have to deal with soldiers who want to deploy, but they know they're just going there for a paycheck, they're not really going there for the job. Then you have some soldiers who are fully capable to do the job, but they don't want to deploy, and try to get out of it. And they try their hardest. I do see a lot of that. Now I haven't seen it within my company, but I've seen it within my battalion.

They don't want to go back. I believe they are scared to go back. Because they went there the first time and, "Okay, I made it back." And they don't want to do it again. It's simple as that.

That's a dangerous job, what we did over there.

When I got to the medical part [of R-SRP], they asked me what was going on. I told them that I had a hernia... And they said, "Okay, we're going to set you up for an appointment." I told them in December 2010, and they asked me if I had a past medical history. I said, "Yes, I had a hernia repair in September." And they said, "Oh." He was putting my information in the computer and was going to set me up with General Surgery. I told him that I had a hernia repaired two months before, and he just stopped and said they couldn't touch me.

They said I had to go through my PA because I already had a previous surgery... That was it.

[At SRP] all we was doing was getting ready to roll out. They just ask you the basic questions: past medical history, do you have any pain issues, or what's wrong with you right now. [I only had] my back, but I worked through it. It's just my back got worse over there.

...After we did our Reverse-SRP, it was mandatory, everybody had to go see the MFLAC.

Editor's Note: Randal also said he was not given any screenings for PTSD or TBI while in Reverse-SRP. He described what kinds of past briefings he had received on traumatic injuries, and what symptoms he experiences.

...There's the MFLAC. We used to do a lot of PowerPoint on PTSD, what it means. PowerPoint, PowerPoint, PowerPoint. And TBI. There's also a TBI clinic that they actually have on Fort Hood. I dropped a soldier off there once. It's kind of small.

It's a whole bunch of different briefings, just one after the other. PTSD, TBI... I don't even think [each] took 30 minutes.

[I have] definitely irritability, nervousness. Just cannot relax sometimes. Just wanting to be by myself, that's usually how I am once I get off of work. Even during work. I push through the whole day, but once I get off, if my phone rings, I don't answer. I don't feel like talking to anybody. It's just how I get. I get mad, and if I get mad, I go off to be by myself. I'm not really the type of person to take my anger out on other people. If I'm mad at you, then it's probably just going to come out a little rough talking to you. It takes a lot for me personally to strike a person. You have to hit me or try to before I would do anything, but like I said, I just want to be by myself. Easily irritated, very easily. Sometimes I wake up in the middle of the night sweating. It's been probably almost a month now since that happened. Even on my Ambien, I'll still wake up, I'll peek out my window. I'll run and lock doors, even if they're already locked. I'll run and lock those anyway. Check my windows. Go back to sleep.

Sometimes I have nightmares. I can't remember all of them, they're weird. Sometimes I'm being chased. One time I dreamt I got pushed off a tall building. But mostly it's like somebody's after me all the time... Sometimes I don't dream, but I'll wake up, I'll pop up out of the bed, already on my feet. I hear noise, I don't know where it's coming from, it freaks me out. I don't know where it's coming from, I don't know what's going on.

...The only thing right now I can say that's positive for me is my girlfriend. We were together for awhile, then we broke up for almost a month. Now we're back together, but she's in the military and she's on her way out. So I think she's moving back home for right now. I think that she don't want to tell me, but I think she's moving back home.

That's gonna suck... So yeah, between that and my pain, it's like I don't really do too much like I used to.

...I know some [soldiers] are avoiding the help that they need. I can say as far as the section that I work in, a lot of them are avoiding the help. Because they are afraid to be labeled such as myself. But yeah, that night I woke up, I really said to myself, I've got to do something.

Editor's Note: When asked how soldier morale has been affected by multiple deployments, Randal replied emphatically.

Whew. Man. When I first got here, I bumped into a guy in replacement. I talked to him I don't think five minutes, but he left a lasting impression on me. He was working there at replacement in 2008, he was one of the guys who kept telling his unit he had PTSD. They weren't listening. He deployed four times, back-to-back. Lost his family, his family just left him. I think he said he was married for almost eight years, and his wife left him. Back-to-back deployments, and he didn't want to go on. He said he didn't care as long as he could be back one year, you know? He said I don't care if it's every two years, I'll deploy for two years. But four deployments back-to-back. And he just cracked. And that's where they put him at in replacement, that was his job, just signing people.

So I know for a fact back in 2008, and I know it had to be before that too, it was rough on soldiers. And then other people were telling me their stories, and I was just, "Man, I hope this doesn't happen to the unit I get to." I just hoped that we didn't fall into that rotation. And we did. We got back in January 2011 and then they left in February of this year.

Unfortunately, we are needed for the job—we're needed. But that's rough on the family.

Just listen. The soldier says this is wrong with him, so send him for help and see what the results are. 'Cause that one soldier kept acting like he was crazy and they sent him for help. So I thought that was cool. He says something is going on, so they don't say, "Oh you're alright." I mean, if he's lying, it'll come out. But send him to be looked at.

...Every three months we do [trainings]. The sexual assault, sexual harassment, and suicide prevention. Every three months.

It's received by PowerPoint, of course. It's interactive, so you can answer what should this person do in this or that situation. And then we also have a group that does an act. And they physically show you how it goes picking up girls up at the bar, what women do and everything. And then they let the crowd interact. They'll go through a scene and after they finish the scene, they'll ask

the audience what they have seen, was it inappropriate or okay.

A lot of people after their training, they think they have a real problem. Because some things that you think you're doing as fun is really harassment. So they sit in the crowd, and say, "Oh man." They realize. And they actually give you scenarios, what's rape and what's not rape. The training's actually gotten a lot better than when I first joined. When I first joined, they'd call you all into a room and they'd just hold a sheet of paper in their hand and talk, that was it.

I know [sexual assault] still goes on. I don't know if the numbers went up or down, but I know it goes on. 'Cause people gonna do what people gonna do. I actually know a guy who went through it with another soldier. I don't know the exact details... All I know is they were separated, one got sent to another company. A whole other battalion. They split 'em up.

Editor's Note: The interview transitioned back to the details of Randal's experience in MEB, clarifying how he sees confidentiality and communication between providers playing out. He began by saying he does not know whether his care in MEB has been kept confidential. However, because he sees civilian providers for mental health, he thinks MEB does not know about his PTSD.

I can't even answer that. I don't even know, to tell you the truth. Where I'm at now, I don't have a MEB doctor anymore. It's actually my PA, I go see him now. Unless I have an appointment with my pain doctor. But I wouldn't say that's confidential. I don't think it is, [because information is shared between the doctors and command].

...Do I think they share this with the other soldiers just sitting out there in line? No, but... I know [the commanders] know.

I go off-post [for mental health]. And it goes from my psychologist to my case manager. And my case manager is not even in my chain of command, and command doesn't even know about my case manager.

...I will get benefits for my conditions, it just depends on what I choose. That's what actually I'm waiting on now. I already got a letter back saying I'm unfit, which means I'm gonna be processed for medical retirement. I have over eight years, so it's either the VA or the Army. I'm getting a VA Rep. Already have their number, I called them. They said soon as soon as I get my percentages, just give them a call, and they'll represent me.

...What I really want is just to be fixed. I don't care if I get out, don't care if they're paying me all this money per month, I'm still gonna get out and not be able to do what I want to do. That's my biggest complaint.

I want them to figure out what's going on now. Because I was trying to stay in to finish, I have nine years left to retire. I was hoping that they could find out what's going on and leave me in my job, re-class me. Then that would be the end of it and I'd retire as planned.

The drawdown is affecting everything. They have soldiers who want to re-enlist, but they can't re-enlist. And you've got me. And I saw one soldier who was placed in the Med Board just to re-class him. It made no sense, but that's how they're doing it now. I guess it's to fully evaluate the soldier and see if he can stay in. Which is stupid.

Editor's Note: Randal also replied unequivocally that he had seen soldiers chaptered out before their ETS dates during the drawdown.

Our commander has the authorization to do that now because of the surge. Commander can drop chapter paperwork, still honorable discharge, but it's in three months. You're out 90 days before you ETS. They are doing that. Then you have some soldiers who just want to get out 5-17,²²⁴ that's honorable, but you lose all your benefits. And they're doing that too.

I know soldiers who want to get out, but they want to Med Board out so they can at least get a percentage before they get out. But the Med Board is drawing out so long, they just say forget it, go ahead, I'll just take the chapter. And they'll just chapter out with nothing.

...You're supposed to be able to ACAP a year out. That gives you plenty enough time to go through the ACAP process... Now it's, "You gotta get out!" So now that leaves you with one month to do all your ACAP and look for a job before you start your leave. And if you want to take your terminal leave, that cuts your time to find a job back even further. My girlfriend is going through that now. She starts clearing the end of this month, and she's taking two months of leave. She started her ACAP last month and is looking for jobs.

...I know I will not be able to work [as a civilian]. And that's what I want to do. I want to get to a place where I can just go to work, go have some fun. My friends dragged me out to the club one time and after not even two hours, I'm ready to go. I'm hurting, can't sit down too long, can't stand up or walk around too long.

That's my biggest issue out of everything. I don't know what they're doing. I don't know if they're dragging this out to wait 'til I mess up, or dragging this out so that I just take whatever they're gonna give me. But I'm gonna wait 'em out. For as long as they wait me out, I'll wait them out. But it's starting to get very frustrating every day. Even going to work now. Even though I take my pain medication, I'm still in pain moving around. So by 10:30, I want to go back home and lay down for a little bit. So that's what I usually do at lunchtime. I have to wait 'til 11:30, and then I go home and lay down, or I lay in my car.

They haven't even limited my duty hours. I go in at 6:30, I don't do PT. And I come back to work 09:30. And then work 'til 17:00. It's because the only profiles that they can give you are 10-hour profiles and eight-hour profiles. Technically we only work seven hours, because you got the hour and a half for lunch and you got the hour and a half in between for PT. So that's three hours gone out of a 10-hour day. So you only work seven hours. And that's how they get you.

I haven't felt it had anything to do with race. I just think it has something to do with the system, certain systems. When our unit wasn't involved in the Med Board process, it made it really, really

tough. They only had a certain time in the morning you could go to sick call, and other than that, if you were sick, you had to go to the emergency room. And going to the emergency room really ticks them off, because to the ER it's not an emergency room issue. But we're trying to get help. I can't go to my PA to get help or a quarter slip to go home. I went in there in pain so bad one day, but I was in the Med Board process, so they couldn't do anything.

...Soldiers complain every single day. And you still can't go to the emergency room in the middle of the night. If I go to the emergency room for my abdominal pain, they gonna look up in the Med Board that I'm Med Boarded for my abdominal pain. "So sorry, can't do anything."

If I have an emergency that doesn't have anything to do with anything I'm in the Med Board for, then they'll see me... A couple of times, in the middle of the night the pain hit me so bad that I had to be escorted to the emergency room. I'm laying there crying. And they're like, "Well, you're in the med board process, we can't give you anything."

They release me back to my unit and I'm in my car for the rest of the day. 'Cause that's it. It is a little better since they put us back in the aid station, 'cause our PA's can do certain stuff. They can't issue me any narcotics, but they try [to help].

...I don't know what I'm gonna do, but I'm gonna do something. I'm gonna call the Ombudsman back. Now that they put them in place, they've been pretty good with advice. They advise you and they ain't supposed to be under the Congress. I called the Ombudsman, they were the ones who told me to get a VA Rep. I'm really waiting on my percentages so I can talk to VA Rep. 'Cause they said they have the power to make the Army see what's going on. I told them I don't care how long it takes, they gotta figure something out.

...The MEB process already takes awhile, but as far as getting soldiers to their appointments and everything, a lot [needs to change]. Like myself, I hate taking medication, but you tell me in March we can't get you an appointment to see somebody 'til June, and you take these meds 'til then without seeing anyone. The first time they gave me Vicodin to take and they had to take me to the emergency room. I was so tore up I couldn't explain to them, I was so out of it. They thought something bad had happened to me. And when I finally started coming down, I told them that I took one of my pain meds. You got me at work on this stuff every day. I mean I don't want to be home every day. I don't mind going to work, it's just when I'm hurting, I can't do it. Like two weeks ago, I missed a whole week from work, because they wouldn't do anything about my pain medication. It took 'em a whole week to figure out to try this pill and see if it helps.

I plan on going back home...for a couple months. I don't know where I'm gonna end up at. Y'all have a lot of work to do, I can tell you.

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Kimberly MacArthur*

Editor's Note: *Kimberly is a white Army veteran in her early twenties who served as a Signal Intelligence Analyst. Over the course of several years, she was made to run and do other physical activities at work against her medical profiles, which led her to need surgery to implant fake hip parts. At the time of her interview, she had recently received a general discharge from the Army for Patterns of Misconduct. Kimberly described several ways she sees soldiers being chaptered out before their ETS dates amidst the drawdown in ways that are not accountable to soldiers' health. She herself feels her command just wanted to get rid of her, and used the excuse of a recent legal charge which dealt with by civilian authorities and had been expunged from her record.*

I joined the military because everyone in my family is in the military. My dad's a Marine. My grandpa was in the Army, all my uncles are in the Navy, my brother's about to join the Army. It's just what we do.

I was hoping that it would be everything that my family had said it would be—you'll always have help, you'd always have camaraderie with everyone, you'd always have people. And I'm a big people person, so I'm like, "Okay, yeah!" And you get school, so it's just a whole package deal, but it turned out not to be a help.

NCOs, instead of people being selfish and only thinking about themselves, they're supposed to take care of the lower enlisted soldiers that haven't been in the Army or haven't been in the real world for a very long time. I joined the Army right after I got out of high school. I just worked for the summer, and then I was gone. And I didn't have a lot of living on my own experience. I had some issues with it. And no one was there to help me, 'cause they were too wrapped up in their own selves to take time to help their soldiers. Which is a lot of the reason why I got chaptered out, because no one was there to help me.

...I don't have PTSD, I didn't deploy, or anything like that. But I'm 22 years old, and I have fake hip parts in my leg, because of the Army running me on my profile, when it said that I'm not supposed to run. When I'm not supposed to walk up stairs, I'm not supposed to carry stuff, I'm not supposed to wear an IOTV.²²⁵ I'm not supposed to carry a rucksack. I'm not supposed to do anything like that.

And it continuously messed my hip up, because you can't say, "No. I have a profile." They'll be

like, “Psshht,” pretty much will poo on your profile. Cause I’m an NCO and I’m telling you that you’re to go run up that hill, because it’s PT and that’s what you do. And since you have a profile you probably shouldn’t do anything. And that’s a lot of the reason why it got progressively worse and worse and worse and worse, and why I have my hips rubber-banded together, right now.

It started to heal and be fine. And so, they were giving me Cortisone shots in my hip. And that was supposed to help. And they gave me this other shot that’s supposed to enable your cartilage to grow stronger and back together. I don’t remember what that was called. But because I wouldn’t let the leg [heal] and had to do all this stuff—it wasn’t helping. So it got so bad that they just got everything out of my leg, and it’s now rubber-banded together.

When I hurt myself, I fell out of the back of a LMTV troop truck, which is probably about six or seven feet off the ground, give or take. I was in full battle-rattle, and I twisted while I fell, so it the force of the fall and everything caused some of my tendons and my cartilage to rip and be stretched out. And I didn’t think anything of it, I just thought I bruised myself really bad. But then the bruise went away and it still hurt really bad.

I went into the doctor, and they just said, “Oh, you have an internal bruise. You have a bone bruise.” And I was like, “Okay. I’ve had bone bruises before.” That’s fine, it’ll go away. But then I left AIT, because I was on the Air Force Base. And we didn’t have the Army medical, we had Air Force medical care, so we couldn’t get everything that we needed. And when I got here, I went in, and they were just like, “Oh, well, you have a hip sprain.” And I was like, “Okay.” And they were like, “Don’t run, don’t do this, don’t do this.”

It got progressively worse, and got to where sitting would kill me. I’d have to stand up. I couldn’t extend my leg out, at all. It was awful, awful problems. And then, I went to another doctor, because I had felt that the other doctor wasn’t taking all the proper steps. He said I had a hip sprain, but he didn’t take an x-ray, MRI, anything like that. He just poked it, and was like, “Oh, you have a hip sprain.” And I’m like, “Well, how do you know I have a hip sprain?”

Then I went to another doctor, and she’s like, “Well, I’m gonna send you to an x-ray, and I’m gonna send you to get an MRI.” And then, there was an arthrogram, where they inject glowy stuff into your joint, which hurt really bad. And they found out that my tendons and my cartilage were being ripped away. And then, instead of saying “Okay, we need to get this fixed,” she’s like, “Okay, we’re gonna give you shots, to start out with. And then we’re gonna send you to physical therapy.” And then it got to the point where you couldn’t touch from the middle of my back, all the way down, where your muscles connect, couldn’t touch it. If you just barely bumped into me, I would seize up, ‘cause it hurt so bad. And it got worse and it got worse and got worse. And then, I went to that same doctor, and I was like, “Something’s not right. Physical therapy’s not helping, the shots aren’t helping.” I came back again, and it was gone. My joint was pretty much just [gone], like that. It was deteriorated pretty much all the way.

In 2009, I fell off the truck. I want to say it was around summer. I didn’t get an MRI until almost a year later. ‘Cause it was when everyone was deployed. So that’s why I didn’t deploy, because they were like, “Well, there’s this problem with your hip, and you can’t carry”—that’s like, the one

time my profile was respected, was when like, "Oh, you can't deploy because you can't carry anything."

...I had to get counseled and all that, and go to a specialist. I don't trust Army doctors. So I went off post and made sure that's what was going on before they sliced my leg open, so they couldn't be like, "Oh, that isn't the problem, but now you're gonna have rubber bands in your leg." 'Cause I mean, before, they thought I had spinal meningitis, and they took a spinal tap on me, and I didn't have spinal meningitis, I was just really sick.

I don't trust doctors at all. I don't know if this is true, but I have been told by numerous people, is that the Army hires civilian doctors that have lost their license elsewhere. And I've heard that from NCOs... My grandma, she's a nurse. And I'm like, "Grandma, what is," and my grandma will be like, "No, that's not right. Why would they give you that to treat that?"

My [Army] doctor, she was really good. You could go in there and "Oh, I had a fever yesterday. I still have a fever." And she'd be like, "Okay, you're not going to work today." But then, other doctors will be like, "Oh, you have a fever," or, "Oh, you're coughing up blood? You're fine." Just take this prescription, you'll be fine. I had a doctor before I had my good one and I had bronchitis and I couldn't breathe, I had a fever and he still made me go to work. And I got in trouble for falling asleep at work, 'cause the medicine he gave me made me fall asleep. And I have chronic bronchitis now.

Some doctors'll be like, "Yeah, you don't need to be doing this, you don't need to be doing this, you don't need to be doing this, because it's not gonna help." And then, other doctors are like, "Oh yeah! You can do that! It'll be fine." And then it's not okay, and it doesn't help. It's not like they're all on the same page, it's not like they all talk to each other before, [or] like they have the same operating procedure as everyone else.

I had Vicodin and the 800mg Motrin. That's pretty much it. And then Cortisone shots, 'cause it has pain killer in it.

I got a profile when I first got here, when I was in reception. Because I told them, "Hey, my previous unit told me that when I got here I needed to get a profile, because my profile wouldn't carry over, because it was from an Air Force base, and an Air Force doctor." So I had to go to Darnall and get a new one. And then, I had that, and then they would push the limits of my profile. Which they shouldn't do. Like, "Well, it says you can do this." But like, when I'm on a profile, say, "No running, no..." you know, "Can you carry this, can you do this? Can you do this?" And then [the profile] has a remarks block, and it'll say, "Is not recommended," like, "Yeah, she can do it, but it's not recommended that she does."

I wasn't supposed to put pressure on my legs, so I couldn't do push-ups, I couldn't do sit-ups, I couldn't do anything. And so they would be like, "Oh, so you can do push-ups on your knees." No, that still puts pressure on my hips. And they'd be like, "Oh, no, you can do that, you'll be fine."

So, there was a lot of that that I had to deal with, pushing the limits of your profile, and then they wonder why their soldiers are still hurt and still not combat-ready. If you push the limits of my profile, I'm not gonna get better. And I understand there's a lot of people that just get profiles because they don't want to do it. But you have to think what if the soldier really does have a problem? And I did really have a problem. I had brought in all my x-rays and everything, to my first sergeant. And I was like, "Look, this is my leg, this is what's going on." And he was like, "Oh, well, you can still do this, you can still do this." It's like, "No, I can't."

Every unit has a medical team, an aid station where all our medics work. We also have a thing called MEDPROS, and if you need to go to the dentist, it'll be like, "Okay, your medical readiness is Red, because you need to go to the dentist," or you need your hearing done, or you need to go get your HIV test done, or anything like that. It will say online. And all our profiles go through them anyway. So why not have an actual medical officer decide whether or not?

I know there's a lot of people in a whole battalion, but I think it'd be a more helpful way than to have commanders and first sergeants that are just like, "No, she's faking!" Or, "No, he's faking," and when they actually have a problem and you let the actual medical officer sit and be like, "Oh, well, they're doing this, and they're doing this."

I don't know [if people know about MEDCEN-01]. My roommate, he has a lot mental issues. He got sent to the fifth floor of Darnall for a week, last week. I was with his wife, it was awful. But they seemed to be pretty good about recognizing his profile. He can't be around weapons, ammo. He can't drive military vehicles, anything you know, sharp, he can't be around it at all, 'cause he threatened his first sergeant because he has a lot of stuff going on. And they seemed to respect his profile pretty well.

I've heard him saying that some of his NCOs are like, "Oh, you're just being a blah-blah-blah-blah, suck it up." And he'd be like, "Nope. Excuse me," and get them in trouble. So I think it just depends on the unit. Ill Corps is pretty bad. You have, I want to say, 90 days of recovery to get back to where you were, to where you're supposed to be. It's profile recovery. And they don't respect that either, and that's how people get reinjured because they want to push themselves, because their first sergeant's like, "Oh, you don't have a profile anymore," but I'm like, "Well, I'm on profile recovery. I can't just pick up and run two miles."

And that's one thing they don't recognize. But I think it just depends on the unit. 'Cause I know Ill Corps is really bad about it, but my roommate, he's in—I want to say 1-7 Cav. And they seem to do really good with him, and one of his best friends that he deployed with.

Editor's Note: Kimberly was asked what she thought it would take for MEDCEN-01 to be enforced at Fort Hood.

I don't know—I think the army's just like, "Oh, we'll just give 'em a class on it and it's gonna work." Well, obviously not, because if you're gonna be a commander, you're gonna have to go to whatever commanders have to do. And it's not gonna stick with you.

I really think that they just need to make an example. I know that's really awful to say. But I think to get the message out, "Well this commander got his position taken away as a company commander because of blah, blah, blah," and, "This commander did this, blah blah blah." Because people are gonna be like, "Shit, well, I don't want that to happen to me." 'Cause if you command a company, I think you get paid more. Money talks.

I've had more than one soldier come in and say this commander has been doing this and this, and I think lower enlisted soldiers need to learn too that they can go to IG whenever they want. They don't have to have a commander's permission, they don't have to have a first sergeant's permission. They don't have to have their first line permission, you can just go to IG, and if anyone calls and asks you where are, and you say, "I'm at IG," they can't be like, "Oh, well, you need to get back here."

I know that there's town hall meetings. I've never been to one, but it's where the CG²²⁶ and the post sergeant major talk about issues. And I think that they need to have meetings with just lower enlisted. 'Cause town hall meetings are spouses and everyone. And I think there need to be meetings, like census groups, you could say, with lower enlisted soldiers, to say, "Hey this is a problem, and it needs to get fixed." And have the CGC that is a problem, 'cause I know that some people have called in on these CG meetings, especially for like, Don't Ask Don't Tell, and ask what the CG's doing to stop acts of hate and acts of violence. And he didn't answer the question.

Editor's Note: The interview returned to the issues Kimberly experienced with being on profile. She began by describing the exact work restrictions detailed in her profile.

I can't run, I couldn't do sit-ups, I couldn't carry a weapon, I couldn't wear anything over 25 pounds. So even if I took the plates out of my OTV, I still couldn't wear it, 'cause it weighs over 25 pounds without the plates in it. Couldn't carry a ruck-sack. Only thing I think I could wear out of my gear was the kevlar and a gas mask, 'cause they're light. I couldn't swim, I couldn't bike, I wasn't supposed to walk up stairs. I wasn't even supposed to walk.

That's another thing too, 'cause on a profile, it'll say, "Walk at your own pace and distance." Okay, that's my pace, and my distance. It's not what sergeant Joe Schmo says, "Okay, you gotta walk to there." If I start hurting before I get to there, I'm gonna stop, because my profile says at my own pace and my own distance, not what your NCO says. And I think that's something that needs to be put out too, because I've heard many people say, "I need to run or walk at my own pace and distance. And if you can only run like, let's say two blocks. And that was pushing yourself? Fine." It shouldn't be a problem. That's a big problem that I've heard of.

I had that problem when I got off my surgery recovery, I was getting in trouble because I'd step out of the formation. I'd still run, but I couldn't keep the pace with them. And they'd yell at me and say that I'm shamming, and that I'm not trying. And I'm like, "No, I can't do that." And like, "Look, I'm still running! Still running!" Just not the four minute mile pace that you are. You know, so like, "Oh, you can't run sprints. Well that's the pace and distance we're going to." Well, I can't run sprints.

That's why they need to be an actual medical officer [to interpret profiles]. Even every company having a medic, or a medical officer would be helpful. 'Cause I know III Corps has a crap-ton of medical officers and medics that can read a profile, and just as well as an officer can.

I had some problems with [profile re-evaluations] sometimes with some NCOs. I had one NCO, he was really good about it. He'd ask how I was feeling, he'd actually take time. I think he cared 'cause he had a lot of medical issues. I think he had brain cancer. He'd always come check on me. And I had other NCOs be like, "Oh, you're fine. You don't need to go on another profile. You're just riding your profile." Like, no, my leg might fall off. But I didn't really have a problem ever going to get re-evaluated, until my unit got back from Iraq, and it was like, "Oh, I stayed behind 'cause I was getting chaptered," "Oh, I stayed behind because I was overweight," and all this stuff. And I was like, "No! That's not why I stayed behind. I stayed behind because my hips are all messed up."

One of my friends, he found out that he had AIDS. And he's in the Army. And no one knew. And he confided in one of his good friends in his unit, and then his whole unit knew. And he didn't want anyone to know. He didn't even want his close friends to know, until he told one of his friends in his unit, who then spread it to everyone else's unit. And it was awful for him. Because he was like, "Now no one wants to be around me. Now everyone's afraid I'm gonna get sick." And I'm just like, "I don't even know what to tell you." People are jerks.

They make you feel like crap [if you're on profile], pretty much. They call you weak, they say, "Oh, you're malingering." Or, "You're just being lazy," "You shouldn't be in the Army," "You're a terrible soldier. This is a general soldiering task, you should be able to run two miles just fine." My first sergeant would always say it. And some of the NCOs that didn't know me personally, and didn't know the issues that I had, or weren't directly in my chain of command, but were just NCOs that were directing PT. And I'd be like, "Look, I can't do this." And they'd be like, "Let me see your profile!" And I'd take my profile, unfold it and give it to them, and they'd be like, "Well, it says you can do this, and blah blah blah. So you're gonna be fine. It says run at your own pace and distance, or it says that it's not recommended that you do something, but it's gonna be fine, you can do it anyway."

And they'd be like, "Do it 'til it hurts." And I'd be like, "Okay, I can do that." And then as soon as I'd do maybe five push-ups I'd be like, "Okay, I can't do this anymore." And stand up and start doing overhead arm claps or something to work my upper body. And, "Why did you stop?! Why did you stop?!" And he'll get in your face and yell at you, and tell you that you're crap, and that you're worthless, and how you shouldn't be in the Army. Just all kinds of negative stuff that shouldn't be said to people.

They wonder why people snap, and why people get in trouble with their NCOs, and why people punch the shit out of their NCOs. Because they get in your face. It's one thing to be a drill sergeant, 'cause that's your job, to get in people's face. Just to be a regular NCO, you're supposed to be there to help and support your soldiers. I think it's the second or third line in the NCO Creed, that says that you're supposed to be there for your soldiers, and they just overlook it,

completely.

There's a lot of NCOs that are on profile also. And they tend to be the ones that are like, "Okay. What can you do?" Not telling you, "You can do this," but, "What do you feel comfortable and okay with doing?" Because those are usually the ones that have profiles that understand. And there's NCOs that'll be like, "Oh, well, she can't do this." And it'll circulate to another NCO, "She's just not trying. She doesn't want to try." And it'll just get passed NCO to NCO to NCO, and no one stops to say, "Okay, maybe she's really hurt."

It makes you look really bad, because of a rumor circulating about you that you're just not trying, or you're being labeled because you're being a crappy soldier. And it shouldn't be like that.

But the thing about lower enlisted is we really don't care. We'll be like, "Oh, it's just an NCO saying something." 'Cause stuff does happen. You don't hear about NCOs messing with other NCOs that much. You hear about NCOs messing with lower enlisted. So it's kind of like, "Well, it's just an NCO saying something." There's skepticism.

Editor's Note: Kimberly also reflected on how the stigma associated with profiles affects other soldiers' decisions to seek care.

I think that does a lot. A guy in my unit, he pretty much had the same thing happen to him that happened to me, and he is younger than I am and has to walk with a cane. Because he didn't go get help, because it's always frowned upon. They can't stop you from going, but it makes you look like a shitbag, is what they tell you. And he has to walk with a cane now, because he pushed himself, pushed himself, pushed himself, pushed himself, even though he shouldn't have.

Mine could've been a lot worse than what it is now. 'Cause his is like, completely gone, grinded down and everything. Because he kept pushing himself. Because you don't want to be "that soldier." You don't want to be like, "Oh, I'm hurt, oh." 'Cause I'm sure there are people that do fake it. I can't say for sure, because I've never met one, a person who's going to fake having a profile. But I'm sure that they're out there. Because if not, it wouldn't be a problem like it is, with people that are genuinely hurt. And they're made to feel like if they go get help, they're not gonna be treated the same.

Every ten years, I have to go get a new rubber band put in. So when I turn 30, I'll have to go get my leg re-cut open, and have a rubber band, and my pins tightened. It doesn't bug me anymore, 'cause it's just like having regular tendons and whatever, it works just the same. But I think in the long run, like when I get older, like in my 60s or 70s, that it's gonna definitely bother me. I already have arthritis in my hip because of it, because of where it was touching. I foresee that being a problem, and me having a lot of hip problems when I'm older. And probably having to get my hip replaced.

I did go through SRP. They gave me VOA shots, and Station 13 decides whether you deploy or not. And the lady was like, "Do you feel like you can deploy?" She asked me. She was a major and she was a medical officer. And instead of just looking at my profile and saying, "She shouldn't

deploy, I'm not gonna mark you to deploy," she asked me, "Do you feel like you can deploy?"

It says on my profile that I was non-deployable. But she was like, "Oh, do you feel like you can deploy? I can change it." Like, really? No! If my profile says I'm not supposed to deploy, I'm not gonna deploy. And then, my friend, she has epilepsy, and they deployed her. I believe when she was over there she had a few seizures, and they didn't send her back.

Definitely back here [there have been suicides]. Recent things have happened. And one of my friends died from taking the medicine that he was prescribed—not overdosing on it, but taking the recommended dose. And it killed him.

I'm very good friends with his family. And I'm sure they wouldn't lie and be like, "Oh, he was overdosing," or whatever, I don't see it being like that... It [was] a type of medicine that has morphine in it, I want to say. And it killed him—the prescribed amount was too much for his body.

...We didn't have briefings [on PTSD] per se. We had to go online and take these little class things and print out these certificates. You could just skip through it all. And say, "Oh yeah, I did it." And you wouldn't know anything about it.

So I think there needs to be an actual sit-down brief, during a safety stand-down. 'Cause during safety stand-down, we always do the same thing. It's like, whatever 'season' it is safety, and spouse abuse—it is a big deal, but we shouldn't have a class on it like, every single time.

For PTSD, I definitely think there needs to be more classes on that. My dad's been out of the military for almost as long as I've been alive. And he didn't get help until last year. 'Cause he didn't think he had a problem. You know, throwing my mom through a coffee table, or throwing my brother down the stairs 'cause he came around the corner too quick, or driving at night, or anything like that. He didn't think he had a problem, until he went and got help. 'Cause I was like, "Dad, you need help."

It was my mom, and my grandpa and me, we all had a conference call with him—'cause I live here, and they live far away. And I was like, "Dad, you're gonna end up hurting either yourself or mom or my brother, or someone else really bad." 'Cause that's the way he was trained. [He was] Marine Special Forces. So he would really hurt someone, really bad. And he could probably kill someone, if he were having some kind of dream, or if you freaked out for no reason, he could really hurt someone. He clearly has PTSD, and you can't use it as an excuse, 'cause you don't have documented care. 'Cause I've heard it on the news, and they're saying, "Oh, I killed this person 'cause I had PTSD," but they have no records of them going to talk to people about it, or them deploying, or anything like that...

There's people who have deployed multiple times...another one of my friends, he deployed with some unit out of Fort Riley. He got shot, and he'll have his little moments, and I don't know really know how to handle it, but just be there for [him]. But a lot of people have deployed more than once. And a lot of people, they'll have issues with their first deployment, but not their second one, or going back makes it worse. I guess it just varies depending on who you talk to about it.

...One of my friends, he got shot out of a humvee during an IED explosion, on his truck in Iraq. And he'll be talking to me like we're talking right now, and he'll cut out completely, like you're not even here. He'll be like, "What?" And it won't be just for a second. He's gone like, ten minutes, where you're just like, "Eric,* Eric." And he'll just sit there and stare at you. His brain just shuts off completely. He is [still active duty]. And then, one of my other friends during JROTC, which is where you go for pre-deployment training, he got thrown 50 feet from an MRAB, because the people that were driving it were not licensed to drive it. And he got thrown out of the turret 50 feet, and landed on his head. And the same thing happened to him, he'll just randomly black out.

I don't know about Rich* but I know Eric takes medicine that's supposed to help his brain activity stay [up]—'cause his brain will just flat-line. 'Cause the way he landed cut off regular blood flow to his brain, or something. Rich got hurt before deployment. Not only did he hit his head, but he broke his leg in three places, broke all of his ribs on one side, all kinds of craziness happened to him.

He deployed, again. He just got back early last year.

...We receive training on [MST] all the time—SHARP training, Sexual Harassment Assault Rape Prevention, or something like that. And then, the ACT campaign, is the "I am Strong:" Intervene, Act, Motivate, which is a lot of the thing too, especially with my friend, where they said, "Well, if you hadn't gotten drunk, you wouldn't have gotten raped." That doesn't make people want to go get help.

I've heard of people being assaulted or whatever, that didn't tell anyone. And then the victim advocate or the command team, they're not supposed to say anything—that's why, with restricted reporting, no one knows except you, and your commander, and your first sergeant, and the advocate, and the nurse at the hospital. And then you go ask the person like, "Hey, this is going around. Are you okay?" And they're like, "How'd you find out?"

I think [sexual violence] is very prevalent. 'Cause just in my unit, there have been at least six or seven people being raped or assaulted, where they're having their rooms get broken into—it's never happened to me, but there have been people in my unit that it's happened--not out in town, but in the barracks. [Once it] happened to a man, by a girl. But most other times it's just guy on girl.

One of my very, very close friends was raped by someone in our barracks. And they kept him in the barracks. They didn't send him to jail. They didn't do anything like that. They kept him in the barracks. So every time she saw him in the barracks she'd just freeze, and I'd be like, "What's wrong?" And then I'd look around, and be like, "Oh." And she'd just stand there and freeze.

I don't think that's right. Regardless if it was a lie or if the person is lying, or you didn't rape them, or you did rape them, or whatever, you should not be in the same building complex, living in the same place. They should at least move you. They didn't even detain him at all. They still haven't, at all. And it's been like, six months, and he still lives down the hall from her.

I know that some other people that have been not raped, but assaulted, who have had to go to work with the person who assaulted them. I understand that you can't just move someone from a unit, which takes a while. They can't just be like, "Oh, well, you're gonna go here today." It doesn't work like that. There's a lot of paperwork that has to be done. But at least don't make them work together. At least say, "Oh, well, if he's gonna be here, then she needs to be doing whatever, away from him."

But keeping them in the same building is wrong—and I know that they can move you whenever the hell they want. Even if it's not out of the same building, but up a floor, or down a floor, or across the other side, something. But he literally lived four doors down from her, in the barracks.

I think people need to actually get prosecuted in a timely manner—the investigation is still going on for this, and it's been seven months. And it's still going on. It needs to be a quicker process, so people can see like, "If I do this, I'm not gonna get away with it." I'm pretty sure that's how he feels about it. Because he hasn't gotten in trouble, he hasn't gotten reprimanded. He didn't go to jail, he didn't get his rank taken. It's like, "Oh, you raped someone?" Slap on the wrist.

I know that there are groups available out there [for survivors]. But the thing is I believe it's command-referred. So if your command doesn't feel that you need to go, you're not gonna go.

...Not just PTSD, but if you get your arm blown off or your leg blown off, or your face burnt, or something like that, people are going to be like, "Oh, well, I can see that you have trauma. I can see you need help." And I think that [MST] is not taken as seriously, because people are like, "Oh, you're just making it up." A lot of the thing is that his friends—the guy that raped my friend—say, "Oh, he wouldn't do that, he wouldn't do that. She's lying."

Editor's Note: Kimberly also shared reflections on how she thinks the drawdown is affecting soldier health care.

One of my NCOs, he tore something in his knee and he was supposed to go back and get it further repaired, 'cause I guess he tore it so bad that they had to do it in increments. And he hasn't gone back, 'cause he's scared that they're gonna kick him out because of his knee. So he just hobbles around all day and acts like everything's fine, but the lower part of his leg is still injured, but his upper part of his knee is okay. So he won't go back and get help because he's scared that they're gonna kick him out because so many people aren't eligible for re-enlistment right now.

I was chaptered out before I was supposed to be ETS-ed. I was supposed to ETS in September of this year. My chapter date was the 11th of April. And I got chaptered out because I had issues with some finances, and I had been to jail in Killeen. I was punished by civilian court, meaning that the military could not punish me. It's not on my record anymore. You could look it up, it's not gonna exist anywhere, it was expunged off my record, and they still tried to chapter me out on it. And it clearly worked. Because I wouldn't be sitting here talking to you if it didn't.

I feel that there needs to be a process that one goes through—and I know that there is a process instilled, that is just overlooked. 'Cause it's supposed to be, you do one thing wrong, you get a verbal punishment. Second thing you do wrong, you do corrective training. Third thing, you get counseling. Fourth thing, you get a recommendation for Article 15, which can be anything from getting your pay taken, your rank taken, to just having extra duty. And then, it should be recommendation for separation. Mine went, you got counseling statement for not paying your bills, and there was no sending me to get help for my finances. There was no, “Well, you got this counseling, we're going to send you to go to the Financial Specialist, make you a budget. Do all this stuff to help you, so you don't have this issue.” No, it was just, “Here's the counseling, pay your bills.”

I was told they couldn't chapter me out, because I went to jail—I took someone to Wal-Mart, she stole, and because I drove her there, I was an accomplice. I had probation for nine months. Finished everything fine, and it got taken off my record. And I was like, “Look. They can't punish me on this, because I was punished on the civilian side.” So that would be double jeopardy, you'd be punished twice for something. And so I got chaptered out on it.

I'm not saying I was the best soldier ever. But I was a pretty good like, “Okay, that's what you want me to do, I'll go do it, and get it done in a timely manner.” Not sit around and take my sweet ass time doing it. But I mean, there could have been a lot more steps taken before just chaptering me out.

I think that they were just honestly trying to get me out—it'd be a lot easier to chapter me out on those issues than chapter me out over my weight. I'm not that much overweight, but because I can't run or anything 'cause of my profile. And the way I'm built, I have to run, I can't just lift weights or do whatever to stay in shape, I have to do cardio.

I was put on a diet and I did what I could. And I wouldn't just be like, “Oh, I'm done. I did what I could.” No. I'd really, really apply myself to what I was doing. And I think they couldn't chapter me out, 'cause when you're overweight, they put you on a program that you have to lose three to five pounds a month, and I was doing all that just fine. So I think that's why they took the other route instead.

One of my close friends, they're talking about chaptering him out on a chapter 10. Because they're saying that because he is—and this is honest, I was there for the whole situation—because he is gay. This really, really homophobic dude, that everyone knows he's a homophobe, went up and touched him, but didn't touch him inappropriately. Like on the shoulder, he was just like, “Hey, man,” and talking to him or whatever. We're all drinking, and everything. But he said that Jenkins* had put his hand down his pants and was doing whatever. And that did not happen, at all.

And everyone's like, “Well, yeah Jenkins is gay, so it happened,” pretty much, is what everyone has gathered from the situation. 'Cause there's more than one person that was there that said, “No, that did not happen. That did not happen at all.” And I really think it's because he's gay. I think that's a terrible stigma that definitely needs to be taken care of. And I know that a lot of

people in the Army aren't ready for openly gay people. But that never happened. They're trying to chapter him out on assaulting someone, which did not happen at all.

This happened maybe two or three months ago. And that's how quickly it progressed. And that's another thing, all my friends talk about why one friend got raped, and her case is taking so long. And he's gay and this really homophobic dude said that Jenkins was playing with him or whatever, which never happened, and it's snap, like that.

Editor's Note: Kimberly was asked if she had seen soldiers discharged for behaviors caused by their trauma or mental health.

I have. Actually, one of my other really good friends, something really bad happened to him while he was deployed. He was in a group of Iraqis and someone threw a grenade. And it killed almost everyone else in his platoon and only him and three other people lived. And someone just threw a grenade into this huge crowd of people. And so, when he gets in a large group of people and it's really loud and there's a lot of talking, it freaks him out.

And he freaked out and just started beating the shit out of people. And he happened to beat the shit out of his first sergeant, 'cause the first sergeant got in his face. And Simon* is NOT a little person at all, he's like, 6'7" and 350 pounds. He's a huge, huge guy. And started beating the crap out of people. And they chaptered him out for assaulting an officer and a senior non-commissioned officer. And when he calmed down, he didn't remember what happened. He's like, "I don't remember. What happened? Why am I in this office, sitting in this chair? Why am I handcuffed?" No idea what happened.

My friend, he has sleep issues and he's been late for formation x-amount of times. And they are chaptering him out for being late constantly. Because he falls asleep. He doesn't sleep a lot, but when he falls asleep, he's out.

I haven't had a lot of trouble [getting a job]. My discharge was a chapter 14-12, which is Patterns of Misconduct. But I got a general discharge. It doesn't matter what chapter number you got, it's what characterization of chapter you got. 'Cause I got a general, and I get everything but school. In six months I can go and try to get my school benefits, and that's it.

One of my friends that got thrown from the MRAB, he doesn't do anything but sit at home and smoke pot, and live off his parents. But my friend that beat the crap out of everyone, he makes \$150,000 a year working on an oil rig. [Job prospects] just vary case-to-case, and how the person is, or the severity of their issues.

Editor's Note: Kimberly continued by sharing her thoughts on what it is like to be a service-woman, whether there is pressure to be as 'tough' as men and if that affects their ability to seek medical care.

I'm not in a combat MOS, but I know people that are in, not necessarily combat MOSs, but combat units, like Cav or like 3rd ACR, that the guys complain all the time that like, "Oh, well, your

PT standards aren't as high as ours," or, "You're not as tough as us."

I didn't have this problem in my unit, 'cause my company was military intelligence, so there was no like, "Oh, you're not strong enough." It was all your mind. And I do think that women in 3rd ACR or Cav or combat units do have a lot more pressure on them to be extra extra hoo-ah. And to not be like, "Oh, I'm a girl, I can't do this." And, "I don't want to go get a profile, because it's gonna make me look weak." And they're like, "Oh, well, she's a girl," blah blah blah blah blah. I have heard about that happening to people.

...The majority of my friends are gay, and I'm very, very supportive of them. And I've been asked to leave places because people run their mouths about how it's an abomination, or it's a sin, and I'm gonna go to hell for supporting it. And I'm like, "Whoa. You need to get out of my face. You know nothing."

There is a lot of homophobia. But I'm definitely a very big supporter, I believe they should have the exact same rights as everyone else should. They're just people, they're not gonna cough on you and you're not gonna turn gay 'cause they coughed on you. I've heard that. Like, "Oh, I don't want to be around him, 'cause if he coughs on me I'm gonna get the gay." I've been around gay people for many, many years, and been coughed on by them plenty of times, and I'm not gay. I'm pretty sure it's okay.

I think that when you have to get command referral for something, and one of the first sergeants in my battalion, he's like super holy-crap Jesus. When he has training meetings, he'll pray first. I'm just like, "Whoa. Take it down a notch." Like, I'm all for Jesus and whatever, but you're up here, you need to be down here. But I definitely think that if your command team does know that you're gay or lesbian, that they're gonna look at you differently. To say, "Well, you don't need this because I don't feel that you're a good person." And I think that's a big problem.

Editor's Note: In wrapping up the interview, Kimberly spoke about what she thinks it would take to get soldiers the care they deserve and win the right to heal.

I think a lot [needs to change]. Like I said, people need to be made an example of. And I know that sounds really mean and vindictive, but I think it needs to be done. People definitely need to start losing their jobs. That's not how people are supposed to be treated. Not just soldiers, but people, in general, are not supposed to be treated that way. I definitely think that people need to be made an example of, and make it known that these people have had their jobs taken away. Not just word of mouth, but have a meeting. Like, a slideshow presentation and pictures, and this is what they did, this is what they lost. People just hear it, and they're gonna be like, 'La, la, la,' but if people see it, and see the consequences along with it, that would definitely help a lot.

Let people know that IG is always an option, you do not have to have commander permission, you do not have to have first sergeant, and no one has to know you were there. They're the ones that get people fired. Their office is on the first floor of the Corps building, in the East side. It's like the third, fourth door on the left. But you do not have to go through anyone to get to them—and the more people you have to go with you, to verify your story, to say that this shit's going on, and

it's not okay, the better off you will be.

28 Jesse Bowe*

Editor's Note: *Jesse* is an African-American soldier in his twenties who has served on two previous deployments.*

I'm a specialist in the United States Army. I've been in the Army since January 2005.

The first reason I'm on profile is because I have a heart condition. I've had it ever since I've been in the military, but I didn't really know about it until 2010, when I passed out during a battalion run here at Fort Hood. I blacked out completely and had to be picked up and carried off onto the side, where they gave me first aid. From that point on, I've had a series of tests done to determine what was wrong with me. The Army hasn't officially found out specifically what is wrong, but they diagnosed me with syncope, which is pretty much passing out. I was put on red flag because I can't really be in the heat or in the sun for too long, which excludes me from deployment. So my first profile says I can't be in the heat, can't pick up more than 10 pounds, can't go higher than five feet, can't do any combat training or anything like that.

I also have a temporary profile for Post Traumatic Stress Disorder. I still having lingering effects from that, from my 2006-2008 deployment and my 2009-2010 deployment. My second profile, for the PTSD, is that I can't have access to weapons, can't be deployed, and can't operate military vehicles or anything like that.

For my heart, I had a total of five profiles, because they were temporary, before it got changed to permanent. And I've been on these profiles since September 2010. Each temporary profile I had lasted for three months.

Before the unit deployed, it made me break my profile pretty much every week. It was usually the NCOs who told me to break it. And they were aware of my condition, but you know, sometimes the military doesn't care. They always try to find loopholes to where they can still use me. They find their loopholes, or they literally mind-fuck the profile to see what they can do to use me.

I've seen other soldiers forced to break their profiles plenty of times. Pretty much every day. Even when a soldier pulls out the profile, they still don't really acknowledge it. I saw guys deploy in my unit who should not have gone because of their conditions. Often. I don't know a specific number. But I do know of guys who've been discharged as soon as they've gotten back from deployment. Because they should not have been deployed altogether. A good buddy of mine actually has severe PTSD, and he was about to get deployed again. When he went to train he had a violent episode, so he just got out recently because of his PTSD.

In my early years, I saw NCOs make people go to SRP even though they shouldn't be deploying. Not so much in recent years though, because of the fact that soldiers are committing suicide down-range, or soldiers are just completely burning down mentally.

Whenever I used to have to go to sick call, I'd get that scornful look from NCOs. And the stigma never really stops. They would say, "Oh, he's weak. Screw him, he's weak. He's trying to find an excuse, he's trying to malingering." It didn't stop me from getting help though, because at the end of the day, it's my health.

I did deter other people in my platoon. They were so gung-ho that they put their health on the side, just to look better in somebody else's eyes, when really they were hurting themselves. The stigma comes from NCOs, peers, all the way up to officers, even.

I ended up getting punished for stuff that was coming from my PTSD. In 2010, when we first got back from deployment, I came back to no money, no house, no nothing, because my wife—the person who I married and trusted—cheated on me and pretty much took all my money. And during that time, I was in a severe depression, along with coping with the PTSD, and I lost a lot of weight because of the stress I was under.

There were a lot of days where they were just saying, "Bowe, you're fucking up. Correct it." They never tried to ask me, "Alright, Bowe, what's really going on?" It's always, "Oh, he's just a shitbag."

It literally took until after I passed out—I think it was July 2010—where I finally broke down and told them I was thinking about committing suicide. I don't really tell too many people that because there's a stigma to it, but I was going through a lot at that time. Once I told them that, it seemed like the finger snapped and they were like, "Oh, this is really something serious that we've just been blowing off," and I was able to have the time during the work day not doing something. I had the time to go to mental health, went to the doctor to get a physical done, so they could see where I was physically. I was in really bad shape.

After they found out about my heart, there really wasn't a lot of treatment. There were mostly tests. I remember a lot of tests being done, and I did have surgery. That was October 2010. They installed a heart loop recorder into my chest. That means that if I were to pass out, there's a remote that you can put to the device that's in my chest, and you press the button on it, and it records or saves that recording of my heartbeat so the doctors can actually see with their own eyes what went wrong with my heart.

After the surgery, there hasn't been any treatment. I'm just being Med-Boarded now. It's really not something they can fix. It's just something that I have to be careful with, in terms of what I do.

I've never received any training about the symptoms of PTSD. I've pretty much researched it on my own. They don't talk about it enough. They do cover suicide, which is coupled with PTSD, but I haven't gotten any specific training about how to cope with PTSD. We get a little bit of training

on symptoms of TBI, but not often enough.

As far as the sexual assault training we get, people don't take it seriously. The classes aren't given by a professional. They're just given by the NCO. We just watch a slideshow. Sometimes it's hard for soldiers to keep their attention on subjects. The Army really does need to hire professionals to teach it and get the word out about how serious the subject is.

29 Jim Frank*

Editor's Note: *Jim* is an Army veteran in his mid-thirties who is Latino and white, originally from a large, midwestern city. He enlisted in 2003, and worked radar, serving three deployments to Iraq between 2004 and 2010. His son was four at the time of his first deployment, and he expresses regret at losing so much time with him. Jim was honorably discharged in 2010 and at the time of the interview in mid-2012 was struggling to access the care he needed at the VA, despite already having a 90% VA disability rating and a diagnosis of PTSD.*

I was a construction worker. I was 25, so I was kind of old for joining the military. But it was after 9/11, in 2003. And I kept getting laid off from construction jobs. It kept getting harder and harder to find a job. So I decided to go into the Army, for money, stabilization for my family, stuff like that.

I have one son. And a wife. Actually I'm also raising two kids that aren't mine now. My little brother lives with me too, he's handicapped. He gets a \$600 check every month. He can't really do much.

Other than the stability while I'm in the military for my family, my grandfather was military, my mom married a Navy guy eventually. It's been in the family, so I thought that that would be a good thing. But it bit me in the butt, because I wasn't there for my son, and I kept getting deployed, so my son kind of went nuts at school, and started getting into a lot of trouble. That's more or less the reason I left the military, because my son needed me, and I couldn't keep getting deployed. I would have already had two more deployments, if I had stayed in.

He was four [when I first deployed]. So I missed a big chunk of his life. He's 15 now. But I've been out for two years, so he's getting straight. He needs Dad. He doesn't get into trouble, especially like I did when I was his age. So, I guess I'm kind of blessed in that area.

That's offset by my sister's two kids, that I have. A 16-year old girl, and a 12-year old boy, that came from a very bad situation. They came from a very bad situation in North Carolina, and I'm helping them out. And...they're a handful.

I'm a very strict parent. It's alright. I actually enjoy it. I know that the benefits in the future are going to very much outweigh what I'm going through right now. I feel the same way about the few people in my past that had a very big impact on me. Even though, back then, I hated them. So I'm not worried about it.

...[The military] didn't care. Every time I came back from a deployment, they would have the health re-assessment²²⁷ thing, where everybody had to go to. And one of the things you had to do was talk to a social worker. I don't think they were real psychiatrists. And they asked you if you have bad dreams, if you have memories that won't go away, and stuff like that. Every time I came back, and even while I was in Iraq, I would wake up in the middle of the night thinking that bombs had just gone off. It still happens, just not as often.

At first, right when I got back, it was violent, and scared the living daylights out of my wife. And I don't even remember this, but apparently I freaked out on her, and tried choking her in the middle of the night. There were a few times where I would get up in the middle of the night, and I'd search around my room for my full battle rattle,²²⁸ stuff like that. And I did tell the guys at R-SRP this, every single time that I came back from Iraq. Nothing. They didn't tell me to go any appointments. I guess I could have by myself, but they didn't tell me to, even though I told them that I was having issues. Which might have been good, because the psychiatrist I would have seen ended up shooting a whole bunch of people.²²⁹

They were DoD social workers [at R-SRP]. They had to have put my symptoms in there, because after I got out, I was able to very easily get VA and get PTSD diagnosed. A lot of what soldiers are going through—and I've seen this personally—is that they're so messed up in the head that all they want to do is get out of the Army. They don't care about getting help or getting benefits, and they're screwing themselves, really.

When I was ETSing, I ended up getting a referral before I got out. But I had to go and ask for it myself. I wanted to make sure I would be able to get into the VA. He wasn't even a psychiatrist either. He was a civilian counselor. And I talked to him for a while, even had my wife go in there and talk to him with me, once. He was the one that wrote the paperwork to the VA, saying that I had PTSD.

But I didn't [feel the care was adequate]. I really didn't like the direction the guy was going. He kept trying to go in a religious direction with me. And I'm an honest person, I told him I'm an atheist. I truly believe that religion poisons everything. Religion's the whole reason that most of these wars are happening. Regardless of the fact that we just went [to Iraq] for oil...

...I'm still working on it. I missed my appointment yesterday with the psychiatrist at the VA. Some really crazy stuff happened, and I wasn't able to go in. This town is bad. Very bad. I really need to get out of here. And I live on the good side of [Killeen], on the other side of the highway. And it's still not good. It reminds me of Detroit.

I had two knee surgeries while I was in the military. The second one was right after my ETS. The first one was right after my first tour. The second one they couldn't do while I was still in the Army, so they referred it to a civilian doctor. When I had surgery on my left leg, it took a month and a half before I could even put pressure on my leg. When I had the civilian surgery, I was walking within two days. I don't know what kind of butchers they had doing my left leg, but it was only a five year difference between surgeries.

With the left leg, I had to have it racked up, and then walked on a cane for two months, because it took that long to heal. And I could walk on the other one within two days. And it's [still] giving me problems. My knees and my shoulders are both on my VA too. I'm actually 90% disabled.

...I have no idea what [was prescribed]. I think one of them was Meloxicam, from the VA. And it was for mood, and stress. It didn't work. I have anger problems. I can't really explain it. But I have Medicaid, and I had to go to a doctor and pay them a lot of money to get prescription help. I have to take Xanax. That's the only thing that calms me down and keeps me clear...

...I asked them and they said that the VA doesn't give out Xanax. And I asked if there was anything else that works like Xanax that they could give me. They said no, that Xanax is the only thing that works like Xanax. Xanax is the only thing that keeps me calm, that stops my anxiety attacks and my panic attacks. And that Meloxicam didn't.

Editor's Note: The interview transitioned to talk about Jim's experience with mental health concerns while in active duty.

...That would be the last thing I would do, to let [my command] know. Like I said, I told them at Reverse-SRP, but I wouldn't tell my commanders or my NCOs...they could tell that I wasn't doing real well...it's like, everybody's going through the same shit over there, and you do what you have to do.

Do your job. I mean, there were exceptions. One of my soldiers, in my second tour, he came in 10 months into it, which was also when we found out that our tour was gonna change from 12 months to 15 months. So we weren't happy at all. We were all mad. And this kid comes in and starts going nuts, within two or three weeks. We didn't know why. One day, he's in his room with his roommate, and two other soldiers walk in and he's putting rounds into his weapon. He said he was gonna kill everybody!

They beat the living daylight out of him, strapped him up, and I had to take him to Germany. I really don't understand why he flipped out as bad as he did. I don't even remember the kid's name. He wasn't there very long... They tied him up, put him in the orderly room. He was there for about six hours before we went to a hospital in the Green Zone. They took his shoelaces, all that. They untied him, they let him sit and chill. The only thing they did to deal with it was send him home. And I mean, at that point, he had threatened soldiers' lives with a loaded weapon, so he's not going to be allowed to stay there. We were on a plane to Germany within 12 hours. And from Germany, within 24 hours he was on a plane back to the States...

He was the dog of the lot, which I think is why he went nuts. He smoked a lot. We had all been there for so long, and we were all so set in how we did everything. And he just jumps in and has no clue what's happening. And I guess it was just too much for him. He started getting other NCOs mad, started smoking in 115-degree weather. And getting smoked outside in Iraq is not funny. After he got hog-tied, he got put in the orderly room, and...ignored. For a few hours, until they could get everything situated, make sure there was room at the hospital in the Green Zone

for him. I'm not an asshole, I wouldn't have done that. I would talk to him. He was actually my soldier. I talked to him on the flight, and by the time we got to Germany, he was calm. He wasn't trying to kill anybody. He was happy to go home.

It was kind of messed up.

...Different people dealt with it different ways. There was another guy that was with us for that 15-month tour, and went home, and turned into a total alcoholic. He was babysitting for somebody, and was drinking. He had the baby on the couch, and rolled over on the baby and killed it... And I blame the parents just as much as I blame him. He came back, and just went downhill. He wasn't an alcoholic before he went to Iraq.

Other issues that I've seen...this guy that used to be my neighbor, he just came back from Iraq seven or eight months ago, and he's having issues. Same issues most guys have when they come back. Anger issues, can't sleep, PTSD. He couldn't get help. His unit didn't like him. He was a troublemaker in the unit, and on top of that, everybody that was getting in trouble in the unit stayed with him at his house. So they didn't help him until it was too late. He decided to take his family home, and ended up being AWOL for three days before he came back. They threw him into the fifth floor of Darnall for a month, and left his family without him. He's got a wife and two kids, and [his command] just said, "Whatever, who cares."

His family was about a month away from getting housing on post, and his wife had to go back to San Antonio until they got housing. Now he's back in housing, and he hasn't gotten kicked out. I'm surprised, actually, because he's done a lot of stupid shit. Getting in fights, stuff like that.

Editor's Note: The interview turned to Jim's experiences with medical issues during active duty.

When I had my first ACL knee surgery, I was given a no-run profile. I've had a bunch of messed up things that've happened to me because of that. They wouldn't let me go to the Board, to get my E-5. They wouldn't let me go to the Board because I had a profile, and they always come up with some other excuse, but it was because I had a profile. I wouldn't say I was made to run anyway. But I was told that since I had a permanent profile, if I wanted to make E-5, I would have to ignore my profile and run anyway.

[By] first sergeants, and the higher NCOs. And I had already been in for three years, so I should've had my E-5. And they were saying, "Your PT score, as good as it is, it's a walk. It's not a run." They wanted me to run. And I told them, "I can, but I'm gonna be in so much pain by the end of it that I'm not gonna want to do anything else!" But I did it anyway and got my E-5. Technically, they should not let me run at all. But that's not the way they work.

...After my knee went out, the next thing that went out were my shoulders, during my second tour. I didn't even realize what was happening for a while.

We were on the fifth floor of a castle in the Green Zone. We were doing escort, for 24-on, 24-off, and sometimes we'd barely get our boots off before we had another mission. And every time we

had to come up and down the stairs, we'd have to bring our full battle rattle, our crew-served weapons, on top off the turrets. So running up and down the stairs with full battle rattle, ammo, weapons, and water, just destroyed my shoulders. I never told them anything. After I got out, I told the VA, and I started getting treated there.

...My first tour was horrible. They would walk mortars in on us. And you'd hear it, "Boom..." and then [louder], "Boom!" And [louder], "Boom!" It'd get louder and louder as it's coming to you. And you're thinking, "Oh, fuck." I was working night shifts, and one time I was sleeping, and a rocket hit. The end of this building was where the door was to the room I was sleeping in. Right on the other side of the door were oil tanks. The rocket hit the oil tanks. And I swear, I raised about three feet off the ground, a foot over, down, and under the bed, in one move. I couldn't see, dust everywhere. Grabbed my full battle rattle. And this is where I think the nightmares come from. I went out to see what happened. At first I thought the building got hit. I didn't know what was happening. It was a big explosion, because it hit a gas tank. And I walked out there, and it was...about three dead people out there, in body parts. Horrible. And that's where I think I get my PTSD.

I don't know [if I needed a PTSD profile]. I was always professional. It affected family life more than my military job life. And that's not the case for everybody. But I was able to stay professional at work. If not, I probably wouldn't have gotten an honorable discharge. I probably would've done something stupid, like started doing drugs. I've started to see that a lot more around here.

...Someone I served with had been overweight, his whole time in the Army. And there's nothing worse than being overweight in the Army, especially at that time, because they weren't kicking anybody out. Right now, they're kicking everybody out as fast as they can. But back in 2004, 2005, 2006, they didn't care. They'd keep you in. You'd be getting in tons of trouble, just because you're overweight. Even me! I was overweight too. I'm so short, I'm supposed to be 158 pounds. I stayed 170 my whole career.

But this other guy, he couldn't lose the weight, because he had a no-running profile. He was pressured, he was messed with. He was one of the most deserving guys to get rank, and it didn't happen, just because of his weight. He was really good at his job, really smart, really punctual, he was a good soldier. He'd been in the Army for just as long as I have, and he never made it above E-3, because he's overweight... [because of] Sergeant Turbian.* He was of the mindset that if you weren't perfect Army material, you shouldn't even be there. And at that time, they weren't kicking anybody out. And he knew that, so his mindset was, since I can't get him kicked out, I'm just gonna make his life a living hell. And that's what he did.

Editor's Note: When asked if anyone else in Jim's unit was pressured to violate their profile or had similar experiences to that soldier, he replied emphatically. He also clarified that this was happened despite soldiers in his unit being aware of MEDCEN-01.

...Every single one. Every single one. I mean, I should've gotten profiles for my shoulders, because it got to the point where I could do maybe 30 or 40 push-ups before I'm just [choking]. And I wouldn't do it. I already can't run. And if on top of that, I can't do push-ups either, these

guys are gonna look at me like...and it's gonna be horrible. So I needed to get the hell out.

...III-Corps put out a memorandum, that they made all the first sergeants tell everybody [about MEDCEN-01]. And then, it gets around.

...There would have to be real, detrimental effects for the higher command of the units that are letting profiles be ignored [to enforce the policy]. Because there isn't. It's a good-old-boy conspiracy type thing, once you get higher rank, and they all protect each other.

My first tour, I wasn't there, but a warrant officer pulled his weapon on a NCO, and cocked his 9mm. Afterward, nothing happened to him. Everybody knew about it. He did it in front of four or five other people, two of them were other NCOs. This was a warrant officer, an E-6, who had been in for 14 years. Absolutely nothing happened to him. In fact, he got promoted not too much longer after that. Craziness. He was slapped on the wrist. But other than that, there was no paperwork, there was no official looking into it, nothing. Now, on the other hand, when a soldier puts things into his weapon saying he is gonna kill everybody, and not even cocking it and putting it in somebody's face, and he gets kicked out right away. Something should've been done with that guy. He was not stable. Instead, they ignored it, told him not to do it again, and he had a raise before we even left Iraq.

Editor's Note: In turning to Jim's experience as an NCO, he clarified that he was originally misled upon his recruitment, and then processed in as an E-3.

...It was 2003. I was a construction worker, I kept getting laid off. I ended up having to work under the table, with the people that were responsible for me getting laid off... But I got sick of that after a while, because they were a bunch of crackheads. So I went to the recruiter, and he didn't believe me. I had hair down to the middle of my back. So I came back the next day, shaved. And he said, "Alright, I believe you."

We started talking about the different MOSs. I picked one that looked good, and I asked him about it. One of the main reasons I wanted to go was to go to college afterwards, and have a good career. He told me, "This radar is just like the radar that they use at the airports. And once you're trained, you'll be good to go." Total lie. He had no idea what 13-Romeo was. He just knew it was radar, fire-finder operator, and then made up the rest. That has nothing to do with the radars that they use at airports. I was 25, and I already had a family. He said he'd get me in as an E-1, or if I passed a PT test, passed a piss test, and passed a written exam about Army knowledge, he would get me in as an E-3. I looked at all the stuff and said okay. And he said, "Don't even worry about it. I'll fill it all out. You're an E-3." So I wasn't going to argue with him. He was pretty dishonest. I thought that was messed up. I did get [the E-3]. I had a family, and I needed the extra money.

...I got my E-5 in 2006. I was an NCO for half of my time in the military.

...There was a lot of stigma if you [sought care]. You were looked down-upon, and you were thought of as just trying to get out of there, if we were out in tour. When we're here, it's even

worse, because all they do is tell you to suck it up and drive on. They don't do anything. Unless you push it, and then they will.

But, like my neighbor, he didn't tell anybody about the problems he was having. They were plain to see, though. An NCO can tell if a soldier has issues, and an NCO should do what they have to do if they see that a soldier has issues. Other than that one soldier that I had to bring to Germany, I've never had a soldier that had issues. At least not that they talked about. A lot of people hide their feelings, and won't talk about it.

[As an NCO] I was more or less told, especially when it came to smoking soldiers, and writing them up, to do everything I could to fuck them up without breaking their profile. Like, some people's profiles say, "Run at own pace and distance." The Army takes that as, "You run until you fucking die." Until you can't run anymore, because you're so hurt. And that's just the way it was. Apparently they're not allowed to smoke soldiers like they used to. We used to think it was funny. It happened to me when I was a soldier too, so we passed it down. Like making someone hold chalk blocks out for as long as they can. You're not allowed to do that anymore.

...Especially if they didn't have their profile physically on them. Oh, they're screwed then. As messed up as that is. If you don't have your profile on you, and you don't do what you're told to do, they're gonna write you up for not doing what you're told, and you're going to get in even more trouble. It'll go all the way up, and you'll get in trouble, and your profile won't even matter.

...Usually profiles just get ignored. And if they need the soldier, they take him anyway.

[Officers] should be more involved in the platoon activities. The lieutenant that I had was always so busy doing the captain's paperwork that he didn't know what was going on, until the NCOs told him. And the NCOs only told him what he wanted to hear anyway. It seemed like lieutenants and the lower-ranking officers were fodder for the captains. They worked so hard that on top of having to be the leader of a platoon, they had to do all kinds of stuff for the captain. Like, PowerPoint slides, reports, company-wide stuff that doesn't have anything to do with our platoon. So I think, give the officers more time with their platoon, to be able to know their guys, and have more of a stake in what happens with the platoon. Because when I was in, they were just there for formations.

[The stigma comes from] human nature. Guys thinking that you shouldn't have feelings like that. Any guy that's been in the Army and been over there and been blown up a few times has got to have some issues in their head. But the ones that hide it the most are the ones that are the biggest jerks about it.

It discouraged me from getting help. I waited until I was almost out of the Army. I was ETSing, about three weeks away before I finally said, "I need to see somebody." And then they sent me to that civilian.

You go through a bunch of lines [at SRP], they make sure you have all vaccinations, your anthrax shots. Got so much anthrax in me. That's about it. Make sure all your paperwork's straight, your

will, your power of attorney... They never asked about PTSD. They didn't give a shit. They didn't care about that. And if they had looked up any of the other SRPs, they would have seen that I had told them I had nightmares. Every time I came back, I told them at Reverse-SRP. The SRPs, they don't even ask. And you don't even talk to a social worker...not for SRP.

Editor's Note: Jim also testified that before his third deployment, he was given the ANAM pre-test, however he received no TBI screening after the rocket attack during that deployment. He was also exposed to blast pressure on a few other occasions. He did not receive any cognitive or memory testing until he was seen at the VA.

...There were guys that were there and weren't deployed for very long before they went nuts and did something really silly just to get back. It was sometimes their second or third tour. A guy, a friend of mine, and his NCO, both got into civilian clothes, stole the sergeant major's truck, went to the civilian shopette, that only civilians are allowed to go to. They bought a bunch of liquor, got really drunk, and crashed the sergeant major's truck. And they did it on purpose.

I think they were trying to get kicked out. Another messed up thing is that the NCO got knocked down one rank, to E-4. The E-3 that was with them got knocked down to E-1, and kicked out of the Army. And he stayed the rest of the tour being the Commander's bitch, doing crap work for the rest of the year. Cleaning, anything. The NCO got his E-5 back before he even got back from Iraq, he didn't get kicked out. The other guy did get kicked out. And the NCO should've been the responsible party in that whole fiasco, but as soon as they kicked the E-3 out, they gave him his E-5 back.

I know the NCO. The NCO had a lot of issues. He was, no doubt, gay. But of course, he had to hide it. He was probably a very angry person. The other guy, he had a lot of issues too, but I think that was just because, like I said, they were letting anybody in at that time. And he was more or less a criminal. Just not a very good person.

That was our first tour, so everybody was getting blown up. They were throwing mortars everywhere.

...The guy that showed up the 10th month and got kicked out, that screwed a lot of peoples' heads up. That pissed off so many people. The fact that that guy came in, just whined and cried about everything, and then ended up wrecking peoples' lives, after we had been there getting blown up for the last 10 months. And in the three weeks he was there, we went on missions, but we didn't get blown up once. I think we might've got shot at a few times. He flipped out... And then, on top of that, while he's whining and crying about stuff, all the other soldiers are just ridiculing him, like, "Shut up and get to work!"

Right after it happened, I was gone, because I took the guy to Germany, and was stuck there for a while. So I didn't see the aftermath right after it happened. But when I got back, they were more pissed off that he was only there for two weeks and got to go home. I don't know what happened to the kid. I'm sure he got kicked out, but I don't know if he got psychiatric help...

If anything, it brought our platoon closer together. Because we had been there the whole 15 months, we had gone through all this stuff together. We just felt like he can't deal with it, and we can. I mean, we deal with it in our own way, and we might have our own issues ourselves, but we're here to do a job, and that's what we're doing.

...I'm actually very good with people, talking to people. There was a guy who worked in the orderly room. His wife cheated on him. He got depressed, and tried to kill himself—he tried hanging himself. And this was after I had already gone to Germany that first time, so they got me again. They told me to go to the Green Zone hospital with him, and then go to Germany with him. I said, “Roger.” We went to the hospital, and I sat there and talked with him for four or five hours. Everything takes a while, especially when there's a lot of other shit going on. They're gonna worry about the guy gushing blood before they worry about the guy trying to kill himself. By the time the helicopter came to take him, he had calmed down, and he wanted to stay. He didn't want to kill himself anymore. He stayed for the rest of the tour, and he was fine. So I feel like that was a good accomplishment of mine, that I helped a guy out. And I'm married too, and being married in Army isn't the best thing.

...There should've been [command response]. We should've had some kind of a discussion, about suicide and about problems we were having, especially the fact that we had just been pushed from 12 months to 15 months, and only found out on our 10th month. It should've been a priority issue. But there was so much other stuff going on, so much other training going on, that I guess they didn't feel that it was important enough. It was more important to have medical training, and be able to save somebody's life that got shot or got blown up.

...My first tour, I think three people killed themselves in the porta-johns. They just couldn't take it anymore. They messed up the porta-johns, not too far away from where I worked. Two of them I actually heard the gunshot, and saw them go get them. Pretty bad. They weren't in my unit. They were people that were going out into the Red Zone.²³⁰ My first tour I didn't go to the Red Zone at all. I was at FOB, doing my job. My second tour, I was. I could better understand how they could get to that feeling. I've got some pictures that are just...how could people do this to each other?

...[I didn't see mental health] until I was almost out. At least one time, they asked me if I wanted to see a psychiatrist, and I said no. It had to have been my second [deployment]. That's the one I got blown up the most on. [I said no] because it would've gone to my unit, and they would've known, at that point. And I didn't want it out there.

Editor's Note: Jim went on to describe what kinds of briefings he had received for issues related to traumatic injuries, and spoke about the effects PTSD has had on his family life.

[There] was a day-long, five-hour training, and they covered a bunch of different stuff, at one of the big theaters on post, with probably six or seven hundred soldiers. And PTSD was one of the topics. The training was everything for pre-deployment. Everything from the culture of Iraq, to how to not piss them off... I'd say probably every section was covered about a half-hour, 45 minutes. Maybe an hour.

I mean, I understood [the PTSD section] because I already had PTSD at that point. What they were showing was worse than what I go through. Truly, I didn't think I was gonna get PTSD, because of what I've seen, and what they show you is people totally flipping out. I don't totally flip out. I just wake up with nightmares, and sometimes run around my room looking for my full battle-rattle.

It [was] a video of a guy in Iraq, and he's doing his thing, and there's bloody guys and everything. And the next thing you know, his wife's screaming, and he's in his house the whole time. It doesn't quite happen that way for me. But I guess it could.

I get really antsy. Because I drove a lot, I was in vehicles a lot. And when there's a lot of traffic, I start getting anxiety, and it can get to the point where I have to pull over and get out of the car, because I'm just [nauseous]. Because there were too many times when I've been in Iraq, in traffic jams, and gotten shot at. One time we had to go somewhere, and there was a big walking pilgrimage in this city in Iraq, where everybody goes to where the Shi'ite guy died. And we had a mission on that day, and got stuck. Next thing you know, we're getting shot at from three, four different directions, and we couldn't move. So we sat there and waited for helicopters to come and clear everything out. That's probably why I am the way I am in traffic.

I wouldn't be as high-strung and worried about as much stuff as I am [because of PTSD]. Maybe I wouldn't be so quick to anger with my family. Which I do have an issue with, and I didn't before. Like, going shopping with my wife. If I go shopping, I go get what I get and get out of there. If my wife goes shopping, she's gonna want to go shopping. I can't do that with her. I get her so mad. Because I'm like, "Let's go. Let's go. Let's go." It's gotten to the point where I was like, "I'll be out in the car. Here's the credit card."

[My wife] is more careful at night. She knows not to wake me up. Because I think that's what happened, that one time when she said I choked her. I don't remember it, of course. She said that I was having a nightmare, and she tried to wake me up, and I jumped on top of her and started choking her. She said other times that I've just jumped up out of bed, and ran around the room. I wouldn't say she's scared of me, but she's more cautious. She knows that stuff can set me off.

But we're doing alright. We've been together for 15 years.

I would have to say Xanax is about the only thing that'll help. Either that, or try and go to sleep. I'll start feeling it right here, feeling panic or anxiety starting. Just take a half a bar of Xanax, and I'm fine after about 10 or 15 minutes... Actually, I had [a panic attack] two days ago.

...[We had briefings] not really about sexual trauma, but about sexual harassment. That it can be anybody, anywhere, it can be guys against guys, anything. We did have a lot of training for that. [It was] a joke. I mean, as much as it did happen... I was in a Combat Arms Battery, so we had, I think, two females. And as far as I know, we've never had any guy-on-guy issues. I never saw or heard of any issues in my command about it.

I've met a few females that have had a lot of issues. And even one that got molested by a drill sergeant while she was in AIT.²³¹ She was telling him, "No, no," and he said, "If you want to pass, you're gonna do this," and she got molested. She reported it, and she actually got out with 100% disability, and they're paying her a lot of money. But I bet you that drill sergeant still has his rank.

Editor's Note: Jim reflected on the effects of the drawdown on soldiers leaving the military, and whether exiting service-members are prepared to work in the civilian sector. He then continued to testify to his experience as a person of color in the military, as well as his struggles accessing care at the VA.

...The guys that were friends with my neighbor next door, most of them were getting chaptered out for one reason or another...I don't know what kind of discharges they were. But I could tell you that they all had issues.

...It depends on your MOS. In my MOS, I could probably get a job working for the people that do software and hardware for the radars. Especially because that's what I'm going to college for. Most people that had technical jobs like mine, and most of the artillery jobs, other than people that were just humping shells, can easily get a job with the civilian companies that do that kind of work.

I don't really look like I'm a person of color, but I am a quarter Cuban. My mom's half Cuban. So I do see it, and I see it a lot more than most people of color, because I look light. And [racial discrimination] is prevalent, very prevalent.

But just like anything in the military, you have to be persistent. Because nobody's gonna do for you what you need to do for yourself. Your NCO should, and I tried when I was an NCO, but even then, you can only do so much. The color of your skin doesn't matter if you're on top of your own shit.

...They have an OEF and OIF office in the VA, in Temple. Just like they have one right down the hall for Vietnam, and then there's another one for Korea. I had an appointment with the OEF and OIF office, after I talked to all the doctors. And they were the ones who sent me to the psychiatrist at the VA. They can't give me the pills that I need, the Xanax. At least, that's what they're saying. So I have to pay a doctor outside of the VA \$600 a year, \$20 a visit, and then pay for the prescriptions to be able to get it. And it's a lot nicer if you get it for free. I don't have insurance at all, I'm just paying out of pocket.

Editor's Note: Jim confirmed that this is the case even though he has a diagnosis of PTSD from the VA. He has never been offered an alternative treatment or prescription, and has been attempting to get this care for his PTSD at the VA for a year and a half at the time of the interview.

I missed my appointment yesterday. I was going to talk to them about it more, and see if they couldn't give me something.

The other things that are on my record are my knees and my shoulders, and my hearing. I have

diminished hearing, a lot. They told me by the time I'm 50, I'll probably need a hearing aid.

[What helps is] persistence on the soldier's part. Because nobody's gonna help you but yourself. That's really the way I feel about it. As much as NCOs are supposed to help you, it's really your own life, your own issues. The Army will not ignore you if you're persistent. You can go all the way up. Open door policy. If somebody wanted to go and talk to the III Corps sergeant major and say, "I have a permanent profile, and they're making me run," they can. On the other hand, that sergeant major's gonna go back, and rip the first sergeant a new asshole, and it's gonna come back on that soldier. One way or the other, it's gonna come back on that soldier.

...I was an NCO, and I do enjoy helping soldiers with the problems they have, family life, marital problems. I've had a few of them myself. I've done a lot of different stuff in my life. My father was a heroin addict, and crackhead. I've learned from him how not to live. When I look back at all the stuff that I've gone through, I can see that a lot of people have gone through the same thing, and I know I can help. That would make me feel good.

30 Devon Sawyer*

Editor's Note: Devon* is a white Army veteran in his mid-twenties, who is originally from the suburban Southwest. He served as a Tanker and deployed once to Iraq. A few months before deploying, Devon suffered a TBI when an armored hatch was dropped on his head by another service-member. Although he received medical treatment in the wake of this incident, he was not officially diagnosed with a TBI until returning from deployment. Devon believes he had a TBI from the incident before deploying, and that he should not have been medically cleared—he questions what role his own desire to deploy played in his pre-deployment evaluation. Suffering post-traumatic stress and concussive head injuries, Devon sought care during and after his deployment, and was hospitalized on post for being suicidal. He was subsequently transferred to a Warrior Transition Unit and completed a lengthy Medical Evaluation Board process before being medically retired at 100% disabled.

It was the whole Shock Doctrine of 9/11 that really got me. I was a little too young at the time. But that was definitely a big influence in my decision of joining. I was brought up in a family that had a military background, not an extensive one, but my grandfather was in the military, and he talked highly about it. He was in the Army and the Navy. And both of those reasons combined was pretty much why I joined. It was a life-long kind of goal.

I didn't really join for the money or for the college. I mean, those were things that helped my decision in joining, but I think it was mostly the experience and getting out of my hometown. And being able to be off on my own for the first time. This was in 2006, so I was about 19.

I think I was always afforded pretty outstanding medical health care, when it came to having a cold, scraping my knee, for preventative things. But when it came to things more serious, like mental health and combat stress, there was a really negative stigma attached to that. Not just with enlisted personnel, but officers and higher NCOs alike. It was just very looked down-upon if you went to a combat stress clinic or mental health, or admitted having depression or something like that. But after you got over that and went to the facility itself, the facility and the people there seemed genuinely like they cared, and would try to help you.

I didn't really need mental health until I deployed. About my eighth week into my deployment, I started having recurring nightmares and dreams, and a lot of stress. And I approached my

commander—my boss basically, my first-line supervisor—about it. And he told me, “You know, it's not a big deal, this is part of the adjustment to war. You'll get used to it. It's okay.” And that was the whole end of the discussion. I didn't like that answer, so I went above his head to his boss. And pretty much got a little bit longer, but the same answer from him.

Eventually, toward the end of the deployment, I actually broke down and went to a combat stress clinic. I told one boss where I was going. Asked him not to tell anyone. And, so when I came back from the combat stress clinic, I was met with a lot of resistance from people for going to seek help.

To see a [medical] specialist, there was a little bit of a wait-time. But it was nothing extremely ridiculous. In general the wait times were pretty good. I would say my overall health care was really good, except for getting time off work, and being able to leave your unit to go to appointments. As long as you can get away from your unit, as long as you can get into the medical system, I thought that was taken care of properly.

There was one part of the care I didn't really enjoy, I didn't really feel it was useful, and it was done for a long time. And it was EMDR therapy. They would just basically just ask me about traumatic experiences, and they'd make me follow the therapist's finger, and they moved it back and forth, trying to bilaterally stimulate my brain. I thought that was ridiculous and pointless. But we tried that for a year. But other than that, I felt I was able to get appointments and I was able to see my counselor when I needed it.

But then again, I was in a totally different unit at this point, too. I was in a medical unit, where my whole job was to make medical appointments. That's towards when I was getting out of the military. But when I was in the combat unit it was really, really hard to get in and see [providers]. The commanders say, “Yes, yes, you can go anytime. Anytime you have an appointment, yeah yeah, by law what we have to say, yeah yeah. We'll let you go.” But when it comes down to it, when you're actually working and it's really hard to get away from your unit. They don't say no, but they'll find reasons why you can't go, like, “Oh, you need to reschedule this appointment.” It's not illegal to have them reschedule your appointment, either. “You need to go reschedule your appointment because we have critical training this day. You need to reschedule your appointment because we're going to the field this day,” or whatever. They can always reschedule your appointment to put off your treatment of being taken care of medically, and you can definitely bet they'll do it.

Editor's Note: Devon was asked if he was ever prescribed medication during his service.

Oh God. I would say approximately 30 different kinds. I took antipsychotics, antidepressants, antianxiety, antipsychotics, and I took tranquilizers, muscle relaxants, and they prescribed me one or two pain killers. Generally, just about anything you could think of.

At certain points, I was on multiple different psychotic medications. I tried probably a full array of different kinds. I'm sure at some point I was taking two different kinds. It's really, really blurry for me to recall a lot of this, 'cause of all the medications.

Editor's Note: The interviewer followed-up on this by asking whether Devon thought he was over-prescribed or cross-prescribed medications that might have been incompatible.

Oh, yes, definitely, 100%. I was given so many medications that I even showed my list of what I was taking to a medical doctor, outside of the military, and they said that, "You shouldn't be taking this many drugs in such short a period of time." There's so many different cross-levels, medication reactions that could have happened that were really bad.

I actually had procedures done to me that were not cleared medically to be done on US civilians. For example, they injected Botulinum toxin in around my skull—inside the skin, on the outside of the skull, to try to prevent headaches. Which, all it effectively did to me was not be able to make a wrinkled forehead for 30 days. It wasn't cleared by any medical agency, it's not even supposed to be practiced. And at that point, I'm not sure if it is now, but they did that to me. That was kind of scary, when he told me that.

When I was on the combat line unit straight after my deployment, I wasn't on a whole bunch of medications. Maybe a couple antidepressants. But I was going downhill at a bad rate. So I was removed from the combat unit and placed into a medical unit, where I didn't really have much of a job. So in a sense, I wasn't able to be a soldier and fulfill my duties as a soldier. I had to be removed from my job and placed into a special unit to be taken care of. I came back [from Iraq] in March. It was around November 2009 when I was put in the medical unit.

I have a list of diagnoses. I have Post-Traumatic Stress Disorder, Traumatic Brain Injury, I'm rated for migraines, my left and my right knees are bad, and my back is also bad. I just had a bunch of biopsies done on my lower intestine and my stomach to see if I have Crohn's Disease, or ulcerative colitis—I got that disease most likely from the environment from Iraq, from the water conditions or something like that.

[The mental health issues] started a few months before I left Iraq. I went to a combat stress unit, and coming back, the person I'd told in confidence, my boss, had pretty much told some other people, and it had spread through the unit. So they knew where I'd been and what I'd been doing. The younger enlisted people, they really couldn't do anything, not bullying, but they'd make fun of you like, "Oh, don't anger him, he might have to go to combat stress," kind of poking and prodding at you. And then, you would get some of that from the lower higher-enlisted people, like the NCOs, the lower ranking ones, like the sergeants and stuff.

My commander...me and him used to be pretty close, I would be able to joke with him and he would smile when he saw me, and I considered him to be close, for a commander and a Joe, at least, a lower-enlisted personnel. He really couldn't say anything to me after I went to combat stress, and especially after I was admitted to the psych ward. I was in the combat unit when I was admitted to the psych ward. I had to do seven or eight days in a psych ward, at Fort Hood. And especially after both those incidents, he wouldn't look at me, wouldn't talk to me. But he didn't really say anything directly to me.

It was mostly my direct bosses, my NCOs, my sergeants. They would purposefully exclude me from situations, try to exclude me from the group. Which was fine with me, I already hated the military at this point. But I had Under the Hood to support me. If it wasn't for Under the Hood, I have no idea where I would be. Without that support I wouldn't have been able to do it. I can just imagine how soldiers feel when they don't have that kind of support, and they're being excluded and made fun of.

Once again, all this is illegal for them to do, but they find loopholes in the law. That's what the Army's all about, trying to get through the loopholes of the system. And there's definitely ways to make someone feel excluded.

I was given many profiles. I'm pretty sure you've heard this—profiles don't really have to be acknowledged by your commander. Your commander has ultimate, final discretion over whether you can do it or not. While in the combat unit, any profile I had was just basically broken by my commander, just overridden, like, “No, you're able to do this, you're gonna do it with us.” But when I went to my medical unit, I had to follow my profile to a T, and if I was caught breaking my profile it was a serious consequence.

Some of the stuff in my profile at the beginning of my treatment, I would be in treatment for my back, so I couldn't put body armor on, couldn't carry weapons. Especially after I said I was depressed, no access to weapons...I think that was broken also, by my commander. But it was nothing too severe, as my treatment progressed, and I actually found a doctor that really took care of me, and he actually hooked me up with some pretty cool things on my profile. Like, I had to be off-base by four o'clock, because at five o'clock on base they launch cannons. I don't know if they still do that, but it's the stupidest fucking thing I could imagine, launching cannons with a bunch of soldiers all wired out on PTSD. He told me I had to live off-post, because the sound of revelry and taps being played added too much stress for me. Which was really awesome, I loved living off post.

I've had just about anything you can think of on a profile... I was one of the first soldiers to go through the medical system on Under the Hood, and I was very, very outspoken. Any profile I wanted, I just went to my doctor and told him what I wanted, and he pretty much would give it to me. I'm a pretty unique case.

In my combat unit...there was basically no profiles, the commander had overridden every profile that was out there and he just didn't abide by them. He didn't believe what doctors said, essentially.

III Corps has that policy [against profile violation], but 4ID²³² doesn't. 4ID has a completely opposite policy, where they could just say no, basically. You can get away with it. And when they do that, because of the whole rank structure, the captain in my unit is not gonna be yelled at for that. It's gonna be the two-star general that's in charge of 4ID that made the regulation. So when I tried talking to soldiers about it, it was pretty frivolous, to try to explain that III Corps had a policy.

I had the Inspector General on speed-dial. I would call and literally every day whenever people

were there breaking profiles. And the Inspector General couldn't even do anything. Because Fort Hood, they had that regulation. Yeah, III Corps is a higher rank. But-a four-star general's not gonna get off his lazy ass and come out of his office to go yell at a two-star because he made a different rule. It's just not gonna happen. It's professional courtesy.

The Army is all about loopholes. So even if 4ID had a law, or had a regulation, saying that you had to honor profiles, commanders would still find a way to break that rule, or just blatantly still break them. This is one of the things that's happening every day. I don't know if there's a way we can make things better. I really don't. I think we need a huge social change, and that's not something any government's gonna be able to do for us. I don't think there's really anything we can do. It really has to come from the people, it has to come from the ground-up. We have to want to change the military, and we're at a point where we don't want to.

I had a few small profiles, but my major person that wrote me all the profiles was Dr. Samuelson.* I hope he's still being used at Under the Hood. He was a doctor at combat stress unit. I never received a permanent profile until I had paperwork to exit the military. The way I understood it, all profiles were temporary, until you have a permanent disability that you were getting out of the military for it and you would be issued a permanent profile. So, all mine were temporary until I got my paperwork to get out.

A lot of times, it really wasn't pressure, it was just kind of known, like, "We're not gonna honor your profile." If you want his name, it was Captain Izzo was the deciding factor that made the call on breaking profiles in my combat unit. I would show up to work and my boss knew I had a profile, I told my first line supervisor, "Hey sergeant, I got a profile. Here's your copy, here's my copy, okay?" Now, I've done what I needed to do—I'm sure he did whatever he needed to do, maybe he told his boss, maybe he reported to the commander like he was supposed to. But work would come the next day, or PT.

Basic example, one day I got a profile saying I did not go to PT formation. So to fuck with my unit, I just didn't go to formation that day, even though I knew we were supposed to break profile every single time. But I got in trouble, because I didn't show up to PT, and so I said, "I got a profile that said I didn't have to." And my NCO kind of laughed at me and said, "You know we don't honor profiles in this unit. You should know that by now." And a lot of times, whenever I would get a new profile, or a different profile, nothing would ever happen in my unit. It would just be like nothing happened. You'd just have to show up to work, and you'd still have to do your normal duties and still have to clean a weapon, even though you weren't supposed to touch weapons.

It's a horrible, horrible stigma [for people on profile]. The lower enlisted would do school-yard type stuff, trying to make fun of you. Lower-enlisted NCOs would do the same thing, and you were just kind of swept aside by the people that had something to lose rank-wise, like the higher enlisted NCOs or the officers. They wouldn't really talk to you, you wouldn't really be treated like a soldier anymore. You wouldn't be treated like one of the people of the unit. You would just be treated like shit. Any bad detail that would come up, like, if you're at a detail where you'd have to go pick up trash on the side of the road for six hours, you know who'd be on that detail? Me. Because I had

a profile that I was going to the doctor frequently. I wouldn't be able to go off and just chill for the rest of the day like the rest of my unit. I'd be on detail and I'd be on special duty all the time. Because I'm just not one of the unit anymore.

That pretty much changed when I went to a medical unit. But not everyone is afforded the opportunity to go to a medical unit like I was. It's very few and far between, for people to go to a medical unit.

There were some times while I was in the combat unit that people were made fun of and subsequently removed from the unit. They just disappeared. I'm not saying they were killed or anything, they were just moved to other units. They were constantly, constantly being harassed, tormented.

It's really hard to get to a medical unit, and there's really only one reason I was able to get to one. When we came back from deployment my company got a new first sergeant, and he seemed to be very passionate for things like this. I wrote him an e-mail, and explained the situation I was in. He basically took me under his wing and made sure I got into the unit I needed to be in, the medical unit. But I had a first sergeant going to bat for me basically. A lot of soldiers don't have the balls to just go up to a first sergeant or write him an e-mail explaining the situation. For one, they think it's against your regulations, it's against everything you're taught in the military. You don't go to the top-ranking dude and explain to him. Unless you've exhausted all other resources, which I thought I had had at that point. Because I had a high-ranking NCO, a really high-ranking NCO going to bat for me, was the only reason I was able to get the adequate help I needed in the military.

I believe [the stigma] is a social thing. Not necessarily in the military, but in society, males are supposed to be the strong, and fearless, brave. And even more so in the military, that's the idea and the model, the cookie-cutter model you're supposed to follow. And even more so in a combat unit, the arrogance, and people's heads just explode to gigantic proportions. And, "We're strong Army men, that ride around in tanks all day and kill stuff, hoo-ah hoo-ah," when in reality we're human beings. We have needs, we have problems, there's shit medically we need to take care of. We're not robots. We're not what society puts us out to be. I think that's really where I'd say 90%- 95% of the stigma comes from.

The other five percent would probably be commanders. We have safety briefing, every Friday, they go over every little thing of what not to do on the weekends. "Don't drink and drive, don't have unprotected sex, don't do this, don't do that, don't get shot, don't do this, blah blah blah." It's downright ridiculous. But during those briefings, they'll be like, "If you feel like harming yourself, ha ha." Captain Izzo would be giving the speech, and he'd be like, "If you're thinking about killing yourself, go ahead and kill yourself. But I'm not supposed to say that, go ahead and go to mental health." Shit like that. You know, he's saying it in chosen manner where no one's gonna take him to court over it, or no one's gonna act on it, but it's pretty obvious how he feels about it.

And this is another thing that's in my head that causes the stigma. I was actually called out in

front of my unit, my whole entire unit, when I came back from the combat stress unit, when I was in Iraq, when I had three months left. We had just got a brand new platoon sergeant. I hate this man. Once he found out that I had gone to combat stress the night before, he called a special formation just for me, and called me out in front of the entire company, to ask me, in front of everyone, if I felt like hurting myself. If I felt like I was a danger to everyone else or to myself, in the unit. Just asked me all these stupid, grueling questions, in front of everyone. It definitely was shit that he wasn't supposed to do. That was a form of direct stigma that I was receiving from the higher-ups.

That was a special occasion—I really think the first sergeant, the one that took me under his wing, kind of grabbed him at this point and said, “Hey, you can't do this,” 'cause he never did that to me again. It was never anything direct anymore, after that. I think he was told not to.

It would just be passive-aggressive. I owned a motorcycle, and when I came back to my unit, they were like, “Well, I want you to go get evaluated for riding your motorcycle, because I don't think you should be able to ride your motorcycle with a head injury.” I'm like, “You're not a fucking doctor. You have never been to medical school. You have just as much education, if not less, than me, fuck you, you don't know what the fuck you're talking about.” It was just little things like that, where he was technically in the right, yeah, it is something I needed to get taken care of, but he didn't really need to be a dick about it like that, call me out and that in front of my entire platoon.

[SRP] is a very, very long...I believe it took care of groups of people. I didn't really have a problem with pre-deployment SRP. You know what you're getting into, you know you're going into the Army, you know you're going to war. Obviously you're going to have a bunch of tests, a bunch of vaccinations, and shit like that. I have personal beliefs against those vaccinations, but that's a whole other story.

I felt I was properly screened before deployment, and I felt I was improperly screened post-deployment. I felt that I was not afforded an opportunity to talk to a medical professional one-on-one, when asked if I was having psychiatric problems. I was asked in a group setting, with lots of people. So it was kind of discouraged to speak up in that form, because you don't really want to say, “Yeah, I'm having problems,” with a bunch of people sitting around. And then, you'd have to go up to him, to the guy who asked you the questions, and follow him, and go ask him later. And you'd just look like a fool. And the other thing about SRP is they try to get so many damn soldiers through there so fast. And I don't believe they take care, or even take consideration to make sure the information they're putting in the computer or whatever, it maybe is correct. I don't think they care.

Editor's Note: Devon was asked if he had seen anyone who should not have been deployed get pushed through the SRP process.

Yeah, actually, me. I definitely had Traumatic Brain Injury before I deployed. In a training incident, I'd say probably five to three months before my deployment, I was a tanker, and was getting my tank ready for a mock mission. Wasn't wearing any body armor, no Kevlar on my head or anything. And they ended up dropping a 200-pound hatch, the hatch to get in and out of the

tank, on my head, and I was unconscious in the bottom of the tank for a while, and I had to be air-lifted out. It was a pretty bad process. I was in the hospital for a few days after that. I had lesions on my brain. I got a diagnosis before deployment, and it was severe post-concussive syndrome. Which, it basically was another word for migraines, but they didn't actually give me Traumatic Brain Injury, the diagnosis, until I got back.

But I think it also should be noted that I was not actively trying to get out of the military or trying to get out of my deployment. I was really excited about my deployment. I think that was probably another reason that I was pushed through. I mean, it's not a good reason, it's not the right reason, but I think that was also part of the reason why I was pushed through, was because I was wanting to go, it was my first time, I didn't know any other better. If I was a little older and wiser and had done this before, maybe I would have been able to get out of deployment. But I think I would have been afforded a little bit more opportunity.

I definitely, definitely should not have been passed medically to go to Iraq.

Editor's Note: Devon continued by reflecting on how the safety and morale of soldiers around him were affected by soldiers who should not have been deployed, or who needed treatment.

We had one soldier snap on patrol, and pick up a puppy, and just like, got a group of kids around, little kids—mind you, in the middle of Iraq. Picked up a puppy and then threw it on the ground as hard as he could, and just started stepping on the head. Lost it, and started walking off by himself, on patrol. I'm not a medical professional or anything, but I'm pretty sure that dude has a problem. He cost us the mission that day, and he definitely cost us our safety. We didn't get hit... But it did compromise our safety. And there was a few other...situations, I'm not sure if they were all medical reasons, I'm not sure if we just had really incompetent people, but I do know that there were some people in the military that should not have been in the military.

The dude that dropped the hatch on my head had a disfigured thumb. I'm not sure on regulations, but that was something that I saw that shouldn't have been processed through. He actually had problems firing his weapon, because of his weird-shaped thumb. Which was definitely something that probably shouldn't have been able to let him go to Iraq, and especially fighting in a combat situation.

There was definitely examples like that. A lot of people breaking down mentally and not being able to continue—or ending up going missing before a mission, or something like that. Just 'cause they freaked out or something. There was a couple times that people weren't properly taken care of, and they should've been screened medically better.

[There] was a lot of steroids going around. I didn't have any knowledge or sight of steroids. But of course, I wasn't one of the guys going to the gym every day. I'm pretty sure those guys were pumping steroids. I know it was being used rapidly. I partake, and I knew of people using ecstasy in Iraq, drinking of course. Anytime we went outside the wire, we would get a local to buy us alcohol of some kind. But primarily, I would say, it was ecstasy and steroids, anabolic steroids.

...We had a couple suicides before deployment... I think we had one actually in deployment—put a bullet in his head while they were on patrol. Regulation is: he died on a combat mission, so the family got the 400k. That was in a separate platoon than me, so it really didn't affect me a whole lot, but I was semi-close to the guy actually.

First it was really quiet. We weren't really talking about it, it was under investigation. There was a fight that actually happened because of this. They were coming to clean out his room, his barracks room, and I'm not sure what happened, but I do know that something along the lines of they were cleaning up his stuff, like some soldiers from another unit came over and were cleaning it up and grabbed a piece of armor you were supposed to wear, it's called a flak. And he goes, "Oh—he wasn't wearing these. I guess his family isn't gonna get that 400k." He said it to his friend, and one of these guys just punched the dude, knocked him out. He did get the 400k, but they were just kind of assholes about it. That wasn't my command. That was just the Army in general. We didn't have a memorial, it was hush-hush, I guess. We really tried not to talk about it.

...When we had people that died in the line of duty, we had full memorial services. The unit that actually had the killed in action would have x-amount of days off of duty. We would have to pick up slack from that unit. It was definitely treated 100% different.

Once again, [R-SRP] is just a lot of people going through this process really fast. I don't feel that they were properly screened, they were just, "Check the box." If you have a problem, no, check the box, kind of deal. I do know they changed it since then, I don't know how it works now, but when I went through, I was asked in a group setting about having any problems, having any suicidal ideation, having depressive problems, anything like that. And that's not something that I believe most people would admit in a group setting, or should be asked in a group setting. I think that's something that's private.

I got blood work [at R-SRP], I got a lot of physical things done to make sure I was still having full range of motion on my back. I think it was 'cause I was complaining of back issues at that point, too. I'm not sure if that was because I was having extra problems, if they were giving me extra tests or not, but all the tests seemed pretty rushed. They just wanted to get out of there.

They asked us in multiple group settings, "If you feel you might have a Traumatic Brain Injury, raise your hand, we'll come and help you," or, "Come with us, and we'll help you." I didn't really feel comfortable at that point to seek help in a group setting like that.

Even if we sat down on a one-on-one basis with a doctor or something, I don't believe...it would be effective. Just because there's too many soldiers going through the system, too quick. Imagine yourself in a line going [separately] to go risk talking to a doctor. Everyone knows what the line is for. You know you're gonna go in there and he's gonna ask you if you have PTSD. And if you're in there for too long, explaining, "Yeah, I feel like I have some problems," it's gonna cause some suspicion.

I don't really know how it could be made better. The military sent out some special survey, and had some commander, some major actually come down to Under the Hood, to give me this

interview and ask me questions about it. I was just randomly selected. But I told him, "I don't know if there's any way that it could be made better." I really think it has to come down to the soldier, to seek the help themselves. I just think we were not really trained enough to know the problems, know the situations that suicidal people would be in, or depressed people would be in, and what to do when you talk to a vet. Towards the end of being in the military, there were a lot more classes, especially after the Nidal Malik Hasan shooting. There was a lot of things changing, I'm not sure how things are now, but people definitely need to be educated, and I feel that with the proper education, the soldiers would be able to seek out medical help. It sucks.

I think the stigma's a really big thing that we need to address. I don't think we really have an answer to how to fix it. I don't believe there's much more the higher command could do to fix it. It's something they need to come from the people...

Whenever my unit or platoon would talk about Post-Traumatic Stress Disorder, it would be made fun of. Like, if you have Post-Traumatic Stress Disorder and you feel like you're gonna kill yourself, go back and go do it. Just put the rest of us out of our misery, or whatever. "Oh, ha ha, just kidding." It wasn't really taken serious enough.

The screening process for Post-Traumatic Stress Disorder I believe really was a questionnaire. And a plate system off that questionnaire, like, "On a scale of one to five how likely do you agree with this, or do you not agree with this? How much does this describe you or not?" I think to actually get the final diagnosis, you had to sit down with a therapist, and talk with him. And he gave you the questionnaire...

When I was still in-country, I went to combat stress, and I continued going to combat stress clinics when I came back to the States. I bounced around with a few doctors, that kind of blew me off, didn't really take me seriously, didn't really help me.

I was really fortunate to find Dr. Samuelson. He bent over backwards, he actually called my unit a number of times, and told them that they were being fucking retarded for not listening to the III Corps policy of listening to profiles. He did a lot for me. But there was only so much he could do, also. He's the one, I believe, that gave me my Post-Traumatic Stress Disorder diagnosis. I was rejected from that diagnosis from a couple other doctors, at least two. They see so many soldiers, too fast, all these doctors, and they don't really care. They are getting their paycheck at the end of the week, and they're just checking a box. That's how it was with a lot of the doctors there. I don't know if they're burnt out on their job, or they're over-worked, or what it is, but a lot of the doctors there didn't give proper diagnosis.

After I first got diagnosed with it, after I came back from Iraq, I experienced flashbacks, disturbing thoughts, recurring nightmares, intrusive thoughts. I mean, go Google 'PTSD,' if it's on the list, I probably experienced it. It was pretty rough.

But with talk therapy—no medication, I might add—I really think the biggest thing that helped me was removing myself from the military environment, and not even living in the city of Killeen... That's still a military environment. Even living there, I needed to remove myself from that area. I

believe that was the best course of treatment for me. I don't know if I would really classify my PTSD now as mild or moderate. Depending on the day, I guess.

I do have an extreme memory problem. I'm currently only taking one class in college per semester. Due to my disability, I'm not really able to keep up with a lot of people and keep up with a lot of conversation. And I get confused a lot of times, real easy, if I try to process information quickly. But that could also be from the TBI, 'cause they play in with each other.

I do have increased anxiety, especially in public events, public places, when it's really crowded, I'm really on-edge. For example, just last weekend I was in Las Vegas, and I was on a street corner, and it was just so damn packed with people. I was with a group of friends. I had to leave my group of friends, walk across the boulevard, walk across the strip, at eleven o'clock at night, with cars rushing by, without a green light or a cross-walk or anything. I was like fuck this, I cannot stay in this group anymore. And I had to dodge traffic and just get to the other side of the strip. I could not be near people that jam-packed. I get angry a lot of the time, especially when I'm being exacerbated by people or situations, or I'm just really stressed or something. But it's manageable, I feel every day I'm getting a little bit better, with the PTSD.

I used to be a very extroverted person. I used to be the center of attention, I used to be able to make friends really easy. Used to have lots of relationships with a lot of friends. I would have a lot of friends, mostly. I've been in Arizona for two and a half years, and I don't think I've made any friends since being in the military. Even going to college, I'm a very introverted person now. I don't really talk to a lot of people. I try to avoid people mostly. I would only consider one person to be my friend out here. It definitely affects your personal relationships and stuff.

Definitely, it affected [family relationships] quite a bit. It's really hard for me to express emotion a lot of the time. And at some other times, I just have way too much emotion. When it first started happening, it was hard for my parents to understand what was going on with me. But as I got better, they kind of understood what was going on with me, and they've been able to manage it, so far. I live with my parents.

Medically, the thing that's helped me the best was speech pathology. I've been seeing a speech pathologist for a few years now, and I don't have a stutter, she's helped me cognitively overcome some major hurdles. Like being able to read again, for one. It was really hard for me to read, and at one point, I just completely gave up on reading altogether. But little things, that I didn't even think about, such as underlining key words and using bookmarks, have made me able to read again. I'm not sure if it's the person I'm seeing, them as an individual, or if it's the practice I'm getting, the medical practice, but speech pathology probably has been one of the biggest helps, medically, for me.

I'm gonna say 'cause of the memory part that it's both [for PTSD and TBI]. A lot of the times I'll get angry, because I'm not able to find something, or I'm not able to do something. And because I'm seeing her, and I'm able to do these things—like, I would get angry 'cause I couldn't find my keys in my car, or I couldn't find my sunglasses. Now she's taught me systems, where you can completely skip the step of getting angry, because I can find the stuff, it's right where I left it. I

have a certain way to do things now. So in that way, it's kind of helped.

I also have been getting more [help] connected to PTSD, I've been seeing a counselor. But I really think the speech pathology was definitely the way to go. The counselor, we're not doing the EMDR anymore, and we're doing just a talk therapy kind of thing. But there's only so much you can really talk out. I mean, I talked out everything, every situation, every encounter, every bad encounter I had in Iraq. And I'm still not 100% better. I don't think counseling can give you everything. But it does help. I think it has lowered my PTSD. But I really have to give it up to speech pathology.

The biggest thing that I saw with the people that I deployed with—which, mind you, I didn't stay in contact with a lot of them after I got back, 'cause I was pretty quickly pretty much moved to a psych ward. But I mostly saw, when I first got back, a lot of memory problems in my unit. A lot of people were peering over simple instructions, or would lose little things. Their mind seemed to be going a million miles a minute, where they couldn't process any information, it just was going in one ear and out the other. They thought about it, but lost it just as quick. And it caused a lot of arguments and fights that were pretty pointless, but it raised the aggressiveness of the morale.

I think that with most people, memory loss was a huge, huge indicator of PTSD. But I was kind of shoved off and ignored, “Oh, man, I don't have a problem like that.” I don't really think that they acknowledged it.

I don't know if you've ever heard of the she-man. The she-man is a counter-mortar and artillery device that we have in Iraq. It basically lets a loud siren off, whenever artillery or incoming is coming in, indirect fire, like a mortar. Someone took that sound, isolated it, put it onto their phone, and during a formation, played it. Just about every single person in that formation—and mind you, this was probably a month after we got back from Iraq—dropped to the floor like we were getting mortared. I think at that point that we all realized that we all had PTSD, and all kind of joked about it. But it was never anything serious, to the point where we knew we needed to get help for it.

The people that killed themselves before deployment, we had memorial services, and we had grief counselors come in and talk to us about it. The grief counselors actually said it was pretty common for people to kill themselves before a big deployment like this, which was kind of comforting. But like I said, in Iraq, we didn't have anything, it was kind of hush-hush, and I think it just caught us all off-guard and we barely knew how to handle it...

They didn't really affect me directly, because no one in my platoon personally killed themselves, or none of my close friends actually killed themselves. It was sad that they would kill themselves, but I didn't have a strong emotional attachment to them. So I guess I didn't really feel it, or I was affected by the suicides in the military that much. I do think when we lost people, it was definitely worse with suicide. I kind of felt with suicide, at least it was their option, they went on their terms, and it wasn't always that way when we lost people out in combat.

As far as myself, I was actually at Under the Hood when the people here decided that I would not be ‘mentally available,’ we'll say, and checked me into Darnall, and that's when I did my eight

days in the psych ward. That's really kind of hazy. Once again, I was on a lot of medications at that point. I do remember that I told people I wanted to kill myself. I don't know if I had a plan or actually tried to, I don't believe I did. But I did have suicidal ideations at that point. It was really weird. I know that's the only time I felt kind of out of body. I was kind of like, checked out mentally. I didn't really give a fuck what happened to me. I could've died and laid in the freeway for all I cared at that point. 'Cause I wasn't making the decisions. So it was really weird. I'm not sure if it was 100% me in my depression, or if medication had something to do with it.

I think I was taking a couple antidepressants [at that time]. Nothing too serious—my big stints with prescription medications came after my time in the psych ward. They started putting me on all these kinds of medications, so many kinds. And I was essentially a zombie. But I really don't know before that, it's kind of hazy...

Editor's Note: Devon was asked to reflect on how he thought multiple deployments affected soldiers' morale and well-being.

First, I can't imagine going through it with a wife, I can't even imagine going through it with a partner, a relationship, girlfriend, whatever. That's gotta be a huge toll on the people. We had a special room in our out-post in Iraq, it was called like, the breakup-divorce room. That alone, being alone from your family, is a huge stressor. And then, adding the whole situation of war, on top of that, [is] an unnatural experience.

When I went on my deployment, I was excited to go, and usually the first tour deployment, people are. The people that have gone their second and their third time look worn, they look tired. You can tell it's taking shit from them, physically, emotionally, and mentally, all around. I don't think even one deployment is healthy, or good for you, in any means. Let alone multiple. I've only been on one deployment, I don't have that experience or that knowledge, but I can't even fathom it. There's no way in hell they'd have sent me back. I would've gone and moved to goddamn Mexico, Alaska, Australia, wherever, not to go back to that place, at least not as a soldier.

[War] is unnatural, as human beings, we're not programmed to take another life. And when we come to that situation, to do it, a lot of the times we won't do it. But being in the military, you're exposed to certain kinds of training, like reflexive fire, and stuff like that. That takes the thinking out of it, and makes you automatically pull the trigger when you bring your weapon up. I really felt that training hurt me a lot, the reflexive fire training. 'Cause there was situations in Iraq where I pulled my weapon up and discharged rounds when I wasn't even thinking about what I was doing, it just happened too quickly. But that was what I was trained to do.

I certainly believe anyone that's even just left the base has PTSD, some form of emotional disturbance, definitely. For two short answers, killing and betraying, was definitely something that caused the trauma for me.

[Counterinsurgency] is kind of like the War on Drugs. We're fighting a faith, we're not fighting a group of people, we're fighting an idea—insurgency. It's never gonna be over. I believe the best way to stop these insurgencies would be to pull out of this country, because I believe a lot of the

'insurgents' that we're fighting are people in this country that just don't want us to be there.

Fighting a War on Terror is the same as fighting a war on pot. You're never gonna eradicate every crop of marijuana in the world, and make it extinct. You're not going to! Give up... Terrorism, it exists, yes. On the scale of that the US portrays it? No. Is it something that we need to address? Yes. Are we addressing it the right way by invading a country and doing what we're doing? No. I don't really have the correct answer of what we need to be doing to stop it. But we all know that we're in Iraq for daddy's little fight, to go in there and finish it. There's no reason why we're in Iraq. At least we had a legitimate backup for why we're in Afghanistan—or semi-legitimate, I don't believe either of them are legitimate wars.

...I personally think any soldier that deploys, any soldier, combat, non-combat, whether you stared at and never fired your weapon all day—I think you need to go through at least 90-day, three-month minimum counseling kind of deal. Because a lot of the soldiers, just because of the stigma, will not admit to having problems. A licensed, fully professional counselor can detect those problems, even if they're not admitting them. They won't be able to detect them within a first encounter, they won't be able to detect them within a week. But after a few times meeting with that patient, the doctor would be able to properly diagnose what was wrong with that person.

...I think it's gonna cost way, way, way too much to properly take care of it. And the military will never do it. No one has enough money to take care of it.

My unit was kind of special for TBI. We had quite a few briefings about it. Mostly because they were inserting special little chips in our helmets, G-force kind of things to see what our head would be getting. So my unit actually had a lot of explanation of what TBI was, and what the signs were, and why they were doing this. I believe it was randomly selected. I don't know if it was because of the location we were going or not, but it was pre-deployment, that they determined it was going to be us.

Editor's Note: Devon confirmed that, while deployed, he was exposed to conditions that could have caused a brain injury.

Any time that we were next to indirect fire, or anytime we got hit with an IED, EFP,²³³ anything like that, the next available time that we were at the FOB we were sent to the medical unit to go get evaluated. They would ask us a few comprehensive questions, make sure we were alert, knew the date, knew the president, stuff like that. They would look in our eyes, do a flashlight, making sure our pupils would dilate properly in sync, and stuff like that.

I think we were checked out pretty thoroughly when it was available. A lot of times we were out at the out-post and we only had one or two medical guys with us. And if anyone in the platoon got hit, they would have to go through and do this test to like, 24 dudes. So I mean, a lot of the times we'd just be like, "Yeah, I'm fine," to check the blocks kind of deal. But when the post was available, I think we were screened pretty well.

I'd say about 30% of the time I was on the FOB, and that was where all the real doctors were. I had a medic that went with me off FOB. But only trauma stuff, not full medical care.

I'm also rated for migraines, I believe it's connected to my Traumatic Brain Injury. I'm extremely, extremely forgetful. I'm cognitively slower. I don't really have a sense of smell anymore. My tastes are different. That's how my memory is. My memory is shot.

...I just recently was retired from the military at 90% [disabled]. Last week I got my rating from the VA finally, after two and a half years of being out of the military. They're gonna finally rate me at 100%. I've been unemployed the entire time, just because of the disabilities I received in deployment.

This is my first semester back at school. I'm getting pretty—I'm not gonna say overwhelmed, but I'm pretty close to my limit on cognitive capability, with this one class.

Out of my unit, out of my platoon, out of 16 guys, I know for a fact one other person was diagnosed with TBI. Me and him would always joke that we were gonna move in together when we got released from the military. We were gonna own one DVD and watch it every single night, like over and over. You know, 'cause we can never remember shit. He's pretty much in the same boat I am. He lives over in Kentucky. And kind of the same thing as me, he's off by himself, doesn't have a social life much. He's already done with the school. He tried it and he was done. He said it was too hard. But yeah, the same exact situation that I was feeling, I've seen other soldiers go through too.

Editor's Note: Devon was asked what kind of training he had received in the military on sexual assault and harassment, as well as his experience in MEB.

Really none...when we first got to Fort Hood, we were instructed to be careful, because there was a lot of MST going on, a lot of rapes, guy-on-guy, guy-on-girl. On and around Fort Hood, they said it was really common. Really that's the only time I think I was talked to about Military Sexual Trauma. But I was a combat soldier, in my unit it's illegal for girls to be there. There was no girls in my unit, I didn't work with girls. While deployed we try to get female soldiers to search female detainees, in country. And for that reason we were brought two female soldiers to our out-post. And I don't know physically went on, I think I was on guard duty when it actually happened. It wasn't a rape, but it was like, an attempted rape, started happening in my unit. But shortly after that, we had a special unit come out and take the girls away from our out-post and take them back to the FOB, and we never had girls at our out-post again. But that right there was my only experience with military sexual trauma.

Just like any kind of safety briefing, any time they made us get in a group and talk about PTSD in a safety briefing, or military sexual trauma, it was never taken seriously. It was just, "Okay, we're gonna go home after this. Can we hurry it up?"

...The military is not really a good place. It's a bunch of kids fresh out of high school, getting a pay-check, a place to live, and a gun, and a sense of authority. They've never had any of that,

and all of a sudden one day, after two and a half months of training, boom, they have all of it. They get a sense of being invincible and think they can get away with anything. I don't know if there's really a way we could stop [MST], let alone disbanding the military in general. Look at the Ukrainian military, or air force, they allow a lot more females in, they let females even do combat jobs. But they still have astronomical amounts of rapes and MST.

I don't really know if there's a way to fix it. When you put people in a situation like the military, give them the idea of false power, and make them fight all the time? Assault is going to take a hold. And males are made for pretty much one thing, from an evolutionary standpoint, they're made for one thing. To breed. And it's sick that that happens. I don't know of any way that that could be stopped. I'm not saying it's right. But I really have no idea, let alone putting all females out of the military. But that doesn't stop all MST, there's still guy-on-guy, it goes on.

...The MEB process takes forever. But to get accepted into the MEB process, in my experience, was the hardest thing. One, getting out of your combat unit. Two, dealing with all the stigma. Three, getting to a unit that you can actually go to appointments when you need to. It's very hard to get that. And then having my commander, from my old unit, my commander from my current unit, and the hospital commander all agree that yes, I was screwed up enough to get into this process and be removed from the military. That's really, really hard to do, and I can't stress that enough, how hard it is for soldiers to accomplish that or even do that.

But once I got into the system, God, it took forever. Yeah, I did have some bad experiences with some doctors, like doctors told me, "No, you don't have TBI," when I have visible lesions on my brain, that any MRI or I'm not sure what ones would show it, but an MRI shows it. And they'd just be like, "No, you don't have it." You have to actually sit there and really fight in the MEB process. Just like anything medical in the military, you really need to fight to your death. And basically not take no for an answer. It's rough.

My nurse case manager was really mad, she really helped me out and took care of me. I think all the nurse case managers seemed pretty nice, and pretty much on the same page with her. But like, doctors seemed over-worked, didn't care. And a lot of them did not want to give diagnoses. Because they know the military's going to be paying for that. And whether it's said or not, it probably looks bad if you give out way too many diagnoses. Their boss probably looks at them worse. The person gives out the least diagnoses, in my opinion, would probably be looked at more favorably than the person that gives out a shit-load of them. Every diagnosis costs a shit-load of money, 'cause they have to pay them for their life.

They released me on Medical Board, 100% disability, 50% for Post-Traumatic Stress Disorder, and 70% for Traumatic Brain Injury, which with very special math, they told me 90 for some reason. But those were the two that I got from the military. Then, eventually, a few weeks ago they added migraines, and both my knees and my back to that.

It was my captain of my medical unit, a Warrior Transition Unit [who referred to MEB]. The only reason [I got adequate care after that] was because I was in the WTU. I was in a special medical unit. If I was in a line unit, no, I would not have been able to get the access to the proper medical

care. But I was one of the few that was afforded proper medical care, I believe.

I saw a lot of providers. I saw primary care doctors, and then I would see neuro-practitioners, neurological people that do stuff with my head, therapists, different therapists. I saw some ribcage specialists for my back and my knee problems. Sometimes it was like, a three-month wait for something like that, but I was able to see some sort of specialist for it. All of my injuries are service-related and connected...

Excluding my time when I was in that combat unit, and I was called out in front of my entire platoon about my medical problems, it has been kept confidential.

I got horrible responses from everyone, except from my first sergeant [when I was moved to WTU]. My first sergeant was very helpful in getting me into the Warrior Transition Unit. He wasn't really my first sergeant, he was a first sergeant to another company, which tied in with my first sergeant. It's a weird situation, that's neither here nor there. But if it wasn't for him, I wouldn't have been able to do it. I got horrible responses from everyone else. I was very lucky to have him.

Editor's Note: Devon was enlisted during the troop surges to Iraq and Afghanistan, and was discharged before the drawdown took effect, but shared some reflections on how things were different then from what he hears today.

...ASAP was always full, and all those substance abuse places are always full. They would never chapter people out for substance abuse when I was in. I'm sure they would now, it's totally different. And as a veteran, being on the outside, I know that it's hard at the VA, it's kind of packed, there's so many veterans. There's so many of us that have problems.

...My unit was pretty lax. It's pretty hard to get in trouble in my unit. The other guy I told you had traumatic brain injury showed up late all the time. A couple of times he never even showed up. And people didn't notice, didn't care, if he was late and he walked up in the middle of formation when they were talking, they didn't care.

...I think [the VA] is severely understaffed. I think it is really underprepared. Yes, they have taken some good initiatives, and steps towards providing aid to veterans. But unless you want to fill up auditoriums of people, you're not gonna have enough room, you're not gonna have enough doctors, or even be ready enough to deal with the amount of people that are actually having problems with this war...both wars. But a lot of them aren't gonna actually even get help, they're just gonna be the crazy 25% homeless people out on the street. Which makes me sad.

My family would tell you I've calmed down a whole lot since I first got out of the military. I still have extremely bad road rage, and some things really get me. It's really difficult adjusting. Like, the first day that I was out of the military, I didn't eat, 'cause no one told me to. It was really weird. It was a very liberating feeling, 'cause I was trying to get out for so long.

But it was very weird. If I had to go out and get a job, I don't know if I'd be able to. I don't think it's really part of PTSD, but the whole culture of being in the military is weird. You can't really get

fired, and everyone knows that. And that changes some things that most people don't really take into effect when they're thinking about jobs. A good example is like, I can go run into a soldier, while working and fart on him and run away laughing. You can't do that in a normal civilian job. You'd be fired pretty quickly, if not arrested. But in the military, that's kind of funny. I would run up to my commander and go fart on him and run away.

...And I guess a lot of that culture rubbed off on me. That culture involves little inappropriate pranks like that, lots of cursing, and lots of 'excited talk,' let's say. A lot of times I'm not angry, I'm just speaking very loudly, and people think I'm screaming at them. I'm not angry, I'm just excited. It's hard for me to maintain relationships, because people think I'm fucking insane! I'm screaming at them, when really I'm thinking I'm talking normal to them.

...Time will heal all wounds, pretty much. Almost all of them. But it's slow, it's a slow process. It's a hard process. But it's for your own good.

Personally, I believe I'm probably gonna die pretty young. I don't think I'm gonna live to be the average life expectancy of 80. I'm guessing probably somewhere around 50, just with all the medical things I have wrong with me. My back's gonna give out, and my knees are gonna give out. I know by the time I'm older I'm not gonna be able to walk. So with those injuries alone, and having to deal with being mentally slower than everyone else around me, and cognitively different, and being angry all the time, it's difficult.

Editor's Note: In wrapping up the interview, Devon shared his reflections on what it will take to get soldiers the care they deserve and the right to heal.

Ending the war would be something that would give us the right to heal. I don't think there's really much else we could do, besides completely stop doing what we're doing. Anytime you send someone to do something like war, it's a maxim, you're gonna get problems with the person, no one is supposed to be doing this kind of shit. No one's supposed to be taking another person's life. We're not programmed for that...

...We need a full array of things to end these wars, and I believe more direct action is needed. We need to be in the streets, outside of military bases, letting the commanders of the military bases know that we're not standing for this. As civilians, we're not standing for wars that for years have been under 50% approval rate. No. We're sick and tired of sending our fathers, our mothers, our daughters, our sons, to go die in these stupid fucking wars for profit. We need to have that more vocalized.

31 Mitchell Tate*

Editor's Note: Mitchell* is a white active duty soldier in his mid-twenties from the Southwest, serving in an Infantry unit. At the time of his interview in 2012, he had been in the Army for three years, and the year prior had broken his back in a training exercise, resulting in severe, long-term injuries. He and his wife were expecting a baby at the time of the interview, and Mitchell was being evaluated for medical retirement.

I'm from [a city in the Southwest]. I joined the National Guard when I was in high school, and then I went through basic training—I went through OSUT, station unit training.²³⁴ When I came back, I filled in papers to go on active duty. I went on active duty in December of 2009 and I was assigned to South Korea. I arrived in South Korea in about January or February of 2010. I did my year there, and came over to Fort Hood. I've been here a little over a year.

It's kind of hard to say what I wanted to get out of the military. I wanted to see the world and, in the meantime, do something that was meaningful—something I thought had purpose, I guess. I broke my back at in training in 2011. Shortly after arriving at Fort Hood, I went with my unit to the National Training Center out at Fort Irwin for a month. I suffered two fractures to my T-11 and T-12 vertebrae. When we came back, it was a battle to get the help that I needed.

I went to sick call and complained of back pain. I did that a few times. I tried to get an MRI, but the individuals in charge of me refused to give me one. They sent me to a knee and back class instead. I think that it was kind of foolish to refer me to a knee and back class.

Then I went to physical therapy. But I kept trying to get an MRI because I knew that there was something seriously wrong with my back. None of the doctors were willing to admit that. They just kept putting me through physical therapy, which I couldn't do because it was too painful, and I had not been treated properly for my injuries.

After seeing a physical therapist for a while, I just decided to pay out of my own pocket to see a neurologist at Central Texas Neurology. I explained to him my situation—that there wasn't much being done to help me or to evaluate me. The Army can say that they tried to help me by putting me through physical therapy, but they didn't help me. You can't put somebody through physical therapy without identifying the problem.

I was told that I may have strained a muscle, but having been very active—I played basketball in

high school, and I did a lot of PT even when I came with the Army, I scored a 293—I knew what a muscle strain felt like. I tried to explain to the doctors that there was no way this was a muscle strain, but they ignored me and just made their diagnosis based on opinion, not fact.

[I have] muscle spasms. My back becomes really tight. That was actually something that the physical therapist noted, but still she refused to order an MRI. I have a lot of pain running down my back into the upper portion of my legs and my thighs.

I was running and I had a lot of gear on me [when the accident happened]. The unit that we were attached to at NTC, during one of the missions forgot to bring their automatic weapon. So I was picked to carry an automatic weapon, and I also had all my ammunition and my own gear. Then I ended up having to carry the CLS stuff because my team leader had ended up not being able to; in NTC, you have these graders, and they sit there and say, "Well, you're down, you're blind" or whatever...it's all a fake scenario. I had to carry his gear, or the CLS stuff, because he went down. So I was carrying a lot of gear, and at one point in time, I was running and I fell. I landed on my butt, and that's what caused the compression fracture.

Editor's Note: Mitchell was asked how long it had been after that until he got an MRI and figured out what his injury was.

Months... Finally, I got fed up with the Army system refusing to pay for an MRI. What it all comes down to is budget cuts. Maybe the Army doesn't want to pay for an MRI or they just don't care—I don't know. But eventually, around June of 2011, months after I injured myself, I finally went to see a civilian doctor, and he thought there was something wrong, so he ordered an MRI. I took that back to the Army, and the Army still didn't want to give me an MRI, even though I had a recommendation from a board-certified neurologist.

So what they did was they just sent me to another doctor, who in turn agreed to the MRI. Finally, I took the MRI, and they found that there were two deformities from the fracture. The reason the bones were deformed is because even a major fracture, after six weeks, the bone won't heal. So it was healed, but you could still see that it had been fractured because the vertebrae, the T-11 and T-12 are deformed—they're wedged like this, instead of even they're more like that, which is what causes the degenerative disc disease. There are two protruding discs in my T-4 and T-5, and the wedging, the unevenness of the bone is what causes the muscle spasm because it's uneven, so it's pulling at the muscles. At that point in time, they initiated an MEB.

...I still have muscle spasms. The degenerative disc disease is permanent. There's also thecal sac compression, which is the thecal sacs around the spinal cord, and it's compressed because degenerative disc disease is pushing on the thecal sac and causing significant compression. But I don't know if it's gotten worse, or if it would have been better [with earlier treatment].

It was unfair. I did have a profile that was written by the physical therapist. I believe it was a no lifting, no bending profile, but I was still made to work in the motor pool [while injured]. I still had to lift equipment that weighed probably 40 or 50 pounds, with a back injury. On top of that, I was working in the motor pool where you have moving tanks, Bradleys moving. That's the first time I

ever took a pain killer in my life.

[I took] Vicodin, I think maybe seven or eight months. I stopped it a few months ago, and the doctor agreed with me, but he's an off-post provider, a civilian provider. Way after my unit left to Iraq, I asked to be taken off of it, because of the headaches and how you get really agitated when you come down from it. But at the time, when my unit was here, I was working in the motor pool and I was taking the Vicodin, and I had a muscle relaxant.

My squad leader and the non-commissioned officer in charge of me were aware that I had been taking painkillers. They were aware of my profile. I don't think it's safe for somebody on painkillers to be in motor pool, where you have motor vehicles and tanks moving about. Inside a tank, your visibility is very reduced, which is why you need a guide. And if you're dealing with somebody whose mind is altered due to these pain killers—if I'm not aware of my surroundings, and the guy in the tank can't see well—it's just not safe. I informed my NCO that I was taking pain killers, and that were sedating me, because they were central nervous system depressants, so my ability to react was severely reduced and all that. I don't think I needed to be in the motor pool. It definitely was not safe.

You're not even supposed to drive when you're taking painkillers, so why was I being forced to work in a motor pool with tanks and humvees driving around? It definitely wasn't right to have me out there.

Editor's Note: Mitchell clarified that he experienced pressure to violate his profile by lifting and other duties in the motor pool, and that the pressure came from his squad leader, who was a staff sergeant.

I wasn't aware of MEDCEN-01 until maybe about a month before Curtis left [the military].²³⁵

I've always been told that a profile is a recommendation and that a commander doesn't have to abide by it. However, if he doesn't abide by it, and it results in further injury, then he could be held accountable, which I doubt he would be. A profile shouldn't be a recommendation, which, according to MEDCEN-01, it's not. But I wasn't aware that MEDCEN-01 existed. I don't think my commander was either.

...I've had several [profiles]. My first profile was when I went through physical therapy—so maybe May, 2011... To be honest, I can't recall the specifics. I do have a copy of it at home. That was before the MRI. If you're in physical therapy for an injury, it's pretty common procedure for them to also issue a profile.

There was [a re-evaluation prior to it expiring]. The Army doesn't want to issue out profiles, and it wasn't a permanent profile—I want to say it was between one and three months. Then I stopped seeing the physical therapist, and I had to get another profile, and all that did was recommend a MEB. They didn't really write that profile to protect me. They wrote it because me and my platoon sergeant walked in to see the lieutenant, because my platoon sergeant wanted to see whether I was going to deploy or not. And the lieutenant wrote a profile just to refer MEB.

It did not protect me. It was not detailed enough. Based on what I've seen, it's common for providers not to write very detailed profiles, unless a soldier is very demanding. To get the current profile that I have, I had to be very demanding, which I shouldn't have to be. The medical provider should realize that, being in the Army, you're made to do a lot of strenuous things, and if that profile is not adequate, then you're going to have to do those things.

Maybe they're being pressured from above. Maybe they don't care. I think it depends. With my lieutenant [a PA], I think he just didn't care. He looked at my MRI, and said, "Okay, so, so what?" Exact words.

I don't know what his degree of [medical] training is, but he sat there and told me that it wasn't serious, when it was. Not even two hours before that, I had seen a specialist who said I had serious structural abnormalities. I can't speak for every provider in the Army, but with this lieutenant, I think he just legitimately did not care.

Based on what I have seen, I think that [medical providers] are more concerned with getting soldiers back to work. They serve the Army, not the soldier. They take an enlistment, just like I did, and their obligation is to the Army; they don't take an oath to individual soldiers. I honestly think that the Army's medical system should be run solely by civilians. I think that the private sector is always better than the government, whether it be in economics, in business, or in health care. I think that I should receive health care from a doctor who has his own practice.

I don't think that chain of command should be able to pressure PAs into rewriting a profile, or maybe making it a little bit more lenient. You can't pressure a civilian. You can't tell a Baylor School of Medicine graduate, who knows more about neurology than sergeant first class so-and-so ever will, that he needs to change a profile. You can't tell him that he's wrong. But a PA, a lieutenant, I don't know.

...I've seen [other] soldiers being made to work beyond their profiles. I've never seen somebody say, "Hey, go break your profile." They don't do it that way, because they've been in long enough to play the system. But you can subtly push someone into breaking their profile. Most soldiers, they just don't care. On the rear,²³⁶ what I see in a lot of soldiers is that they're fed up with the Army. They've been wronged in one way or the other, and they just don't care—if they do it, fine, whatever. If the soldiers do stand up, they're afraid of hazing, I guess; which we see in the media, we've seen a few cases of hazing that kind of shed light. There were two soldiers that killed themselves recently.

Hazing is very common in the United States Army. It's just not well known. Any lower enlisted soldier can tell you that hazing is common. If you stand up for yourself, then you might just get hazed. I think a lot of soldiers are afraid of reprisal. If they stand up, then they're going to get yelled at or treated differently.

I've seen it. It's happened to me. When I was in NTC, I was told by a corporal to get down and do push-ups with my buddy. Actually, his exact words were, "Your buddy's fox is getting smoked, why don't you go out and join him?" I told him I wasn't going to do it. I did it respectfully at

Parade Rest. Then I had an NCO who flipped out and told me to go and do this exercise, and I said, "No, I'm not going to do it, sergeant." I'm not going to be bullied, bottom line. Then the NCO put his hands on me. He started screaming at me, poking me in the chest. At that point, I just said, "Sergeant, I'm going to walk away," and I did. He grabbed me by my arm and pulled me back; at that point, I got physical with him. I put my hands in his face, right on his face, and we got into a physical confrontation.

So I was standing up, and I was being hazed. I was the new guy in the unit. Corporal tried to smoke me, which by Army regulations is not allowed. That's another issue with the Army—there's a lot of non-commissioned officers out there that either don't care about the regulations or they don't know them. But I know that smoking is banned in the Army—it's called corrective training, and you can't give corrective training when there's no action that needs to be corrected.

[The stigma] is just the Army culture. All these policies that the Army has are just a front. They have to be able to say, "Well, we've been trying to address hazing; we've been trying to address rape; we've been trying to make people with mental illness seem accepted; we've been trying to reduce the stigma." But all that is a front. What happens on the ground, from what I've seen, is that if you have a profile, nine times out of 10 you're going to be labeled a shitbag.

Editor's Note: Mitchell was asked if he thinks the stigma discourages other soldiers from getting care when they need it. He continued by reflecting on what got him to the point of being able to stand up and advocate for his own needs, despite that stigma.

Of course it does. Nobody wants to deal with that. I think some people are less likely to go on sick call and get a profile—or stand up or utilize their profile—because they don't want to be labeled a shitbag.

I don't care what the Army thinks. The only opinion that matters is mine. I've thought that way from day one, even before I came in the Army. I could care less what some five-star general thinks. I came into the Army with a 293 PT score. I could outdo most Army Rangers. I injured myself and I needed to take care of myself. That's just my mentality. I don't care what labels are thrown out there at me. It doesn't bother me.

Some soldiers aren't that confident. They don't have that.

Honestly, I think that [change] starts with the soldier. A soldier has to advocate for himself. But if you really wanted to make it so that he can go into sick call and not feel embarrassed or ashamed, you'd have to change the Army culture.

In Basic Training, if somebody is suicidal, they have to wear a big orange vest. Drill sergeants sit there and demonize this individual. I've seen it. They take your shoelaces; you've got to have an escort everywhere you go. They're demonized. It's really bad. The Army can say this doesn't happen. A general who doesn't see his Joe's, who doesn't see what happens on the ground, can sit there and say this doesn't happen. But I can tell you because I've been there on the ground that it does happen—that from day one, mental health patients are treated like crap. So when you go into your unit, if that's what you see from the start, you're not going to want to be that guy.

You're not going to want to be treated like that.

The Army says it's for safety. This guy's got to wear an orange vest for his safety. This guy's got to have his shoelaces taken for safety. And he's got to have three guys hovering over him while he sleeps for his safety.

The Army sits there and says, "We're doing that to protect the soldier," but that's demeaning to have to sit there and walk around with an orange vest. Guess what? Everybody knows that that dude with three guys walking around him, walking with him everywhere with an orange vest and no shoelaces—everybody knows that he's got mental health issues. Is that fair? You're putting his business out there inadvertently. The Army's good. They know how to treat people like crap and make it seem legitimate.

I don't think [profile violation] made it worse. I'd have to get another MRI to say. But the profile that the lieutenant wrote for me was not helpful at all. It didn't protect me for my condition, it was very vague. That actually was in one of my Senatorial inquiries—that this profile was too vague, it didn't protect me, and I couldn't get it changed. I ended up having to jump down from a tank, and that really hurt. So there have been times when my profile didn't protect me enough, and I had to go to the ER.

A lot of things, like shopping, are difficult. I get really agitated when I'm on my feet for so long. I get crabby because I'm in pain, and I just want to be done. I'm like, "Hurry up, let's go, let's get this done, we'll get it another day, let's just leave." I can't do a lot of things. I can't exercise. I put on 40-50 pounds since I've injured myself. I can't go out with my wife as much and do things that we like to do—hiking, bowling, things like that are extremely difficult.

...I think once I get out of the Army, I'm going to go and see some separate doctors. I'm going to go to North American Spinal Institute because I don't have much faith in the Army's medical system. I think once I get out and I'm able to see reliable doctors, I think that they'll provide better treatment options for me. I think it'll get better. I think there are great doctors out there, but I don't think there are great military doctors—maybe a few.

[SRP] is what helped me. They were going to make me deploy. I mean, can you imagine deploying? It's a numbers game. There was a PFC who deployed with a unit, and it was known that he had serious mental health issues, and they still made him deploy. He ended up killing a contractor in Kuwait. He shot the dude in the head and dumped his body in a port-a-john and tried to board a Black Hawk to the states. He was caught, obviously. Recently, he was found not guilty by reason of insanity, because he was. I sat there on guard with the guy.

He shot the guy before I came to this unit, but I know what happened, because I sat on guard one time at the mental health facility at Fort Hood when they had him here. Some guy is dead now, and the PFC's life is ruined because he should have gotten the treatment beforehand and been discharged from the Army. That's the DoD's failure, you know. They failed to tell the command that it's not about numbers; that if you have somebody who can't deploy, then he doesn't deploy. There's a man that's dead, who was probably somebody's husband and

somebody's father, because the Army failed.

...Both my platoon sergeant and my first sergeant wanted me to deploy. They were probably being pushed from a higher level. The Army's about numbers. The Army likes to sit there and have some guy in a suit go on TV and say, "Well, we really care about your family," but they don't give a shit, and that's the truth.

There was one NCO who helped me through this whole process. He saw that I was being wronged, and he really helped me to get the treatment that I needed... He's old-school Army. The dude's been on five deployments. He was injured, but before that, the dude's a great soldier. And he was just looking out for a soldier... He drove me out to Central Texas Neurology, and he's the one that helped me. There are good NCOs in the Army. There are amazing people. But there are a lot of pieces of shit.

A civilian [blocked the deployment]. Because of my profile, she said I couldn't go. She said, "I don't even know why you're here."

I hadn't gotten the MRI yet. I came back and said, "Look, they said I can't go," but the sergeant major wanted me to go, so that's when me and my platoon sergeant went to see the lieutenant, and they recommended the MEB.

...Based on what I've seen, I think substance abuse is a problem in my unit. But I don't know if that's from PTSD, or if it's because a lot of the soldiers just hate the fact that they're in the Army—they've been mistreated, they've been wronged, and they're tired of being here and they just want out, and they resort to drugs or alcohol.

Even in the rear-D, there are guys who just want out. There was a kid who was told by his command that he was being sent back because his grandfather had died and he was going on his two-week leave from deployment. But that wasn't the case. They sent him back, and they tried to chapter him for patterns of misconduct, but there were no patterns of misconduct. They had nothing. They had no counseling statements. You can't discharge somebody for patterns of misconduct when there's no way to prove. They didn't like him, maybe. They just had a problem with him. I don't know. I mean, it is that easy. We like to sit there and say that the Army is this place with these perfect people, and they can do no wrong. That's as far from the truth as you can get.

There are times when leaders abuse their position. Like with counseling statements, the Army likes to say that it's a great idea and that it's beneficial to the soldier; but to me, it leaves a lot of room for abuse. Say I'm working, and my shoelace comes undone—that's out of uniform. You can get a counseling statement for something that miniscule. After about three counseling statements, they can give you an Article 15.

A dude is a pound overweight—a pound overweight—and they're trying to chapter him for being a pound overweight. I saw it even before the drawdown. A lot of times, if a leader does not like a subordinate, that leader will abuse the system. It seems like the system was created to be

abused. It is so easy to kick somebody out. On paper, it's legit—you've got three counseling statements, you're not meeting the Army's standards, you can't stay in uniform.

Should you ruin somebody's career over that? Is it fair? Instead of fixing the soldier, maybe the NCOs should look at themselves and say, "Maybe I'm the problem." But you'll never see that when somebody has that much power. NCOs are taught to think that they're always right, that they're the best of the best, that they're superior. So somebody with that much power...is not going to come around and say, "Well, I'm wrong." The Army's a dictatorship. You follow orders, bottom line...it's abusive.

[Under the drawdown] they're starting to get people for whatever they can get them for. From what I've seen, there are a lot of people that are getting discharged for stupid things that they can improve. If you're a little bit overweight, you can improve that. I came into the Army 182 pounds, 293 on my PT test, and it's just slowly declined because the Army's PT program is garbage.

...I think the Army has realized that there's a problem. There are people who have been wronged. I even read an article about it in Army Times. There are people who I think have PTSD who are being discharged for stuff.

There's a soldier who does have PTSD, and he's been abused by the unit on a rear-D. The abuse and the harassment has exasperated his mental health conditions, and he did smoke marijuana. I'm not saying it's right, but now he's being discharged for that. I mean, the guy's sick. He's being harassed.

...For a lot of the guys, [job prospects elsewhere] are not great. But that I really do believe is an individual thing... Some people will struggle. If you have mental health issues, it's always going to be harder, no matter what. Whether it's PTSD or Bipolar, I imagine that it's always going to be very difficult for you to maintain a job. My sister has Bipolar—it's difficult for her to get a job. I think anybody with a mental health issue is going to have trouble getting a job—that's why the Army has to take care of them.

Editor's Note: Mitchell clarified that he had received briefings on PTSD and TBI, as well as MST, and shared reflections on what he felt lacking in that training.

...A lot of [MST training] is bogus, to be honest. They give you training, but I don't think they talk about what happens to guys enough. They rarely focus on men being wronged.

...I don't think [MST prevalence] is the command's fault at all; I think that's the soldier's fault. If someone chooses to go out and rape somebody, that's their fault. If you choose to go and do bad things to people, that's a choice that we all make. And it all starts at recruitment. The problem with the Army is that, for the past 10 years, they recruited anyone and they promoted anyone... In the Army, you study for a couple of weeks, you put on a show, you go in front of a sergeant major, and you pretend to be this person. You go in front of a board and you answer questions.

I like the Navy's system of promotion: you can't just go. I think it should be very difficult to get promoted. To become a non-commissioned officer, it should be very, very difficult. If you get a

young guy who's not experienced put in as an NCO, he might abuse that position or do the wrong thing. But if you make people wait longer to get promoted, and they have to go through rigorous testing, then maybe you might prevent rape, because you get somebody who's older, who's more experienced—he wasn't just thrown NCO rank.

Some guy in a suit can stand on TV and say, no, we don't just hand out rank, we don't just throw it—but I'm here on the ground, and yeah, it does get thrown at people. You have a lot of instances where NCOs abuse their position and they might rape somebody.

...[MEB] has been pretty good. Because I did the Congressional thing, I was able to get more care. I was able to continue to see the civilian provider—that was authorized. They reimbursed what I paid for. They have to, and they should. They let me go see an off-post pain management provider, so it's been fairly decent. But why should I have to fight like hell for something that I deserve? I'm not asking for free medical care. I worked for it. It's all part of my contract. I did a WT matrix and I didn't qualify for it. I think you have to be really, really, really damaged to get into the WTU.

...They're probably not going to give me 30% or more, because if you get 30%, you get Tri-Care for the rest of your life, and so do your spouse and your dependents. They're probably going to give me 20%, which means I'm going to get a lump sum that I'm going to then, in turn, have to pay back. They're supposed to take care of my back for the rest of my life, but to be honest, I'm going to avoid the Army doctors. My mom's going to help me there financially so that I can see real doctors.

...I just want to see a civilian doctor outside of the Army, see what they offer me. The Army's concerned with budget. I don't know if surgery's the best option. I've heard good and bad, but at least if I go to see a civilian doctor, I think I'll get good treatment plans and an unbiased opinion; whereas, in the Army, doctors don't want you to get surgery. You have the budget being cut, they're cutting down on surgeries, so the doctor's like, "You don't need surgery." But he's saying that because someone else is telling him, "Hey, we don't have the money to give anybody surgery."

[The injuries] have already been determined to be service-connected. Now I'm just waiting on the PEB to determine whether I'm fit or unfit for continued service. I'm obviously unfit. The way it works is, the Army's going to give me a rating and the VA's going to give me a rating. If the Army gives me a lump sum, then I'm going to have to pay that back through my VA rating. So instead of getting the disability from the VA, it's going to go to pay the Army back that lump sum—even if I choose to take it. Then they always have to take care of my back injuries since it's service-connected.

Editor's Note: In wrapping up the interview, Mitchell shared what he thought it would take to get soldiers the care they deserve and win the right to heal.

I think you have to change the culture. You'd have to make examples of non-commissioned officers and commissioned officers alike. I hate to say it, but you'd have to relieve several

commissioned officers and non-commissioned officers, so that the rest of the Army would get the picture: you're not going to be mean to your soldier, you're not going to criticize him, you're going to let him go to sick call. Because right now, if you want to go to sick call, you go stand there and the first sergeant tells you, "You don't need to fucking go on sick call."

It happens in our unit. My buddy goes on sick call and later on that day, he's like, "Man, I had to hear the first sergeant chew me out and just talk crap," and disrespect him. Relieve that guy. Take his job away from him. The Army will take away a specialist or a private's job, so why not do that to a commissioned officer?

As long as the Army is lenient on its leadership, then the leadership will continue to abuse their authority. Once the Army starts cracking down on the leadership the way they crack down on the Joe's, that's when you'll see a change. Because then, some guy who's put 15 years in is going to refrain from saying what he wants to say.

Until you start to see officers losing their pay, their job, their benefits—non-commissioned officers—until that happens, the abuse will continue.

...I think the biggest thing you can do for a soldier is tell him to be confident, because if you're confident and you're not afraid of your chain of command, then they'll sit down and listen to you because they have to. At the end of the day, a soldier needs to stand up for themselves. In a respectful manner say, "Sir, you know, you don't need to say this to me. You're not authorized to insult me, sir." It takes a lot to stand up to your command. But if a soldier really wants to get what he needs, he's going to have to be an advocate for himself.

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Glossary of Acronyms and Military Terms

5-17	US Army Chapter 5-17 details conditions under which a soldier may receive a discharge from the army classified as Separation for Convenience of the Government, sometimes for “other designated physical or mental conditions,” as specified in Army Regulation 635-200.
ACAP	Army Career and Alumni Program
AIT	Advanced Individual Training, the portion of training after basic training during which soldiers learn their particular job (MOS) skills.
AKO	Army Knowledge Online, the army’s main intranet. A designation of ‘Red’ means ‘Not ready for deployment.’
ANAM	Automated Neuropsychological Assessment Metrics. A computer-based cognitive assessment test. The Army has commonly administered the partial ANAM as a screening tool for TBI; however, even the full battery is not an appropriate neuropsychological diagnostic tool. Its results are only meaningful when compared between pre- and post-tests.
AR	Army Regulation
Article 15	The section of the Uniform Code of Military Justice regulating discretionary punishments without judicial proceedings. The term is also used as a noun to refer to write-ups under that section.
ASAP	Army Substance Abuse Program
ASVAB	Armed Services Vocational Aptitude Battery
BAH	Basic Allowance for Housing
CHU	Containerized Housing Unit
CID	Criminal Investigation Division
CO	Conscientious Objector; Commanding Officer
Connex	A large metal cargo container used by the military for shipping supplies overseas.
CQ	A soldier who is in Charge of Quarters

DADT	Don't Ask Don't Tell
DoD	Department of Defense
Downrange	Indicates being deployed overseas, usually during wartime.
EO	Equal Opportunity
ETS	Expiration, Term of Service, the date and time when the soldier's enlistment contract ends.
Fifth floor	The fifth floor of Darnall Army Medical Center is where the inpatient psychiatric hospitalization facilities are located on post at Fort Hood.
FOB	Forward Operating Base
FRG	Family Readiness Group, a command-sponsored organization of soldiers' family members, volunteers, and unit staff, tasked with providing information and support to Army families.
IDF	Indirect fire
IED	Improvised Explosive Device
IG	Inspector General
ISAF	International Security Assistance Force
IVAW	Iraq Veterans Against the War
MEDPROS	The Medical Protection System, the Army's electronic tracking system for soldiers' medical information and deployability.
MRAP	Mine-Resistant Ambush Protected vehicle, an armored combat vehicle.
NATO	North Atlantic Treaty Organization
NCO	Non-Commissioned Officer
PCM	Primary Care Manager
PCS	Permanent Change of Station, the order for a soldier to be relocated to another base.
PDHRA	Post-Deployment Health Re-Assessment
POG	Slang for Person Other than Grunt, referring to non-combat, staff, and other support personnel in the military.

PTS(D)	Post-Traumatic Stress (Disorder)
PX	Post Exchange, a supplies store for service-members.
R&R Center	The Resiliency & Restoration Center at Darnall Army Medical Center on Fort Hood
ROE	Rules of Engagement
RPG	Rocket-Propelled Grenade
R-SRP	Reverse-Soldier Readiness Process
SAPRO	Sexual Assault Prevention and Response Office (DoD)
SGLI	Service-members Group Life Insurance
SHARP	Sexual Harassment/Assault Response & Prevention (Army)
SRP	Soldier Readiness Process
TBI	Traumatic Brain Injury
mTBI	Mild or Moderate Traumatic Brain Injury
VA	Veterans Affairs
WTU	Warrior Transition Unit
XO	Executive Officer. In the Army, the XO is a staff position, in charge of day-to-day activities management and logistics.

Endnotes

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⁷ 20 out of 31 testifiers served more than one deployment, ranging from two to four total deployments. Fort Hood is the headquarters of the III Corps of the US Army. This report focuses on DoD, Department of the Army, and Fort Hood command policies and practices. All service-members and veterans testifying in this report have served, or are currently serving, in the Army at Fort Hood.

⁸ DoD Directive 6200.04: Force Health Protection (FHP). October 9, 2004, Certified Current as of April 23, 2007.

⁹ Gail H. McGinn, United States DoD. DODI 6490.07. February 5, 2010.

¹⁰ Command Policy SURG-05: Utilization of the Physical Profile. III Corps and Fort Hood, Department of the Army. Issued June 18, 2012. See Appendix A: SURG-05. This policy was preceded by the III-Corps command policy MEDCEN-01, which also directed commanders and leaders in units for follow health professionals' stipulations on the Physical Profile as orders, not "recommendations."

¹¹ Or post-traumatic stress disorder (PTSD). Some soldiers and veterans believe the term 'post-traumatic stress' to be a less pathologizing label for the effects of trauma.

¹² While the campaign used the term military sexual trauma (MST), advocates have since begun to use the term military sexual violence, or sexual assault and harassment, as survivors and advocates believe the previous term minimizes the violence involved in this abuse and its associated trauma.

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- ¹⁵ Fort Hood active duty suicide statistics are from Schwartz, 2013.
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- ²⁰ Interview with Mark Simons,* Fort Hood veteran, in 2012.
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³⁵ Jeremy Schwartz, "Suicides Drop Sharply at Fort Hood," *Austin-American Statesman*, December 31, 2013.

³⁶ Jeremy Schwartz, "As soldiers leave war behind and return to Fort Hood, what comes next?" *Austin-American Statesman*, November 5, 2011. <http://www.statesman.com/news/news/local/as-soldiers-leave-war-behind-and-return-to-fort--1/nRgxg/>; Fort Hood Public Affairs Office, "Fort Hood Factsheets," <http://www.hood.army.mil/fact.sheets.aspx>.

³⁷ O-3 is a Captain, the third up within the ranks of commissioned officers. For a full listing of military ranks, see <http://www.defense.gov/about/insignias/officers.aspx>

³⁸ We submitted a series of requests for information, including some which had been previously published, to the Fort Hood Public Affairs Office and Darnall Army Medical Center at Fort Hood, all of which resulted in referrals, within minutes, and without explanation, to the FOIA office. Our questions covered post-specific statistics such as deployments, sexual assaults and case outcomes, mental health visits and diagnoses, psychotropic prescriptions, and waiting lists for mental health treatment programs. Further consultation with those who had pursued FOIA requests at Fort Hood confirmed that they were almost always denied, including some which had been previously published.

- ³⁹ Interviews with Chas Jacquier, Fort Hood veteran, Oscar Leighton,* Fort Hood soldier, and Shauna Dione,* spouse of a Fort Hood soldier, in 2012. All interviews are condensed and presented in the report's testimony archive, and full interviews are on file with Iraq Veterans Against the War and Civilian Soldier Alliance.
- ⁴⁰ Interviews with Cory Williams,* Curtis Sirmans, Cynthia Thomas, Malachi Muncy, and Brandon Harris,* in 2012.
- ⁴¹ DODI 6490.12: Mental Health Assessments for Service-Members Deployed in Connection with a Contingency Operation (February 26, 2013) specifies "person-to-person deployment mental health assessments will be conducted for each Service-Member who is deployed in connection with a contingency operation" (p.1), during four time frames and each at least 90 days apart. These include (a) within 120 days before the estimated date of deployment; (b) between 90 and 180 days post-deployment; (c) between 181 days and 18 months post-deployment; and (d) between 18 and 30 months post-deployment. This policy was preceded by Directive-Type Memorandum (DTM) 11-011: Mental Health Assessments for Members of the Military Services Deployed in Connection with a Contingency Operation, August 12, 2011, updated January 3, 2012, which mandated four timed pre- and post-deployment health assessments as well.
- ⁴² Andrew Feickert, Army Drawdown and Restructuring: Background and Issues for Congress. Congressional Research Service, 2014, ii.
- ⁴³ Interview with Cory Williams,* active duty soldier at Fort Hood, in 2012.
- ⁴⁴ Article 15 is a form of non-judicial administrative punishment in the Uniform Code of Military Justice.
- ⁴⁵ Interview with Randal Terrell,* Fort Hood soldier, and Curtis Sirmans, Fort Hood veteran, in 2012.
- ⁴⁶ Interview with Josue Gomez,* active duty soldier at Fort Hood, in 2012.
- ⁴⁷ Interview with Mark Simons,* veteran of Fort Hood, in 2012.
- ⁴⁸ ALARACT 017/2011 Army Implementation of Electronic Profiles (e-Profile), 24 January 2011; AR 40-501 (Chapter 7-4, a).
- ⁴⁹ MEDPROS e-Profile Compliance Report Clarification (1), 13 July 2012, for IAW ALARACT 017/2011 Army Implementation of Electronic Profiles (e-Profile), 24 January 2011.
- ⁵⁰ Interview with Reese Stewart,* active duty soldier at Fort Hood, in 2012.
- ⁵¹ Interviews with Ian Augusto,* Max Diaz,* and Devon Sawyer,* Fort Hood soldiers and veterans, in 2012.
- ⁵² III Corps and Fort Hood Command Policy SURG-01, 5 October 2011.
- ⁵³ Center for Constitutional Rights, "The War is Not Over: Seeking Accountability and Reparations for the United States' Illegal War and Its Lasting Trauma," 36 (January 20, 2014), available at <http://righttoheal.org/2014-right-to-heal-report/>.
- ⁵⁴ Expiration of term of service
- ⁵⁵ See "NCO Creed," Retrieved at <http://www.army.mil/values/nco.html>.
- ⁵⁶ Interviews with Paul Avett,* Reese Stewart,* Randal Terrell,* Brandon Harris,* and Dan Michaels* active duty soldiers and veterans of Fort Hood, in 2012.
- ⁵⁷ Interview with Shauna Dione,* spouse of an active duty soldier at Fort Hood, in 2012.

- ⁵⁸ Interviews with Ryan Holleran, veteran of Fort Hood, and Nicolas Addison* active duty soldier at Fort Hood, in 2012.
- ⁵⁹ Interviews with Allen Dunajs,* Ian Augusto,* and Ryan Holleran, Fort Hood veterans, in 2012.
- ⁶⁰ Interview with Randal Terrell,* Fort Hood soldier, in 2012.
- ⁶¹ Interviews with Allen Dunajs,* Fort Hood veteran, in 2012, and James Cleary,* Fort Hood soldier, in 2013.
- ⁶² Darnall Army Medical Center Online, "Medical Center Facts," October 13, 2013. Last accessed May 11, 2014.
- ⁶³ Interviews with Oscar Leighton* and Josue Gomez,* active duty soldiers at Fort Hood, in 2012.
- ⁶⁴ Interviews with Kimberly MacArthur* and Nora Leighton,* and Julie Avett,* spouses of Fort Hood soldiers, in 2012.
- ⁶⁵ Spouses whose were married to soldiers who served in the Army for twenty years, whose marriages lasted for twenty years, and whose marriages overlapped with their service for twenty years, are eligible for health benefits. Otherwise, they can purchase coverage through temporary premium plans for a limited amount of time only.
- ⁶⁶ Interviews with Jim Frank,* Chas Jacquier, Eve Morgan,*and Anja Perry,* in 2012.
- ⁶⁷ Roy Bragg, "Killeen Residents Worry About PTSD Problem at Fort Hood." San Antonio Express News, April 5, 2014. <http://www.expressnews.com/news/local/military/article/Killeen-residents-worry-about-PTSD-problem-at-5379716.php?t=ffd0a15c3439a20598>
- ⁶⁸ Army Psychiatrist Nidal Malik Hasan perpetrated a mass shooting on post on November 5, 2009, killing 13 people and injuring more than 30, many of whom were soldiers. He is currently imprisoned, awaiting execution pending his case's review in appellate courts. On April 2, 2014, Fort Hood soldier Ivan Lopez perpetrated a mass shooting on post, killing three others and wounding 16, before he shot and killed himself.
- ⁶⁹ Mark Thompson, "America's Medicated Army" Time, June 5th, 2008. <http://www.time.com/time/nation/article/0,8599,1811858-2,00.html>
- ⁷⁰ There were approximately 170 PTSD diagnoses per 100,000 person years in 2000, and approximately 1,110 PTSD diagnoses per 100,000 person years in 2011. Katherine Blakeley & Don J. Jansen, Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress, Congressional Research Service (Aug. 8, 2013) at 52-53, <https://www.fas.org/sgp/crs/natsec/R43175.pdf>.
- ⁷¹ While no similar case has come to light at Fort Hood, the Army identified 285 cases where PTSD diagnoses were reversed at Madigan Army Medical Center in Washington state. See: Associated Press, "285 at Madigan had PTSD diagnoses reversed," The Army Times, 8 March 2012. <http://www.armytimes.com/news/2012/03/ap-285-at-madigan-had-ptsd-diagnosis-reversed-030812/>
- ⁷² Interview with Mark Simons,* Fort Hood veteran, in 2012.
- ⁷³ Rose Thayer, "Herald Investigates: PTSD and Violence." Killeen Daily Herald, February 2, 2014.
- ⁷⁴ Interviews with Cory Williams,* Ian Augusto,* Rebekah Lampman, and Ryan Holleran, Fort Hood soldiers and veterans, in 2012.

⁷⁵ For a summary of brain injury research before the 1990s, see Barth et al. *Mild Head Injury*. New York: Oxford University Press, 1989. For a succinct explanation of ‘postconcussional syndrome’ (a precursor to the term ‘traumatic brain injury’) in Northern Ireland, see McClelland et al. “The Postconcussional Syndrome Revisited.” *Journal of the Royal Society of Medicine*, 87 (1994): 508-10. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1294762/pdf/jrsocmed00081-0016.pdf>

⁷⁶ The Army Surgeon General itself acknowledged the continuing host of problems in DoD’s use of ANAM in a 2010 report, “Automated Neuropsychological Assessment Metric (ANAM) Program White Paper,” September 7, 2010. <http://s3.documentcloud.org/documents/268330/the-dod-anam-program-a-critical-review-of.pdf>

⁷⁷ Assistant Secretary of Defense for Health Affairs, “Baseline Pre-Deployment Neurocognitive Functional Assessment - Interim Guidance,” May 28, 2008. <http://www.propublica.org/documents/item/268426-casscells-order-to-use-anam-may-28-2008>.

⁷⁸ Interviews with Shauna Dione,* Nora Leighton,* and Oscar Leighton* in 2012.

⁷⁹ Interview with Dan Michaels,* in 2012.

⁸⁰ Interview with Devon Sawyer,* Fort Hood veteran, in 2012.

⁸¹ For an in-depth account of depleted uranium’s devastating effects in Iraq and DoD’s lack of accountability, see Wim Zwijnenburg, “In a State of Uncertainty: Impact and Implications of the Use of Depleted Uranium in Iraq.” IKV Pax Christi, 2013. <http://www.ikvpaxchristi.nl/media/files/in-a-state-of-uncertainty.pdf>

⁸² Office of Sexual Assault Prevention and Response, “Department of Defense Annual Report on Sexual Assault in the Military,” Department of Defense (FY2012, released May 2013), at 13, http://www.sapr.mil/public/docs/reports/FY12_DoD_SAPRO_Annual_Report_on_Sexual_Assault-VOLUME_ONE.pdf

⁸³ Office of Sexual Assault Prevention and Response, “Department of Defense Annual Report on Sexual Assault in the Military,” Department of Defense (FY2013, released May 2014), at 2, http://sapr.mil/public/docs/reports/FY13_DoD_SAPRO_Annual_Report_on_Sexual_Assault.pdf

⁸⁴ Laura Aiuppa Denning, Marc Meinere, and Kenneth E. Warner, *Preventing Psychological Disorders in Service-Members and Their Families: An Assessment of Programs*, Institute of Medicine (2014) at 46 (citing DoD SAPR report), <http://www.iom.edu/Reports/2014/Preventing-Psychological-Disorders-in-Service-Members-and-Their-Families.aspx>.

⁸⁵ Interview with Rebekah Lampman, Fort Hood veteran, in 2013.

⁸⁶ Interview with Rebekah Lampman, Fort Hood veteran, in 2013.

⁸⁷ Interview with Curtis Sirmans, Dan Michaels,* and James Clearly,* Fort Hood soldiers and veterans, in 2012.

⁸⁸ Interview with Dan Michaels,* Fort Hood soldier, in 2012.

⁸⁹ Interview with Dan Michaels,* Fort Hood soldier, in 2012.

⁹⁰ We are indebted to Kenneth MacLeish, whose excellent ethnography from Fort Hood, Texas skillfully renders the uncertainty and precarity lived with by soldiers.. Kenneth MacLeish, *Making War At Fort Hood: Life and Uncertainty in a Military Community* (Princeton: Princeton University Press, 2013).

⁹¹ Interviews with Allen Dunajs,* Curtis Sirmans, and other Fort Hood veterans, in 2012.

⁹² A main source of domestic legal rights restrictions for service-members and veterans is the ‘Feres doctrine,’ which comes from the 1950 Supreme Court case *Feres v. United States* (1950). The Feres doctrine denies service-members and veterans the right to sue their employer (the military) or any US government employee to seek monetary damages, and the restriction applies to “all activities performed incident to service” in the military. *Feres v. United States*, 340 US 135 (1950). In this realm, which has been read by many courts to include almost anything that might happen to a soldier while in the military, service-members are permitted recourse only to military justice or administrative mechanisms.

⁹³ Where civilian contractors provide personnel to support US military operations, those private corporations may also have human rights obligations.

⁹⁴ See Organization for Security and Cooperation in Europe (OSCE) Office for Democratic Institutions and Fundamental Rights (ODIHR), Handbook on Human Rights and Fundamental Freedoms of Armed Forces Personnel 11 (2008), available at <http://www.osce.org/odihr/31393?download=true>. The OSCE is an organization of 57 participating nations, including the United States. The Handbook, while not a legally binding document, provides persuasive interpretation of prevailing legal standards, some of which mirror obligations contained in treaties that the United States has signed and ratified. Moreover, as an OSCE participating state, the United States is committed to meeting the standards espoused by the organization.

⁹⁵ These include the rights to humane treatment and personal security; privacy; health; access to justice, judicial protection, and effective judicial recourse; equality and non-discrimination; work; and family.

⁹⁶ See, e.g., UN General Assembly, Universal Declaration of Human Rights, art. 3, Dec. 10, 1948, available at <http://www.un.org/en/documents/udhr/index.shtml> (“Everyone has the right to ... security of person.”); Organization of American States, American Declaration of the Rights and Duties of Man, art. I, Apr. 1948, available at <http://www.oas.org/en/iachr/mandate/Basics/declaration.asp> (“Every human being has the right to ... security of his person.”).

⁹⁷ See, e.g., Universal Declaration of Human Rights, art. 10 (“Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations...”), art. 8 (“Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.”); American Declaration, art. XVIII (“Every person may resort to the courts to ensure respect for his legal rights...”).

⁹⁸ See I/A Court H.R., Case of Fernández Ortega et al. v. Mexico. Preliminary Objection, Merits, Reparations and Costs. Judgment of August 30, 2010. Series C No. 215, paras. 120-128, available at <http://www.coe.int/t/dghl/standardsetting/convention-violence/caselaw/Case%20Fernandez%20Ortega%20et%20al%20v.%20Mexico,%202010.pdf>.

⁹⁹ See UN General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 1, Dec. 10, 1984, United Nations, Treaty Series, vol. 1465, p. 85, available at: <http://www.refworld.org/docid/3ae6b3a94.html> (defining torture as including acts committed with “the consent or acquiescence of a public official or other person acting in an official capacity”).

¹⁰⁰ UN Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation 19: Violence against women, (11th session 1992), UN Doc. A/47/38, 1 (1993), para. 1, available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>.

¹⁰¹ Interviews with Dan Michaels,* Ryan Holleran, and Brandon Harris,* Fort Hood soldiers and veterans, in 2012.

¹⁰² See, e.g., Universal Declaration of Human Rights, art. 23 (“Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment. ... Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.”); American Declaration, art. XIV (“Every person has the right to work, under proper conditions, and to follow his vocation freely, insofar as existing conditions of employment permit. ... Every person who works has the right to receive such remuneration as will, in proportion to his capacity and skill, assure him a standard of living suitable for himself and for his family.”).

¹⁰³ See, e.g., Universal Declaration of Human Rights, art. 25(1) (“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”); American Declaration, art. XI (“Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.”).

¹⁰⁴ Council of Europe, Human rights of members of the armed forces: Recommendation CM/Rec (2010) 4 of the Committee of Ministers and explanatory memorandum, p. 27, available at http://www.coe.int/t/dghl/standardsetting/hrpolicy/publications/cmrec_2010_4en.pdf.

¹⁰⁵ See, e.g., I/A Court H.R., Case of the Sawhoyamaya Indigenous Community v. Paraguay, Judgment of Mar. 29, 2006. Series C No. 146, para. 155, available at http://www.corteidh.or.cr/docs/casos/articulos/seriec_146_ing.pdf.

¹⁰⁶ International Labour Organization (ILO), Convention concerning Occupational Safety and Health and the Working Environment (No. 155), art. 19(f) (adopted June 21, 1981), available at http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312300.

¹⁰⁷ UN General Assembly, Principles for the protection of persons with mental illness and the improvement of mental health care, Resolution 46/119, Principle 8 (Dec. 17, 1991), available at http://www.equalrightstrust.org/ertdocumentbank/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf (hereinafter UN Mental Illness Principles).

¹⁰⁸ UN Mental Illness Principles, Principle 10.

¹⁰⁹ UN Mental Illness Principles, Principle 9.

¹¹⁰ UN Committee on Economic, Social and Cultural Rights (UN CESCR), General Comment No. 18: The Right to Work (Art. 6 of the Covenant), E/C.12/GC/18, para. 4 (adopted Nov. 24, 2005), available at <http://www.refworld.org/docid/4415453b4.html> (hereinafter UN CESCR, General Comment No. 18).

¹¹¹ See, e.g., ILO, Convention concerning Termination of Employment at the Initiative of the Employer (No. 158), 68th ILC Session, art. 7 (adopted June 22, 1982), available at https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312303:NO.

¹¹² See, e.g., Universal Declaration of Human Rights, art. 22 (“Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.”); American Declaration, art. XVI (“Every person has the right to social security which will protect him from the consequences of unemployment, old age, and any disabilities arising from causes beyond his control that make it physically or mentally impossible for him to earn a living.”).

- ¹¹³ See, e.g., UN General Assembly, Convention on the Rights of Persons with Disabilities, (adopted Nov. 13, 2006), available at <http://www.un.org/disabilities/convention/conventionfull.shtml>.
- ¹¹⁴ UN CESCR, General Comment No. 18, para. 12.
- ¹¹⁵ UN Human Rights Committee, General Comment No. 34: Article 19: Freedoms of opinion and expression, CCPR/C/GC/34, para. 18 (adopted July 11, 2011), available at <http://www2.ohchr.org/english/bodies/hrc/docs/gc34.pdf>.
- ¹¹⁶ Interviews with Shauna Dione,* Curtis Sirmans, and Paul Avett,* Fort Hood soldiers and family members, in 2012 and 2014.
- ¹¹⁷ See, e.g., Universal Declaration of Human Rights, art. 19 (“Everyone has the right to freedom of opinion and expression; this right includes freedom ... to seek, receive and impart information and ideas...”); American Declaration, art. IV (“Every person has the right to freedom of investigation...”).
- ¹¹⁸ See Center for Constitutional Rights, “The War is Not Over: Seeking Accountability and Reparations for the United States’ Illegal War and Its Lasting Trauma,” (January 20, 2014), available at <http://righttoheal.org/2014-right-to-heal-report/>.
- ¹¹⁹ UN General Assembly, Human Rights Council, Adverse effects of the illicit movement and dumping of toxic and dangerous products and wastes on the enjoyment of human rights: Report of the Special Rapporteur, Okechukwu Ibeanu, 5th Session (May 5, 2007), A/HRC/5/5, p. 16, para. 37, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07/125/63/PDF/G0712563.pdf?OpenElement> (hereinafter Report of the UN Special Rapporteur on Adverse effects of toxic products (May 5, 2007)).
- ¹²⁰ Report of the UN Special Rapporteur on adverse effects of toxic products (May 5, 2007) p. 16, para. 37.
- ¹²¹ Wim Zwijnenburg. “In a State of Uncertainty: Impact and Implications of the Use of Depleted Uranium in Iraq.” IKV Pax Christi, 2013, available at <http://www.bandedpleteduranium.org/en/in-a-state-of-uncertainty>.
- ¹²² Raquel Martín de Mejía (Peru), Merits Report, Inter-Am. Comm’n H.R., Report No. 5/96, Case 10.970, Section V(B)(3)(b) (March 1, 1996), available at <http://cidh.org/annualrep/95eng/Peru10970.htm>.
- ¹²³ Inter-Am. Comm’n H.R., Access to Justice For Women Victims of Violence in MesoAmerica, OEA/Ser.L/V/II. Doc. 63, December 9, 2011, p. 7, para. 23, available at <https://www.oas.org/en/iachr/women/docs/pdf/WOMEN%20MESOAMERICA%20ENG.pdf> (citing I/A Court H.R., Judicial Guarantees in States of Emergency (Arts. 27.2, 25 and 8 American Convention on Human Rights). Advisory Opinion OC-9/87 of October 6, 1987. Series A No. 9, para. 24.)).
- ¹²⁴ ALARACT 017/2011 Army Implementation of Electronic Profiles (e-Profile), 24 January 2011; AR 40-501 (Chapter 7-4, a); MEDPROS e-Profile Compliance Report Clarification (1), 13 July 2012, for IAW ALARACT 017/2011 Army Implementation of Electronic Profiles (e-Profile), 24 January 2011.
- ¹²⁵ AR 40-501: Standards of Medical Fitness (14 December 2007), Rapid Action Revision (4 August 2011), Chapter 7 regulates Physical Profiling in the Army. Commander discretion over adherence to profiles should be removed from this regulation, including final ruling to deploy a soldier who is medically determined non-deployable (7--3.e.3).
- ¹²⁶ SURG-01 currently specifies that stigma should not be held towards those with mental health concerns. See Appendix B.

¹²⁷ DoDI 1332.14: Enlisted Administrative Separations (January 14, 2014). Section 3.8.c must be enforced consistently at Fort Hood, in particular its stipulation that “a separation for personality disorder, or other mental disorder not constituting a physical disability, is not authorized if service-related PTSD is also diagnosed” (3.8.c.4.c). Section 3.8.d must also be enforced consistently at Fort Hood, as it disallows separation for any mental disorder when separation is warranted on unsatisfactory performance or misconduct--in which case, regulations on adequate treatment and reporting of actions to the service-member should be strictly followed.

¹²⁸ The IDES disability system is beginning to implement aligned military and VA disability ratings.

¹²⁹ All relevant DoD policies, including the following, should be aligned to accord with International Labor Organization (ILO) codes regulating acquired disabilities in the workplace: DoDI 1332.38: Physical Disability Evaluation (November 14, 1996, Incorporating Change 2, April 10, 2013). Section E4.13: Psychiatric disorders; DoDI 1332.14: Enlisted Administrative Separations (January 27, 2014), E3.4.c, procedures for administrative separation for physical disabilities.

¹³⁰ DoD Instruction 6490.07: Deployment-Limiting Medical Conditions for Service-Members and DoD Civilian Employees (February 5, 2010). Ensure enforcement of the Instruction’s mandatory standards for deployment-limiting conditions which are specified as never subject to waiver. See also Policy Guidance for Medical Deferral Pending Deployment to Theatres of Operation, Under Secretary of Defense for Personnel and Readiness, 2006. DoD Instruction 6490.05: Maintenance of Psychological Health in Military Operations (November 22, 2011, Incorporating Change 1, Effective October 2, 2013) must be expanded to allow for adequate mental health resources available to all DoD employees during deployment.

¹³¹ In accordance with DODI 6490.12: Mental Health Assessments for Service-Members Deployed in Connection with a Contingency Operation (February 26, 2013), which specifies “person-to-person deployment mental health assessments will be conducted for each Service-Member who is deployed in connection with a contingency operation” (p.1), during four time frames and each at least 90 days apart. These include (a) Within 120 days before the estimated date of deployment; (b) Between 90 and 180 days post-deployment; (c) between 181 days and 18 months post-deployment; and (d) between 18 and 30 months post-deployment.

¹³² Report No. DODIG-2014-040: Assessment of DoD Wounded Warrior Matters: Managing Risks of Multiple Medications.

¹³³ Department of the Army and Fort Hood Command must actively improve compliance with Army Surgeon General/MEDCOM Policy 13-032: Guidance for Managing Polypharmacy and Preventing Medication Overdose in Soldiers Prescribed Psychotropic Medications and CNS Depressants (May 21, 2013).

¹³⁴ These classes of drugs were to be restricted from treatment for PTSD, per Army Surgeon General/MEDCOM Policy 12-035: Policy Guidance on the Assessment and Treatment of PTSD (April 10, 2012), however, this policy expired on April 10, 2014. OTSG/MEDCOM must immediately issue new policy regulating pharmaceutical treatment for PTSD which includes sufficient monitoring mechanisms.

¹³⁵ DODI 6490.13: Comprehensive Policy on Neurocognitive Assessments by the Military Services (June 4, 2013) designates the ANAM as the diagnostic tool for both pre- and post-testing for TBI across all military departments.

¹³⁶ Mental Health Advisory Team 9 Report (October 10, 2013).

¹³⁷ DoD 6025.18-R, Privacy of Individually Identifiable Health Information in DoD Health Care Programs (2009).

- ¹³⁸ DoD Directive 6200.04, Force Health Protection (FHP) should be revised or amended to clarify the institutional role of standard professional ethics codes in all branches of the US military. Medical practitioners must be held accountable to the current ethical codes and standards of practice established by the American Medical Association. Mental health practitioners must be held accountable to the current ethical codes and standards of practice established by the American Psychiatric Association and the American Psychological Association.
- ¹³⁹ DoD Instruction 6490.09: DoD Directors of Psychological Health (February 27, 2012, Incorporating Change 1, Effective October 2, 2013) outlines a “leadership and advocacy structure” to coordinate services and care in military treatment facilities (MTFs), to integrate with non-MTF mental health services, and promote accessibility of these services to soldiers.
- ¹⁴⁰ DODI 4715.19: Use of Open-Air Burn Pits in Contingency Operations (February 15, 2011, Incorporating Change 2, Effective March 27, 2014).
- ¹⁴¹ The original interview transcripts remain on file with Iraq Veterans Against the War and Civilian Soldier Alliance
- ¹⁴² Army Regulation 635-200: Active Duty Enlisted Administrative Separations designates categories (or ‘chapters’) under which soldiers may receive ‘administrative discharge.’ Chapter 14-2B specifies conditions of Separation for Misconduct.
- ¹⁴³ Equal Opportunity
- ¹⁴⁴ A Connex is a large metal cargo container used by the military for shipping supplies overseas.
- ¹⁴⁵ Army Knowledge Online, the Army’s main intranet. A designation of ‘Red’ means ‘Not ready for deployment.’
- ¹⁴⁶ Mine-Resistant Ambush Protected vehicle, an armored combat vehicle.
- ¹⁴⁷ Posterior condylar offset, an inner curvature of the knee bone.
- ¹⁴⁸ The Resiliency & Restoration Center at Darnall Army Medical Center on Fort Hood
- ¹⁴⁹ ‘Downrange’ indicates being deployed overseas, usually during wartime.
- ¹⁵⁰ The Medical Protection System (MEDPROS) is the Army’s electronic tracking system for soldiers’ medical information and deployability.
- ¹⁵¹ Family Readiness Group, a command-sponsored organization of soldiers’ family members, volunteers, and unit staff, tasked with providing information and support to Army families.
- ¹⁵² Promotion board exams in the Army determine certain gains in rank.
- ¹⁵³ Army Career and Alumni Program
- ¹⁵⁴ 2013 version of Phantom Warrior Handbook: <http://www.hood.army.mil/files/PhantomStandardsBooklet.pdf>
- ¹⁵⁵ The Family First Corps policy is the first policy listed in a series of policy letters posted on Fort Hood's site. A subsequent version of the policy letter signed by General Campbell can be read here: <http://www.hood.army.mil/leaders/policies/corps/CG-01.pdf>
- ¹⁵⁶ Modified Table of Organization and Equipment, an authorization document that prescribes the necessary mission, capabilities, organization, personnel, and equipment needed to meet the needs of a specific unit or group of units.

- ¹⁵⁷ Warrior Transition Unit
- ¹⁵⁸ Post-Deployment Health Re-Assessment
- ¹⁵⁹ An inflammation of the iris and anterior chamber of the eye
- ¹⁶⁰ The online Army medical tracking system
- ¹⁶¹ Track commander, the soldier in a vehicle who is responsible for that vehicle, usually the highest ranking soldier on board.
- ¹⁶² Living quarters or barracks
- ¹⁶³ The inpatient mental health facility at Darnall Army Medical Center is on the fifth floor, on Fort Hood.
- ¹⁶⁴ US Army Chapter 5-17 details conditions under which a soldier may receive a discharge from the Army classified as Separation for Convenience of the Government, sometimes for “other designated physical or mental conditions,” as specified in Army Regulation 635-200.
- ¹⁶⁵ Advanced Individual Training, the portion of training after basic training during which soldiers learn their particular job’s (MOS) skills.
- ¹⁶⁶ Heavy Equipment Transporters
- ¹⁶⁷ Palletized Load System trucks
- ¹⁶⁸ Field Training Exercise
- ¹⁶⁹ To ‘be recycled’ means one must repeat a particular portion of the training, or the whole training.
- ¹⁷⁰ ‘Hajji’ or ‘Haji’ is an Arabic word which is an honorific title given to a Muslim who has successfully completed the Hajj (pilgrimage) to Mecca. The word has been taken on as a derogatory term by US servicemembers and applied to anyone of Arab descent or brown skin, or to identify Iraqi or Afghan people during the occupations.
- ¹⁷¹ The fifth floor of Darnall Army Medical Center is where the inpatient psychiatric hospitalization facilities are located on post at Fort Hood.
- ¹⁷² Permanent Change of Station, the order for a soldier to be relocated to another base.
- ¹⁷³ Indirect fire
- ¹⁷⁴ Forward Operating Base Kalsu was a US military installation in Iskandariya, Iraq, about 20 miles South of Baghdad.
- ¹⁷⁵ Main Supply Route (MSR) Tampa is also known as Highway 1 in Iraq. It runs diagonally out of Kuwait, through Baghdad, into Syria.
- ¹⁷⁶ Vehicle-borne improvised explosive device
- ¹⁷⁷ Containerized housing unit
- ¹⁷⁸ Rocket-propelled grenade
- ¹⁷⁹ The staff department in charge of personnel organization.
- ¹⁸⁰ Range Control Officer

- ¹⁸¹ Operating room
- ¹⁸² Army Substance Abuse Program
- ¹⁸³ Inspector General
- ¹⁸⁴ Service-members Group Life Insurance
- ¹⁸⁵ Expiration, Term of Service, the date and time when the soldier's enlistment contract ends.
- ¹⁸⁶ Soldiers in the Army are typically assigned to a Battalion Aid Station, which is a medical section within a battalion's support company.
- ¹⁸⁷ A Z-Pak is a package of six doses of Azithromycin, a common antibiotic prescription.
- ¹⁸⁸ Primary Care Manager
- ¹⁸⁹ Army Substance Abuse Program
- ¹⁹⁰ Criminal Investigation Division
- ¹⁹¹ Executive Officer. In the Army, the XO is a staff position, in charge of day-to-day activities management and logistics.
- ¹⁹² Nidal Malik Hasan is a former US Army psychiatrist who committed a mass shooting on Fort Hood in 2009.
- ¹⁹³ Dining Facility
- ¹⁹⁴ A soldier who is in Charge of Quarters
- ¹⁹⁵ Post-Deployment Health Re-Assessment
- ¹⁹⁶ The Automated Neuropsychological Assessment Metrics (ANAM) is a computer-based cognitive assessment test. The Army has commonly administered the partial ANAM as a screening tool for TBI; however, even the full battery is not an appropriate neuropsychological diagnostic tool. Its results are only meaningful when compared between pre- and post-tests.
- ¹⁹⁷ Containerized Housing Unit, where soldiers live on deployment
- ¹⁹⁸ Basic Allowance for Housing
- ¹⁹⁹ A district and town in Western Afghanistan.
- ²⁰⁰ Afghan National Army, the main branch of the Afghan Armed Forces.
- ²⁰¹ Rules of Engagement
- ²⁰² Slang for Person Other than Grunt, referring to non-combat, staff, and other support personnel in the military.
- ²⁰³ Armed Services Vocational Aptitude Battery
- ²⁰⁴ A formation of soldiers in combat-ready positioning
- ²⁰⁵ Article 15 is the section of the Uniform Code of Military Justice regulating discretionary punishments without judicial proceedings.

²⁰⁶ Referring to officer or commander rank insignias in the Army.

²⁰⁷ KBR, Inc., formerly known as Kellogg Brown & Root, is an engineering, construction, and private military contracting corporation.

²⁰⁸ Interceptor Body Armor, a bullet-resistant armored vest used by the military from the late 1990s onward.

²⁰⁹ A regiment is a military organizational unit, also called a 'brigade,' which usually ranges from 3,000 to 5,000 soldiers.

²¹⁰ Advanced Combat Helmet, the US Army's current combat helmet.

²¹¹ Post Exchange, a supplies store for service-members.

²¹² Service-members Group Life Insurance

²¹³ 'Redeployment' is also used in the military for when a service-member is transferred back home from deployment.

²¹⁴ Personnel Services Battalion, a unit which provides human resources and general support services for the Army on deployment.

²¹⁵ This indicates the soldier's command filed for a Command Directed Mental Health Evaluation. In the Army, it is distinct from a Self Referral in that a Command Referral initiates a one-time evaluation intended to help the commander determine the issues and needs of the soldier. The commander will receive all the information directly from involved health care providers, instead of the information technically remaining confidential in the case of a Self Referral.

²¹⁶ Record PT test results enter a service-member's official record, and there are special regulations on when they can be administered.

²¹⁷ Digital Training Management System

²¹⁸ Army Knowledge Online

²¹⁹ Human Resources Command

²²⁰ Tactical Mission Command

²²¹ A prescription muscle relaxant

²²² A type of machine gun commonly used in the Infantry

²²³ Scott & White is a civilian medical institution with clinics and hospitals in the region around Killeen and Fort Hood.

²²⁴ Army Chapter 5-17 details conditions under which a soldier may receive a discharge from the army classified as Separation for Convenience of the Government, sometimes for "other designated physical or mental conditions," as specified in Army Regulation 635-200.

²²⁵ Improved Outer Tactical Vest

²²⁶ Commanding General

²²⁷ Part of Reverse-SRP is the Post-Deployment Health Re-Assessment

²²⁸ Full battle rattle means all a soldier's gear needed for combat operations.

²²⁹ Likely a reference to Nidal Malik Hassan, an Army Psychiatrist stationed at Fort Hood who perpetrated a mass shooting on post in 2009.

²³⁰ Service-members and other US personnel referred to the area of Baghdad outside the Green Zone as the 'Red Zone.'

²³¹ Advanced Individual Training is the second component in Basic Training, in which recruits learn skills specific to their assigned MOS.

²³² 4th Infantry Division, a modular division of the Army which was based at Fort Hood until it was relocated in 2009 to Fort Carson in Colorado.

²³³ Explosively formed penetrator, or explosively formed projectile, a specially shaped charge designed to penetrate armor at standoff distances (commonly safe distances away from a hypothetical explosion).

²³⁴ One Station Unit Training (OSUT) indicates a training program in which soldiers remain with the same unit for both Basic Combat Training (BCT), the first part of Basic Training, and for Advanced Individual Training (AIT).

²³⁵ Curtis is a veteran of Fort Hood, whose testimony is also featured in this report.

²³⁶ Mitchell* was on rear detachment at the time of the interview.

Appendices



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
HEADQUARTERS, III CORPS AND FORT HOOD
1001 761ST TANK BATTALION AVENUE
FORT HOOD, TEXAS 76544-5000

COMMAND POLICY SURG-05

JUN 18 2012

AFZF-MD

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Utilization of the Physical Profile

1. References.

- a. AR 40-501, Chapter 7, 14 December 2007.
- b. Standards of Medical Fitness, Rapid Action Revision, 23 August 2010.

2. Applicability. This policy applies to all III Corps and Fort Hood units and tenant activities.

3. Purpose: To inform commanders of the requirement to ensure leaders at all levels in their command adhere to the restrictions/limitations documented on DA Form 3349 (Physical Profile) by medical and behavioral health (BH) personnel and not view them as "recommendations."

4. Bottom Line: The intent of physical profiling is to ensure qualified medical and BH personnel determine functional activities and limitations/restrictions related to medical and BH conditions. If a commander disagrees with the profile issued in e-Profile, they are required to notify the profiling officer to discuss the Soldiers' limitations and request reconsideration. In problematic or controversial cases that cannot be resolved at or below the battalion level, they will be referred to the Medical Treatment Facility Commander by the first O-6 in the Soldier's chain of command.

5. Background:

- a. The DA 3349 is utilized to document the limitations of a Soldier based on evaluation of their mental, medical and physical status. There are two key players in this process, the profiling provider and the unit commander.
- b. The profiling provider is required to evaluate the Soldier's condition and determine restrictions based on the risk of aggravation or further injury if the Soldier participates in certain activities. These limitations must be written clearly and in layman's terms. Limitations will be specific and realistic; general remarks such as "no field duty" will not be utilized. The only exception is BH conditions where "no simulated combat conditions" is a valid profile for certain BH conditions.

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SUBJECT: Utilization of the Physical Profile

6. Unit commanders will review all duty limitations on each Soldier's e-Profile to determine assignments and positions based on a logical progression of those limitations. For example, no Kevlar or improved outer tactical vest, would mean the Soldier is unable to participate in ranges; drive military vehicles, or deploy into a combat environment. Likewise, some limitations require the use of sound judgment on the leader's behalf and should not be taken literally. For example, "no lifting 40 lbs" means that a Soldier should be restricted from lifting heavy objects; it does not mean the Soldier is capable of lifting 39 lbs or less for indefinite periods of time.

(a) There is a standard profile for pregnant Soldiers under AR 40-501, Chapter 7-9. It has very specific limitations for the prenatal and post partum periods.

(b) The DD 689 (Individual Sick Call Slip) is still authorized for use. It should be used in communicating duty performance limitations for an acute minor illness of short duration such as the flu. The DD 689 will not be used for illness or injury greater than 10 days and may only be used for a single profile condition. Medical conditions that require physical limitations beyond 10 days or are subsequently required for the same condition must be entered electronically in e-Profile.

(c) Soldiers recovering from surgery or on convalescent leave will have a documented DA 3349 in e-Profile before being discharged from the hospital. Soldiers are not permitted to "call-in" for accountability unless he/she is on convalescent leave. Medically homebound Soldiers, not on convalescent leave, will require daily physical accountability.

(d) Permanent profiles will be reviewed annually in conjunction with the Soldier's Periodic Health Assessment. The permanent profile will be revised when there is a change in the Soldier's medical or functional status, whichever comes first. Temporary profiles will also be reviewed in accordance with profile review policy.

7. Profiles written by network health care providers will be transposed onto a DA 3349 and entered into e-Profile by the Soldier's primary care manager (PCM) or a military treatment facility (MTF) health care provider.

(a) Soldiers will report to their PCM on the first business day following a network appointment to process a civilian profile and/or report any medications added or changed.

(b) Commanders and health care providers will follow the profiling restrictions stated by network healthcare providers. Healthcare providers will resolve any unclear or

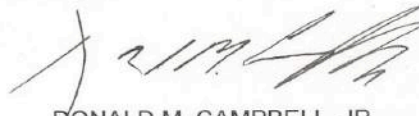
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SUBJECT: Utilization of the Physical Profile

unreasonable restrictions by contacting the network provider who wrote the profile. The chain of command will go through an on-post health care provider to resolve issues associated with profiles written by network providers. If the PCM is unable to resolve issues with the network provider, the PCM will consult with a MTF provider of the same specialty as the referring provider to correct the profile. The MTF provider will produce the final wording for the profile. Network providers can appeal to the CRDAMC Deputy Chief of Clinical Services as needed. The MTF may elect to assign a nurse case manager to any Soldier receiving care in the network.

8. I want to clarify interpretation of profiles that address limited duty hours. If a Soldier is limited to an 8-hour duty day, time starts the moment the Soldier physically reports to duty. Time spent for medical or BH appointments, unit PT or meals will not be added to the Soldier's 8-hour duty day. Furthermore, I encourage leaders to communicate with the profiling provider if there are questions about the limitations/restrictions or reasons for the limitations.

9. This policy letter supersedes policy memorandum MEDCEN-01, 10 June 2011, and will remain in effect until superseded or rescinded.



DONALD M. CAMPBELL, JR.
Lieutenant General, USA
Commanding

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REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
HEADQUARTERS, III CORPS AND FORT HOOD
1001 761ST TANK BATTALION AVENUE
FORT HOOD, TEXAS 76544-5000

COMMAND POLICY
SURG-01

OCT 5 2011

AFZF-MD

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Commanders Guidance to Reduce Stigma of Behavioral Health Assistance and Protect the Rights of Soldiers for Behavioral Health Evaluations

1. **PURPOSE.** To define the responsibilities of Commanders in publicizing Department of Defense efforts to eliminate the stigma associated with behavioral health assistance, encouraging Soldiers to seek behavioral health counseling on their own, and following the requirements when command directed behavioral health evaluations are necessary.

2. **APPLICABILITY.** This policy applies to all military personnel on Fort Hood.

3. **POLICY.**

a. I expect leaders to do everything possible to eliminate any stigma or adverse consequences for Soldiers associated with behavioral health assistance. For example, the Department of Defense successfully advocated a revision of the SF-86, Questionnaire for National Security Positions, to exclude counseling related to marital, Family and grief issues, and counseling for adjustments from service in a military combat environment.

b. This policy change recognizes that, as a Nation at war, Soldiers' well-being must be given the highest priority. Commanders will lead the way in promoting strong behavioral health at Fort Hood by continuing to publicize this policy change and utilize command directed behavioral health evaluations only when appropriate.

c. I want Commanders to continue to actively encourage Soldiers to seek professional care for any behavioral health related issues that could affect their well-being.

d. Commanders and leaders at all levels will create an environment of encouraging Soldiers to seek behavioral health counseling on their own; thus, reducing the stigma of behavior health assistance. This stigma can be reduced by not discriminating against Soldiers who receive mental health counseling; supporting confidentiality between the Soldier and their behavioral health care provider; reviewing unit policies and procedures that could preclude Soldiers from receiving all necessary and indicated assistance; educating all Soldiers and Family members about anxiety, stress, depression, and treatment; increasing behavioral health visibility presence in

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SUBJECT: Commanders Guidance to Reduce Stigma of Behavioral Health Assistance and Protect the Rights of Soldiers for Behavioral Health Evaluations

Soldiers' area (using the Combat Operational Stress Control tactics, techniques, and procedures: COSC; HQ DA, FM 4-02.5(FM 8-51)); and reinforcing the "power" of the buddy system in helping each other in times of crises (TRADOC Pamphlet 600-22).

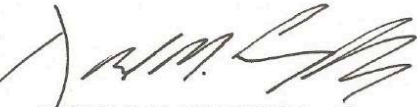
e. Commanders bear the ultimate responsibility for determining whether or not a Soldier should be referred for a command directed behavioral health evaluation. Commanders must personally consult with a behavioral healthcare provider or other healthcare provider to determine whether a command directed behavioral health evaluation is appropriate. This requirement may not be delegated. If a referral is appropriate, the Commander must notify the Soldier of certain rights. DODD 6490.1 contains these requirements and timelines to protect the Soldier and outlines special rules for emergency behavioral health evaluations.

f. Commanders should consult their servicing Staff Judge Advocate office to ensure compliance with applicable regulations when pursuing command directed or emergency behavioral health evaluations.

g. I expect Commanders at all levels to make behavioral healthcare a priority for Soldiers, create an environment that reduces the stigma of behavioral health assistance, and to protect the rights of Soldiers for behavioral health evaluations. Our Soldiers deserve nothing less than the best care possible in an environment free of negative perceptions or adverse consequences.

4. EXPIRATION. This policy memorandum supersedes the policy memorandum dated 02 November 2009, and will remain in effect until superseded or rescinded.

*Let's do all
we can to eliminate
the stigma of
seeking support!*


DONALD M. CAMPBELL, JR.
Lieutenant General, USA
Commanding

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IAW FH Form 1853: A