

The Combat Veteran Paradox: Paradoxes and Dilemmas Encountered With Reintegrating Combat Veterans and the Agencies That Support Them

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The combat veteran paradox proposes that most changes individuals experience resulting from combat exposure are normal, and not indicative of a mental health disorder. Yet, because of the number and complexities of these changes, the combat veteran paradox states that combat veterans who are healthy can benefit from counseling. Counseling should focus on helping the combat veteran understand how combat experiences might influence their thoughts, emotions and behaviors. Counseling can also help combat veterans understand the numerous paradoxes often experienced during and after deployment. Combat veterans also encounter numerous dilemmas, most prominent being the military mental health dilemmas, consisting of multiple double binds imposed on the combat veteran by their partner, the military culture, and him/herself; all of which impede the combat veteran from receiving much needed mental health care support. If left unchecked, these can lead to more significant mental health issues requiring professional intervention. Veteran helping organizations also face dilemmas and paradoxes, which are important to understand to ensure veterans receive maximum care and assistance. Although many dilemmas are unavoidable and many paradoxes unsolvable, a holistic approach to understanding and ameliorating veteran paradoxes and dilemmas is necessary to optimize the veterans transition home. There are also similarities between combat trauma and other types of trauma, and between the military and other occupations with inherent danger. Recognizing these will further aid in the development of interventions that will allow trauma survivors to thrive and grow after traumatic events.

Keywords: combat veteran, combat veteran paradox, trauma, mental health, paradox

The willingness to deploy to combat environments represents the commitment U.S. service members make when deciding to serve their country. The preparation and training they receive for working and living in these highly stressful environments is intensive and comprehensive. Although dangerous and demanding, combat is also often described as exhilarating and intense. In combat service members are constantly living on the edge. For many, it is the highlight of their life: an experience they would not change for the world, and something they would gladly and freely do again. A powerful brotherhood, the bonds and friendships

forged in combat last a lifetime. Yet, it is perhaps a truism that combat changes everyone who has experienced it (Campsie, Geller, & Campise, 2006; Hohman, 1947; Mareth & Brooker, 1985). The experience of killing another human can result in significant psychological changes, whether it is an insurgent or enemy combatant whose killing is justified, or an innocent bystander who happens to get caught in the crossfire (Van Winkle & Safer, 2011). Whether it is the service member's closest friend who dies in their arms or another member of the unit who is blown to pieces by an IED, watching people die changes you (Drescher, 2013). Or if the service member watches insurgents or civilians being needlessly tortured or mistreated, witnessing extreme suffering will have profound emotional consequences (Dombo, Gray, & Early, 2013). Even if the service member does not experience any of these events, constantly being on the alert and acutely aware of the ever present dangers of war can result in change (Kuhn, Hoffman, & Ruzek, 2012). As amply stated by Hoge, "Everyone who has ever deployed to a war zone is changed by his or her experiences; it would be abnormal not to be" (Hoge, 2010, p. 6).

Though participation in combat can certainly lead to mental and physical health injuries, the fact that a veteran experiences changes after combat exposure does not necessarily indicate the presence of a mental health disorder requiring professional care (Hoge et al., 2004). Not having a mental or physical health injury, however, does not mean that a combat veteran cannot benefit from counseling designed assist them in understanding how their combat experience might have transformed them or altered the manner in which they maintain and form new relationships. Helping combat veterans understand how their views and assumptions of the world

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may change after combat is important. At no time are these interventions more essential than when a combat veteran returns home from deployment or when the combat veteran leaves the military. These transition points are especially critical because it is here where combat veterans renew existing relationships, as well as form new ones (Castro, Kintzle, & Hassan, 2014). Counseling, not designed as a mental health intervention but as an opportunity for processing combat experiences, can provide much needed transition support. For example, supervisors at work may mentor combat veterans to assist in employment transition, or college professors might offer guidance for student-veterans in navigating new career choices. Likewise, the community elder, who is also a combat veteran, might impart wisdom to the combat veteran on loss and love. This is not to say that combat cannot lead to mental health issues that does require professional mental health intervention, it can. Instead, it must be appreciated that counseling (non-mental health counseling and mental health counseling) lies on a continuum, with all aspects of prevention and intervention being important for meeting the needs of the combat veteran.

The Combat Veteran Paradox

Many of the changes that combat veterans experience in their emotions, thoughts, and behaviors appear as paradoxes (Castro, Adler, McGurk, & Bliese, 2012). A *paradox* is a statement that seemingly contradicts itself and yet might be true. It is something that is contrary to expectations, existing beliefs or perceived opinion. Although a paradoxical statement may appear trivial or pointless, it often contains a latent or hidden truth. The combat veteran paradox states that combat veterans who are healthy can benefit from counseling.

For many, counseling is viewed as necessary only when someone has a problem. Thus it is often thought that “healthy” combat veterans should not need counseling. However, counseling can be beneficial even in the absence of a mental health disorder, especially when a problem exists yet has not risen to the level of a mental health issue (see Napier et al., 2014; World Health Organization, 2002). Although the typical understanding of counseling may bring to mind the image of a combat veteran lying on a long couch in a darkened room, or a bespectacled therapist doling out psychiatric diagnoses and psychotropic medications, these images represent only a part of the diverse continuum of practices that can be understood as counseling for the combat veteran. Whereas many traditional psychiatric and therapeutic interventions seek to treat diagnosable conditions, there are many counseling practices that can serve as prevention and early intervention models for combat veterans in need of support that do not constitute psychiatric treatment (Napier et al., 2014). The delegates of the American Counseling Association defined counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (American Counseling Association, 2010). Thus, there are many services that could prove useful for combat veterans who might benefit from social and emotional support, but do not have a diagnosable psychiatric condition. This definition is more fully inclusive of essential counseling fields, such as academic counseling, coaching, mentoring, financial counseling, and faith-based counseling. Although the full continuum of counseling interventions can be applied productively in different parts of the combat

veteran population, it is our contention that many combat veterans who experience the paradoxes discussed in this study may benefit from those counseling interventions that do not necessarily seek to diagnose, medicate, or pathologize, but rather to support, nurture, and assist. We believe this approach to counseling will help address the stigma typically associated with seeking mental health interventions.

Although an argument could be made that everyone might benefit from some form of counseling, our argument here is that the combat veteran would especially benefit both because of their deployment and their combat experiences. Counseling for the combat veteran can help to contextualize their experiences, and provide a deepened understanding of the ways in which their combat experiences might influence their thoughts, emotions, and behaviors. Counseling (or mental health education) can also serve to normalize many of the reactions and symptoms that combat veterans might experience following their deployment. In short, counseling is not just for those experiencing mental illness.

The combat veteran paradox should be contrasted with two other related paradoxes: the trauma paradox and the PTSD paradox. The trauma paradox states that “if you react normally to trauma you have a disorder, if you react abnormally to trauma you don’t” (see Mayes, 2014, p. 125). The trauma paradox contains several erroneous assumptions: that all trauma results in a mental health disorder, that mental health disorders are normal responses to trauma, and that it is abnormal not to develop a mental health disorder in response to trauma. The scientific literature fails to support any of these assumptions (see Hoge, Terhakopian, Castro, Messer, & Engel, 2007; McNally, 2007). Not all trauma experiences result in a mental health disorder, thus trauma should not be expected to always produce a mental health disorder, nor should it be considered abnormal not to suffer from a mental health disorder following a trauma experience. In contrast, the combat veteran paradox suggests that change resulting from trauma is normal, yet these changes are not necessarily indicative of a mental health disorder. However, the combat veteran paradox does propose that changes resulting from combat can lead to significant mental health issues if not addressed.

The PTSD paradox states that the symptoms, reactions, and behaviors associated with PTSD are adaptive in combat but not back home (Castro & Adler, 2011b; Hoge, 2011). So, what kept the service member alive and functioning in the combat zone will impede functioning and wellbeing post deployment as well as in the civilian world. The PTSD paradox is only partially correct; not all the symptoms and reactions associated with PTSD are adaptive in combat (see Castro & Adler, 2011b). For instance, it is difficult to see how experiencing dissociative reactions such as flashbacks, engaging in reckless or self-destructive behavior, or having difficulties concentrating would be adaptive in any environment. The combat veteran paradox acknowledges that a veteran may display symptoms and reactions associated with PTSD does not necessarily indicate the presence of a mental health disorder. But if the symptoms and reactions persist or worsen, a diagnosable condition can arise. The combat veteran paradox states that counseling can prevent symptoms and reactions from worsening, as well as attenuate their presence.

Critics of counseling for veterans who do not have a mental health disorder may claim that such an approach (a) “pathologizes” normal combat symptoms and reactions, thereby creating veteran

dependency, (b) interferes with the normal recovery process following combat, (c) enhances the perception that combat veterans are all “screwed up” and pose a danger to society or themselves, (d) diverts scarce mental health resources away from those veterans in greater need, and/or (e) represents a self-serving attempt by mental health professionals to maintain job security by creating a problem that doesn’t exist. While many of these concerns may be valid, the facts regarding the mental health of combat veterans are startling. From 2000 to early 2014, more than 118,000 combat veterans have received a diagnosis of PTSD after returning from deployment, yet are still serving on active duty (Fischer, 2014). At the peak in 2012, more than 17,000 active duty combat veterans were being diagnosed with PTSD every year (Fischer, 2014). Of the more than 1.4 million combat veterans who have separated from military service since 2002, approximately 54% have received health care from the Department of Veterans Affairs, with over 404,000 combat veterans receiving a mental health diagnosis (Department of Veterans Affairs, 2012). More than 8,000 military veterans die by suicide every year; that’s nearly 22 suicides every day (Kemp & Bossarte, 2012); and for those serving on active duty, one service member dies by suicide every 36 hours. These numbers represent the real suffering and death of our combat veterans. We no longer have the luxury of waiting for our combat veterans to become seriously ill before offering assistance, because by then it may be too late. Novel and innovative prevention approaches are needed urgently. In many respects, counseling of combat veterans who do not have a mental health disorder may be

seen as a novel mental health prevention approach similar to psychoeducation and debriefing, which has been shown to reduce PTSD symptomology as measured by the posttraumatic disorder checklist (Adler, Bliese, McGurk, Hoge, & Castro, 2009; Castro et al., 2012).

Paradoxes of the Combat Veteran

The combat veteran experiences numerous paradoxes during and after deployment. Here we have attempted to identify the most common combat veteran paradoxes (see Table 1). Many of these paradoxes were identified by the authors based on findings reported from the research and clinical literature and discussions with clinicians and combat veterans. Further, many of these paradoxes were developed and presented as part of the Battlemind psychoeducation training program (see Adler et al., 2009). Although not every combat veteran experiences all of these paradoxes, we are confident that most combat veterans experience at least one or more of them based on hundreds of conversations with veterans. Moreover, it is important to recognize that experiencing one or several of these combat veteran paradoxes does not indicate the presence of a mental health disorder. On the contrary, these paradoxes are common among combat veterans. However, because of the number and complexity of possible paradoxes, combat veterans may benefit from counseling to assist them in understanding these paradoxes and developing successful coping strategies. If ignored, paradoxes may become exacerbated, leading to mental

Table 1
Combat Veteran Paradoxes

Paradox	Simultaneous thoughts, emotions or behaviors	
Modesty paradox	My service and sacrifice should be recognized. I’m proud of my service People don’t want to help veterans. Don’t talk about self, “it was my team.”	Don’t thank me; I was just doing my job. I don’t want to discuss my service. I want to be left alone. Everyone wants me to talk about me.
Mixed emotions paradox	I’m happy to be home.	I am angry a lot. I am withdrawn a lot. I am often sad.
Back-there paradox	I should share my feelings with family and friends. I want to be home. I miss my family. There is no purpose here.	I don’t want to be hurt or feel vulnerable again. I want to return to deployment. I want to be with the “guys.” I need to be there, “where it matters.”
Kanji paradox	I’m happy to be alive.	Better men were killed. I don’t deserve to be here. I should have saved him/her.
Morpheus paradox	I am physically and mentally exhausted.	I can’t sleep. I can’t calm down. I am constantly “on edge.”
Courage paradox	I proved my strength and courage in combat.	People will think I am weak if I ask for help. Showing emotions is a sign of weakness. Apologizing to loved ones is a sign of weakness.
Aschasia paradox	I want to enjoy life. I wish I could clear my mind and enjoy work.	I cannot relax. Yes, everything matters. People die when mistakes happen.
Intimacy paradox	Being tight with members of the unit is important. If feels good to be loved.	Keeping one’s distance from family and loved ones is important. I can’t show emotions; I can’t take another loss.
Safety paradox	Nothing can harm me. I’m not afraid of death.	The world is an unsafe place. I never turn my back to anyone.
Silence paradox	No one understands what it is like. I need to get this “out of my head.”	I don’t want to talk about it. I don’t even know how to say or describe it.
Risk-taking paradox	Never take unnecessary risks (in combat). It mattered over there.	When your time is up, it’s up. Nothing matters here.
Life–meaning paradox	I appreciate the important things in life. Enjoy life.	I can’t let go of the little things. Why live? For what purpose?

health or relational challenges requiring professional mental health support. We are not suggesting that the presence of these paradoxes causes mental health issues, but rather that these paradoxes might mediate such challenges.

Modesty Paradox

The modesty paradox states combat veterans want to be recognized and appreciated for their service, yet they are embarrassed or bothered when thanked for their service. Military life is hard, requiring tremendous personal sacrifice, as well as sacrifices by the family. Thus, military veterans are usually proud of their service, and equally proud of their accomplishments. Yet, most combat veterans are humble and seldom talk about themselves and describe accomplishments as team accomplishments or that of their comrades. Combat veterans generally do not desire attention nor seek acclaim for their service. At the same time though, veterans can become extremely angry or irritated if their service is ignored, minimized, or not acknowledged (Kleykamp & Hipes, 2015). Further, many combat veterans will become extremely upset if the wars they fought in are criticized, viewing such criticisms as assaults on their service, sacrifice, and accomplishments. Combat veterans may develop a sense of entitlement, believing their personal sacrifices deserve special recognition and consideration when it comes to hiring decisions or receiving health care. Thus, combat veterans may oscillate between wanting to be recognized for their service and wanting to be left alone. This oscillation can lead to confusion on the part of family and friends, and even members of the civilian community, who want to show support for the combat veteran. This is particularly distressing if the combat veterans respond with irritation or anger both when acknowledged and when they are not. Understanding this dynamic can provide insight into the combat veterans' reactions and behaviors.

Mixed-Emotions Paradox

Combat veterans are often happy and angry at the same time. They are happy to be home with their family and friends, and yet angry about things that happened during deployment. Combat veterans might be angry because members of their unit were seriously injured or killed, which in their view could have been prevented; combat veterans might be angry about how their leaders treated them on their deployment; combat veterans might be angry with themselves about how they behaved during the deployment; and for some, combat veterans might simply be angry that they lost a year of their life by being deployed. Combat veterans may also be angry or upset about things that happened back home. It is not uncommon or abnormal for combat veterans to vacillate between joy, sadness, and anger in just a few minutes (Jakupcak et al., 2007; McFall, Wright, Donovan, & Raskind, 1999; Taft, Street, Marshall, Dowdall, & Riggs, 2007). Displaying such an extreme range of emotions so quickly causes the combat veteran to think they are losing their minds. It can be scary for family and friends who witness these extreme and violent changes in emotions. Many combat veterans, however, often do not understand or recognize that such mixed emotions are common. Civilians likewise lack this understanding. Importantly, combat veterans do not recognize that

counseling can assist them in controlling these emotional swings so they become less disturbing and disruptive (Goldin, Manber, Hakimi, Canli, & Gross, 2009).

Back-There Paradox

When combat veterans are at home, all they can think about is being back there (deployed); and when they're back there, all they can think about is being back home. At home, combat veterans report feeling unfulfilled, empty, and without purpose, despite having their family and friends near them, and having a good job. They often report that there is "unfinished business that needs to be taken care of" and they want to return to the location of deployment. They feel as if they left before the mission was complete, and they want to be back in it. Further, a lot of veterans describe the deployed environment as being simpler and focused on conducting a real-world mission. For many combat veterans, garrison life is focused on the trivial and mundane, lacking excitement and meaning. The truth is that many combat veterans love combat. Indeed, the war-fighter's paradox states "combat veterans hate war, but love combat." However, when combat veterans do return to the combat zone, they quickly become disillusioned and cynical. From their perspective, not much progress has been made toward winning the war. Ironically, many combat veterans report that the combat zone has become like garrison, the very environment they were trying to escape from. It is somewhat startling to think that the very place many combat veterans were injured is the very place they want to return, not as a means for obtaining healing (Junger, 2011), but to become an active participant in the war.

Kanji Paradox

Combat veterans are happy to be alive and uninjured, yet feel guilty that teammates might not have been so lucky (Norman, Wilkins, Myers, & Allard, 2014; Opp & Samson, 1989). The Japanese (Kanji) culture is based on shame and guilt, similar to the American culture. Guilt, shame, and second-guessing are strong emotions and reactions displayed by many combat veterans. In particular, combat veterans will second guess decisions they made, or more likely didn't make, that resulted in the injury or death of a team member or civilian. Frequently, combat veterans feel guilty about enjoying life when their teammates might not have been so lucky. Their feelings can sometimes waver between happiness and guilt, leading some combat veterans to withdraw from others or display depressive-like symptoms, which might interfere with their ability to function or enjoy life (Castro & McGurk, 2007). Thus, the Kanji paradox is similar to the mixed emotions paradox, yet it is focused on remorse and guilt. Such reactions and symptoms have been described as a "moral injury" (Litz et al., 2009; Shay, 2014). Although overcoming a moral injury is a necessary part of the healing process, a moral injury is not a mental health disorder. Nevertheless, a combat veteran can benefit from counseling before the moral injury worsens.

Morpheus Paradox

"Combat veterans are physically exhausted yet unable to sleep." Morpheus is the Greek god of dreams. Deployments are physically demanding. Combat veterans report sleeping on average 5 to 6

hours a night for the duration of a deployment, lasting up to year (Peterson, Goodie, Satterfield, & Brim, 2008; Seelig et al., 2010). While deployed and after returning home from a deployment, combat veterans still report having difficulty sleeping, and are often prescribed sleeping medications to help them with their sleep (Capaldi, Guerrero, & Killgore, 2011; Chapman, Lehman, Elliott, & Clark, 2006). For many veterans, their sleeping difficulties arise from being in a continuously hyper-aroused state for such a prolonged period of time, which is necessary for survival in a combat environment (Babson, Blonigen, Boden, Drescher, & Bonn-Miller, 2012; Castro & Adler, 2011b). Other veterans may avoid sleep because of expected nightmares or night terrors, which typically revolve around some aspect of their combat experience (Pigeon, Campbell, Possemato, & Ouimette, 2013). Some veterans of past wars have reported nightmares and sleep problems lasting decades (Schnurr, 1991 for an excellent summary). Both reactions are normal responses to combat deployments, but can be very debilitating in the combat environment and back home. Sleep problems can lead to combat veterans using alcohol and drugs to help them sleep, which can eventually lead to alcohol or substance use problems that interfere with many aspects of their postcombat life (Chakravorty et al., 2013; Hawkins, Lapham, Kivlahan, & Bradley, 2010). Many combat veterans will avoid sleeping in the same bed with their spouse or partner after returning home, and have to learn gradually to share a bed again. Once asleep, it is not unusual for combat veterans, when awoken by a spouse or partner, to react with extreme aggression, resulting in a spouse/partner never wanting to awaken a sleeping combat veteran. Clearly, if a combat veteran has a sleep disorder, then treatment is needed. However, in many cases the sleep issues are nonclinical. For these latter instances, mental health counseling and monitoring can be helpful to the combat veteran in recognizing the source of sleep disturbances and developing healthy coping strategies so alcohol and substance use issues do not arise.

Courage Paradox

The courage paradox states that combat veterans are strong and courageous, yet afraid of being viewed as weak or damaged. Combat veterans will minimize their physical and psychological health symptoms, and usually refuse to ask for help. For many combat veterans, seeking help for a mental health issue is viewed as a sign of personal weakness. Most civilians, however, view combat veterans as brave, having risked their lives in service of their country; and thus tend to ignore or be unaware of the “hidden injuries,” such as mild traumatic brain disorder, mental and physical health issues, and suicidality, to name the most prominent challenges combat veterans may be struggling with. Combat veterans who need help will often report that they have to be strong and handle things on their own, despite all of the evidence telling them otherwise. Therefore, they suffer in silence needlessly until life becomes unmanageable. Combat veterans need to appreciate that it takes courage to seek help, and that seeking help is not a sign of weakness. Implementing practices which encourage mental health counseling for veterans in transition as a customary part of general health promotion may assist in breaking down such barriers to counseling.

Aschhalasia Paradox

Combat veterans want to enjoy life, yet have forgotten how to relax. Aschhalasia literally means the inability to relax. Many combat veterans return home so aroused and keyed-up that they simply cannot relax and enjoy everyday life. Combat has the capacity to alter the physiology of combat veterans so that months or in some cases years are required before their baseline physiology resets (Grossman & Christensen, 2008). Because of this heightened level of arousal, veterans are preoccupied with their surroundings and easily startled by loud, sudden noises. Often not appreciated, nor fully understood, is that the same hyper-arousal condition that prevents combat veterans from being able to relax or engage in leisure activities that they once enjoyed was once vital to their survival on the combat field (Castro & Adler, 2011a). These heightened levels of arousal following combat are normal and alone do not indicate a mental health disorder, yet may disrupt social and occupational functioning. Fortunately, there are relaxation exercises that combat veterans can be taught that will help them manage their hyper-arousal behaviors (Varvogli & Darviri, 2011). That is, if they chose to seek help to learn these exercises.

Intimacy Paradox

Combat veterans formed intimate bonds with their teammates that will last a lifetime, yet struggle to reform/form intimate relationships with others. Many combat veterans struggle because they have changed as a result of the deployment, and it is important to realize that the significant others they left behind might also have changed. Perhaps the combat veteran is afraid to reestablish intimacy with others because of the fear of loss, rejection, or emotional expression. Although this avoidance strategy may serve to protect the combat veteran from emotional pain in the short term, in the long term it can have a profound negative impact on the overall quality of life for the combat veteran. Avoidance behavior can lead to isolation, depression, poor self-esteem, and, in extreme circumstances, suicidal ideation (Hofmann, Litz, & Weathers, 2003; Jakupcak & Varra, 2011; Langlois, 2014). Relationships with fellow combat veterans are important and clearly can serve as a protective factor in combat and even postcombat transitions, but intimacy with others, as defined by the combat veteran, at its most basic level is vitally important for one to fully transition back home (Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012).

Safety Paradox

Combat veterans no longer fear death, but feel the need to carry weapons for personal safety. Combat can lead veterans to develop a sense of invincibility or inevitability (Killgore et al., 2008). Many combat veterans feel indestructible; that after they have served in combat and survived, they come to believe that there is nothing that can harm them. Or having witnessed death up close, combat veterans may come to view death as random and unavoidable; that when your time is up, it's up, and there is nothing that you can do about it. Whether through a sense of invincibility or inevitability, many combat veterans no longer fear death. Nevertheless, many combat veterans will only sit near exits, always face entrances, never leave their back exposed, and usually avoid large

crowds. Often, when going out with family or friends, combat veterans will also direct where they sit as well. Some combat veterans report feeling unsafe, “naked,” without a weapon; thus, many combat veterans will carry a knife or a gun, or have one near them at all times. Although there is nothing inherently wrong with carrying a knife or gun, given the combat veteran’s tendency to act quickly, almost on instinct, to perceived dangerous situations, unforeseen misinterpretations could arise resulting in unnecessary serious injury or death, causing the combat veteran serious problems. Additionally, a high number of suicides occur each year by combat veterans who used an accessible gun (Claassen & Knox, 2011). It is critically important for the combat veteran to fully understand the complexities of this dynamic.

Silence Paradox

Combat veterans want to be understood, but they do not want to talk about their experiences or how they’re feeling or what they’re thinking. Combat veterans want those who have never served in the military to understand what serving in the military means, and what it takes to survive in combat, yet do not want to talk about their combat experiences, or what it is like to kill someone. Most combat veterans become extremely annoyed when someone, especially strangers, ask them if they have killed anyone. In fact, the more one talks about their combat experiences, the less likely they are to be believed by other combat veterans. This conspiracy of silence around talking about combat can interfere with the combat veteran’s ability to adequately process these important experiences (Lloyd et al., 2014). The silence paradox is important because harboring feelings and the associated emotional pain can have long lasting effects on the combat veteran and others. The “I can handle it on my own” belief is dangerous and will only lead to continued suffering in silence. Having someone to share combat experiences with who will not judge the combat veteran can alleviate much of this unnecessary suffering.

Risk-Taking Paradox

Combat veterans are experts at taking calculated risks in combat, yet engage in high-risk behaviors back home. The risk-taking paradox is related to the safety paradox, but it is different in several important aspects. To survive in combat, luck and skill are needed. Almost by definition, combat veterans have both. Combat veterans are experts at making life and death decisions; they know how to assess risks, and they know how to mitigate these risks. Yet, back home, many combat veterans will drink alcohol and drive, have unprotected sex, drive at high speeds, weave in and out of traffic, and abuse alcohol or drugs. Some have described these risk-taking behaviors as “chasing an adrenaline high,” akin to skydiving or bungee jumping (see Killgore et al., 2008). Skydiving and bungee jumping, however, have safety procedures in place that minimize risk, whereas true risk-taking behaviors such as those described above do not. It almost appears as if some combat veterans have developed a “death wish” (see Fässberg et al., 2014), and the leadership and risk reduction procedures that worked in combat appear to be ineffective for many combat veterans back home. Combat veterans could benefit from counseling that assists them in understanding why they engage in high-risk behavior and the possible consequences of their actions.

Life–Meaning Paradox

The life–meaning paradox states that combat veterans have learned to value the important things in life, yet have difficulty letting go of the little things. One of the most positive aspects of a combat deployment reported by veterans is that they now appreciate the important things in life: family, faith, friendship, and belongingness (Barron, Davies, & Wiggins, 2008; Castro & Kintzle, 2014). However, combat veterans continue to be enraged by the little things in life, especially those things that they cannot control. For instance, combat veterans become incensed when people show up late for meetings, show any indecision when ordering at fast food restaurants, arrive late or leave early from work, or drive slow in the fast lane, among many other nuisance or trivial behaviors. Although generally recognizing these behaviors as trivial, combat veterans still cannot let go of the little things, viewing such behavior as a lowering of their personal standards. Yet, at the same time, many combat veterans might turn a blind eye to violations of military standards that mattered to them before combat, such as the proper wear of the military uniform or alcohol use in the barracks, because they learned firsthand that these “little” things do not matter in combat. And when combat veterans are corrected on issues such as improper wearing of their military uniform, they can become irate, especially if the correction is done by a noncombat service member or officer. Despite the fact that these types of outbursts might be common and might not be indicative of a mental health disorder, witnessing them can be terrifying, especially to family members. Here again, the combat veteran could benefit from learning to identify and ameliorate such reactions through counseling.

The paradoxes that combat veterans face are rational and understandable. However, that doesn’t mean that the combat veteran, their family, or civilians necessarily understand them. The symptoms, reactions, and behaviors embedded within the paradoxes do not represent a mental health disorder, although they can create challenges for combat veterans, family members, and others when they try to reestablish relationships and intimacy as the combat veteran transitions from combat back home, and from active military service back to the civilian community. Preventive counseling offers the possibility for early intervention to assist the combat veteran during these critical transitions.

The Military Mental Health “Triple Bind” Dilemma

A *dilemma* is a situation in which a difficult choice has to be made between two or more alternatives, especially equally undesirable ones. The triple bind dilemma consists of multiple double binds resulting in a distressing dilemma involving communications in which an individual or group receives two or more conflicting messages, with one message negating at least one of the other messages (see Bateson, Jackson, Haley, & Weakland, 1956, 1976). This creates a situation in which a successful response to one message results in a failed response to the others (and vice versa), so that the person will automatically be wrong regardless of what they do. You are damned if you do, and damned if you do not, and damned if you say anything about it. Understanding the mental health triple bind dilemma is important as it elucidates many aspects surrounding mental health stigma, which impedes combat veterans from getting the help they need.

Typically, demands are imposed on the combat veteran by someone who they respect (such as a spouse, leader, peer, or even themselves) but the demand itself is inherently impossible to fulfill because some broader context forbids it. The military mental health dilemma is a specific kind of triple bind dilemma, typically involving the spouse or partner, the military, and of course, the combat veteran. The nature of the military mental health dilemma takes the following general form:

First Bind (Spouse/partner): “If you don’t go to mental health, I will leave you. If you lose your job, I will leave you.”

Second Bind (Military Culture): “If you have a mental health problem, you need to get help to ensure your military readiness. If you have a mental health problem, you will not be promoted or selected for tough leadership assignments and you will be treated differently by members of the unit.”

Third Bind (Combat Veteran): “If someone has a mental health problem, they should solve it themselves. If someone has a mental health problem, I am not sure how he or she should resolve it.”

As can be seen when presented in this form, the combat veteran may have difficulty defining the exact nature of the dilemma in which he or she is caught, and who is actually creating the dilemma. In the first bind, the spouse/partner is creating what is called the “the ultimatum double bind,” in which the combat veteran must make a decision regarding one of two choices, neither of which has desirable outcomes. The spouse/partner is demanding that the combat veteran goes to mental health, which the combat veteran does not want to do because of the expected consequences of doing so. Yet, if the combat veteran does not go to mental health, then the spouse/partner will leave, which the combat veteran also does not want. Coercions and threats are key aspects of the ultimatum double bind. Further, if the combat veteran confronts the spouse/partner about the situation, which will result in a consequence the combat veteran does not want to experience, such as arguing with the spouse over the need to go to mental health, and/or listening to the spouse/partner complain about the combat veteran’s behavior. If the combat veteran does nothing, then that will also result in a consequence for the combat veteran they do not want to experience, especially if the spouse/partner has put a timeline on when the combat veteran must get help. The combat veteran is trapped; it is a classic catch-22.

In the second bind, the military creates a double bind for the combat veteran because their words and actions do not match. On one hand, the military communicates the importance of mental health for combat readiness and emphasizes the need for receiving help. Implicit in this assertion is that the military takes care of its members. On the other hand, the culture of the military tells the combat veteran that getting help results in being shunned and passed over for career-enhancing opportunities. This is similar to the police PTSD paradox in law enforcement. Similar to that of the military, police have a strong culture of taking care of their own. However, when PTSD becomes incapacitating, the police officer is spurned, thrown away (Marx & Holowka, 2011). Adding further complexity, the spouse/partner appears to “conspire” with the military to create a dilemma for the combat veteran. The spouse/partner creates a dilemma for the combat veteran by insisting that they get mental health care and maintain their job, yet the combat veteran believes that if they seek mental health care their job will be in jeopardy. So, no matter what the combat veteran does, the spouse will leave. The military also wants combat veterans to

receive mental health care to maintain military readiness, yet in doing so combat veterans jeopardize their military career and status within the unit. It is a double bind, or catch-22. From the perspective of the combat veteran, if they seek mental health care their spouse will leave and they will risk being kicked out of the military. Yet, if they do not seek mental health care, their spouse will still leave and they can remain in the military. It is not surprising given this predicament that the combat veteran often chooses not to go to mental health care.

However, there is a third bind, one created by the combat veterans themselves. In this dilemma, the combat veteran holds two conflicting positions about mental health problems. Implied in the belief that anyone with a mental health problem should solve it themselves is the belief that there are individual actions that can be taken to solve the problem. However, most combat veterans do not know what these actions should be. Notwithstanding the fact that most combat veterans do not know what they should do to handle a mental health problem, many combat veterans prefer to solve their own mental health problems rather than going to mental health care. They often believe that by “self-treating” they will be able to keep both their spouse/partner and their military career without receiving mental health treatment (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). Recall the courage paradox described earlier, in which combat veterans believe they are strong and can handle things on their own. Many combat veterans, though, lack the necessary knowledge to recognize that they have a problem and the skills to treat it once it has been identified. For other combat veterans there might exist other biopsychosocial barriers that prevent them from changing their behavior. Often, combat veterans will resort to self-medication such as alcohol use to treat their mental health issues, or engage in avoidance behavior to escape the issue (Schumm & Chard, 2012). This self-treatment predicament (or paradox) can be extremely stressful and become destructive, especially when the self-treatment results in behaviors and symptoms more damaging than those originally causing the problem.

Thus, the mental health dilemma, involving the spouse/partner, the military culture, and the combat veteran all acting together create three double binds, can prevent the combat veteran from receiving mental health support. To a large extent, these binds represent the critical aspects of the stigma associated with military mental health problems: interpersonal, cultural or societal, and self (see Greene-Shortridge, Britt, & Castro, 2007). It is important to appreciate that any one of these binds alone is sufficient to stop the combat veteran from seeking mental health. The challenge for the combat veteran is to overcome these difficult dilemmas. Making the effort to find the way out of these traps can enable the combat veteran to obtain emotional and psychological growth. We believe that enhancing the service member’s self-awareness is an important beginning to breaking this triple bind.

Paradoxes and Dilemmas of Veteran Support Organizations

Combat veterans are not the only ones facing dilemmas and paradoxes. Organizations that exist to support combat veterans face dilemmas and paradoxes too; and the paradoxes and dilemmas these veteran-helping organizations (public, private, and nonprofit) face can clash with the dilemmas and paradoxes that combat

veterans are struggling with. Thus, if they are going to support combat veterans effectively, it is essential that veteran-helping organizations understand the paradoxes and dilemmas veterans face, the organizational paradoxes and dilemmas they deal with, and how these paradoxes and dilemmas might conflict. Although many of the paradoxes faced by organizations might parallel those faced by combat veterans, in this section we focus on those paradoxes and dilemmas unique to the organization, keeping in mind this important similarity.

Samaritan Dilemma

The Samaritan dilemma involves the choice between providing aid to the combat veteran, thereby improving their condition, or withholding aid, thus preventing dependence. Not providing needed support to the combat veteran, however, will result in continued suffering, and may even prevent the combat veteran from becoming a productive member of society. Nevertheless, veteran helping organizations must be careful to avoid creating a culture of dependence, where the combat veteran comes to rely on the helping organization for support in perpetuity. Veteran helping organizations can avoid creating the necessity for more veteran services by structuring support to prevent mental health problems from ever arising, addressing mental health issues as early as possible before issues become chronic, and, when problems exist, providing comprehensive care with the explicit goal of full recovery and self-sustainment.

Currently, most support for combat veterans occurs after significant problems have arisen, such as homelessness, prolonged unemployment, or chronic health issues, including alcohol and substance use. Many recent veterans do not see themselves in such dire straits and are unlikely to return to organizations or facilities where only such support is provided. Veterans who are only looking for support to get through a temporary setback need services offered to them that are less stigmatizing and insulting, while recognizing their strength and resilience.

Disability Paradox

The Department of Veterans Affairs disability system is designed to ensure that veterans receive needed health care by assigning wounded and injured combat veterans disability ratings, yet these ratings lead to veterans never regaining their health. Veteran disability ratings are linked to health care prioritization and numerous financial benefits, including state and federal tax relief, housing assistance, and disability pension, among others (Murdoch et al., 2011; Sayer, Spont, & Nelson, 2004). All veterans receive these disability benefits as long as they have a disability rating. However, once the veteran no longer has a disability rating, the benefits end. To complicate the situation, higher disability ratings result in greater benefits. Thus, veterans are rewarded for claiming injuries, regardless of how small or seemingly insignificant, as they might contribute to a higher disability rating, and they are encouraged to never recover from any injuries or risk losing existing disability benefits. No veteran wants to leave unclaimed benefits on the table, and be thought a fool, no matter how honorable he or she might be. Veteran benefits determinations need to be decoupled from poor health status so that veterans are rewarded for recovering from injuries and illness instead of being rewarded for remaining ill and incapacitated.

Hobson's Choice

Hobson's "choice" involves a free choice between options in which only one option is really offered. Providing veterans with health care is a tremendous benefit, yet allowing them to receive this health care benefit from whomever they want would be significantly better. Currently, veterans can either use the veteran affairs health care system for free or pay someone else for health care. So, although it appears that veterans have a choice, in reality they do not. Veterans can take it or leave it. Hobson-like choices are also seen in many other veteran-helping organizations. Combat veterans are rarely offered choices as to where or how services will be provided to them. To some extent, the attitude of those individuals working in veteran helping organizations appears to be that veterans should be appreciative of whatever support that they are provided; however, from the perspective of the veteran, they believe that their service and sacrifice to their country has earned them the right to be treated with dignity and respect, even though they may be struggling and in need at the moment. Here, veteran helping organizations must appreciate that one size doesn't fit all, and that not every veteran's needs are the same. Veteran helping organizations must strive to truly understand the needs of each veteran. Having veterans serving other veterans is a means to achieving this understanding, yet veteran helping organizations must still be structured and resourced to provide true choices in what veteran services are provided and how these services are delivered.

The LA Paradox

The LA Paradox is similar to Fenno's Paradox (Fenno, 1978), which states that although Americans largely disapprove of the actions of the U.S. Congress, they approve of the actions of their local congressional representative. Similarly, the LA Paradox is based on the findings from a study of veterans living in Los Angeles who reported that although they generally dislike the Department of Veterans Affairs, they nonetheless are generally happy with the health care they receive at the local Los Angeles VA (Castro, Kintzle, & Hassan, 2014). It is difficult to change a large organization that people are unhappy with if the same people are happy with the subcomponents that make up the larger organization. Changing the larger organization necessarily requires making changes to the subcomponents with which people are satisfied. What is needed in this case is a much more nuanced approach to change. For instance, whereas combat veterans might be happy with the health care they receive at the Department of Veterans Affairs, they might not be happy with the difficulty in accessing that health care, or the manner in which the health care is provided. Thus, improvements to the larger system are possible without making changes to the subcomponents of the system that the veterans are satisfied with. Focus should be directed to improving those subcomponents of the larger system that are not meeting the needs of the veteran.

The Bureaucrat's Dilemma

Bureaucrats perform a very useful and necessary function for organizations: public, private, or nonprofit, large or small, as they ensure the smooth and predictable functioning of organizations by

following organizational policies, rules, and procedures. Effective bureaucrats maximize resource utilization, ensure equal treatment of those in need, and provide essential administrative support. However, bureaucrats have come to be viewed by many in the public with some disdain. There is a perception that bureaucrats are more concerned with procedure or policy than with meeting people's needs. In particular, bureaucrats are often seen as people who follow routines in a mechanical, rigid, and unimaginative way, insisting proper forms be completed, petty rules be followed, and no deviation in procedures be allowed, even when such deviations would benefit both the organization and the person in need. Bureaucrats frequently make decisions based on some arbitrary fixed criterion without using any judgment. The bureaucrat's dilemma occurs when bureaucrats would rather be criticized for using fixed and/or vague criteria with meaningless cutoff points to make decisions rather than be criticized for making errors or justifying decisions based on their own judgment. Invariably, such decisions generally do not go in the favor of the veteran.

For many combat veterans, the unwillingness of bureaucrats to make reasonable decisions that directly affect their service eligibility sends them into a fury. Veterans feel they successfully fought the enemy abroad, and now they are fighting a new enemy back home. What many veterans are particularly frustrated with is the "lost" or missing paperwork, wait times for appointments, and denied benefits, including the wait time to learn that benefits were denied. Given the courage to overcome the social and personal stigma associated with seeking help, especially mental health care, having to wait to receive an appointment or worse yet, being inappropriately denied health care benefits, almost certainly ensures that the veteran will never return. Additionally, many veterans believe the disability guidelines are inconsistently interpreted and applied. This appears to be especially true when the policy or guidelines are vague and inconsistent.

Bureaucratic support for veterans could be significantly improved by following three basic rules. First, when there is doubt always err on the side of the veteran. Second, always do what is best for the veteran first, and the organization second. Finally, advocate for the veteran by ensuring they receive all the support they need to fully recover so they can enjoy life.

We recognize that many bureaucrats are not always able to freely make decisions that are in the best interests of the veteran, and that they too might be stuck in paradoxes and dilemmas not of their own making, yet which reflect the policies and procedures of the organization in which they work. When this occurs, bureaucrats need to work to end such policies and practices. For leaders within veteran helping organizations: trust and encourage your staff to make the tough decisions regarding benefits and eligibility requirements, do not second guess your staff's decisions, and never encourage your staff to cut corners or fudge data to meet arbitrary performance goals, especially when veterans suffer in the process. Finally, fight to ensure your organization has sufficient resources to meet the needs of the veterans you are supporting.

Invention Paradox

The invention paradox states that it is often easier to solve a more general problem that covers the specifics of the sought-after solution rather than trying to solve the individual-specific problem. Veteran helping organizations are generally structured to support only one or

two of a variety of veteran needs. For instance, thousands of organizations exist to help veterans with employment, housing, health care, education, finances, legal issues, and so forth. Few organizations exist that provide comprehensive support to veterans. Veterans are generally bounced around from agency to agency depending on their most immediate need. Further, most veteran helping organizations only provide support to veterans who are in dire straits (i.e., homeless, addicted to alcohol and/or drugs, or suffering from severe mental or physical health issues to name but a few) with very little attention paid to prevention and early intervention.

In many respects veteran helping organizations appear to have taken a "whack-a-mole" approach to supporting veterans, dealing with veteran issues one at a time as they arise. Although ending veteran homelessness and ensuring that veterans obtain meaningful employment are essential for a successful transition, other needs are equally important, such as mental and physical health, and personal and social identity. As such, these needs are also interconnected; providing residence for a homeless veteran will have little long term effect if the underlying needs that lead to homelessness are not also addressed. We are beginning to understand how military structure provides active duty personnel the ability to function while suffering from mental and physical health issues (Castro & Adler, 2011b). While our future veterans remain on active military service, neither employment nor housing are critical issues because our active duty service members have a job and place to live. Once these service members leave the military and become veterans, they lose this structure and support. Housing and jobs are no longer provided for them and their families. Any unmet mental and physical health needs remain unmet, and perhaps most importantly, their personal and social identity, anchored within the culture of the military, becomes lost. A more fruitful strategy for supporting veterans as they transition back home from the combat environment, and from military service to civilian life, would be a holistic approach that includes all of these critical components for a successful and meaningful life (Castro, Kintzle, & Hassan, 2014).

Trauma and Paradoxes

Combat trauma is not the only type of trauma that can lead to changes in the individual. Traumas resulting from a physical or sexual attack, a severe car accident, witnessing death or destruction, an injury, or illness, can also change the individual (Calhoun & Tedeschi, 2008). Similar to combat trauma, not all of these changes are indicative of a mental health disorder (Kessler et al., 2014). Also similar to combat trauma, these changes can result in the development of paradoxes, with incongruent thoughts, emotions, and behaviors emerging. Perhaps the best illustration of a paradox that emerges after many types of trauma is the Kanji paradox, in which survivors are happy to be alive, yet feel guilty for having survived and experiencing such happiness. The Kanji paradox can be seen following traumas involving automobile accidents and natural disasters in which close friends or family members were seriously injured or killed. Many of the paradoxes that are present following combat trauma, however, may not be present after other types of trauma. For example, the back-there paradox in which the combat veteran longs to return to the warzone and possibly reexperience the combat trauma just to be with their buddies, or just to feel that they are doing something useful again, is not seen in other types of trauma; for example, survivors of rape never report a desire to experience such trauma again, yet the back-there

paradox might be seen in other occupations such as firefighters and first responders.

Many individuals who have been exposed to trauma are still able to function at fairly high levels, even when they may be suffering from a mental health disorder. For instance, it is not uncommon for combat veterans to report that they have been suffering from symptoms associated with PTSD, such as severe night terrors and suicidal thoughts, for years or decades before they actually sought help (Solomon & Mikulincer, 2006). In fact, there have been instances in which relatively junior officers or enlisted soldiers have experienced combat trauma, developed PTSD for which treatment was never received, and gone on to become senior leaders, in some instances obtaining the rank of general (see Cantwell, 2012). Likewise, many survivors of sexual assault often go on to pursue successful careers, only reporting the trauma years later, when the psychological problems become too much to endure.

It is important to appreciate that delays in seeking care after trauma are not unusual (see, e.g., Bunting, Murphy, O'Neill, & Ferry, 2012). Care following trauma is generally only provided when the psychological symptoms associated with the trauma become overwhelming or the coping mechanisms employed to enable functioning following the trauma are no longer effective. Thus, although the affected individual may be able to function for some period of time following the trauma, eventually the changes that the trauma induced require the survivor to seek help. Indeed, many believe that the only time a trauma survivor should receive help is when symptoms are severe or when the survivor can no longer successfully cope. Demanding that trauma survivors wait until such times ignores the tremendous amount of suffering that a trauma survivor might endure in the meantime. And in cases of trauma survivors who may become suicidal, such delays in receiving care may be provided too late (Bryan & Rudd, 2012; Chu, 1999). Similar to combat veterans, survivors of other types of trauma may also benefit from early prevention interventions, such as counseling and psychoeducation.

The paradoxes experienced by combat veterans can be seen in other occupations as well, such as humanitarian workers, police officers, firefighters, correctional officers, and medical first responders (Brough & Williams, 2007; Ko et al., 2008; Meyer et al., 2012; Violanti, 1999). It has been argued that occupation-related traumas, such as combat trauma, possess unique aspects that are different than non-occupation-related traumas (Adler & Castro, 2013; Castro & Adler, 2011a, 2011b). Unlike non-occupation-related traumas such as rape and automobile accidents, in which the traumas are typically discrete events, unwanted and unpredictable, occupation-related traumas are varied and numerous, often desirable, and expected. These occupation-related characteristics of trauma can exert tremendous influence on how one responds to trauma, and subsequently how trauma changes the individual. Similar occupations are more likely to elicit similar changes and paradoxes in the individuals experiencing the trauma. Thus, members of professions in which trauma exposure is an expected aspect of the job might likewise benefit from counseling as a preventative intervention, both before and after the secondary trauma.

Conclusion

Normalizing how combat and other traumas can change a person is an important intervention for preventing subsequent mental and behavioral health issues (Adler et al., 2009; Wenzel, 2014).

Nearly all changes resulting from trauma, especially combat, are normal and predictable. The changes resulting from combat often result in numerous complex paradoxes and dilemmas, many of which are not fully understood by the combat veteran. Counseling aimed at providing understanding about how specific traumas affect an individual, as well as useful coping skills for managing symptoms and reactions, can be especially beneficial in preventing the symptoms and reactions from worsening and resulting in more serious mental health issues.

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