

## Micah Christopher Wright

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I served four years in the Marine Corps with the Third Battalion 1st Marines (Thundering Third). I was in Lima Company, Weapons Platoon, Assault Section. I served in OIF I, II, and III in the Al Anbar Province of Iraq. During my second deployment, I served in Operation Phantom Fury (the second assault on Fallujah) and received the Navy and Marine Corps Achievement Medal for actions in combat. I truly learned what it meant to be a United States Marine on this tour. During my Third Deployment, I participated in the clearing of Haditha and helped 3/1 hold the triad cities: Haditha, Barwanah, and Haqlaniyah. I

received the Purple Heart on January 19, 2006, after my humvee struck an anti-tank landmine that was attached to a 120mm mortar on the outskirts of Barwanah.

I started writing for the emotional engagement after a friend encouraged me to do so and after I attended the Veteran's Voices Workshop led by Caitlin McCrory and Jason Coates. Now, I realize that my story is important: writing helps me heal.

## Linguistic Manipulation: PTSD and the Re-Training of Warriors

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Micah Christopher Wright

When I was a marine, I was confident. I trusted in my abilities to perform my duties, to be efficient in combat. However, when I returned from war, my confidence dwindled; I was informed that I had Post Traumatic Stress Disorder (PTSD). The traits that I had utilized in combat, hypervigilance and repressed emotions, were now seen as mental deficiencies. The civilian world proved difficult to fit into. The warrior mentality that I was used to was no longer beneficial. Not long after I left the marines, the VA recommended that I seek counseling for PTSD. I confessed to my assigned therapist that I disliked most of the people (strangers) I was around because I did not trust them. I was hypervigilant, especially in crowds, and although I had been trained that these actions were appropriate—in fact, they were vital to sustaining my life in combat—the PTSD label that was attributed to my actions in a civilian environment perpetuated the isolation that I felt. I was no longer a marine; I was a mentally defective other, living in a world of people who provided me with a disorder instead of the training that I needed. Instead of being remobilized to be useful in the civilian world, the skills that had been deemed necessary to help my fellow marines and me, not only in the mobilization and preparation of combat but also in the actual combat environment, were now seen as useless and abnormal qualities of an unfamiliar world.

PTSD as a label is readily utilized by the very civilian and government entities that are tasked out to help veterans succeed after their return from combat. In a 175 page document entitled, “VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress,” the Veterans Administration (VA) states, “Post Traumatic Stress Disorder is the most prevalent mental disorder arising from combat. It also strikes military men and women deployed in peacekeeping or humanitarian missions, responding to acts of terrorism, caught up in training accidents, or victimized by sexual trauma. Its burden may be transient or last a lifetime” (i). In this first sentence of the document, the VA sets a tone for the explanation of PTSD. The dominant civilian population will now see both combat and non-combat veterans who have done their job as having a mental disorder. Considering that the military culture is different than the civilian culture, it is important to understand how certain characteristics are viewed differently in both worlds. In *When Johnny and Jane Come Marching Home: How All Of Us Can*

*Help Veterans*, Paula Caplan, a psychologist, discusses how the misconceptions of veterans affect possible treatments: "The psychiatrizing of society, which is what I call the casting of negative emotions and difficult behavior as mental illness, has made it hard for the American public to see the nature and scope of veterans' problems and the full array of possible solutions to those problems" (485). In other words, there is a stigma that is attached to PTSD, and that stigma makes it hard for veterans to seek the necessary help. A mental health disorder may be seen as a weakness or a failure on their part, which makes it hard for mental health providers to administer appropriate care.

Caplan continues by theorizing the reasons behind the labeling of returning veterans: "The psychiatric diagnosing of so many troubled veterans is based partly on the bizarre expectation for veterans to come back from war exactly as they were before they went away. Clearly, this is impossible. But since they don't come back the same as before, we rush to conclude that they are mentally ill" (499). The utilization of the term PTSD perpetuates the concept that our veterans are broken; unfortunately, if a veteran feels such incapacity, chances of isolation increase. The expectations the civilian world has for our nation's veterans is that they must *transition*, or change to match what is normal outside of the military. However, through this ideology of *transition*, the warrior mentality is stigmatized and lost instead of adapted to a new environment.

The VA further describes PTSD as "often associated with withdrawal from participation in social activities, limited friendships, and reduced emotional intimacy. Some research also suggests that veterans with PTSD have greater rates of social anxiety disorder. Poor social support predicts development of PTSD and a more chronic course of the disorder" (50-51). Withdrawal (isolation), lack of emotional intimacy with friends and family (repressed emotions), and social anxiety (perpetuated by hypervigilance) are the elements the VA attributes to a veteran with a mental disorder. These characteristics are understood as abnormal in the civilian world, but military culture demands them.

In combat, there is a requirement that most civilians will never be required to perform: a service member must be able to become emotionally numb to the horrors of war. Caplan asserts, "To do that, one has to focus on the moment-to-moment tasks that help toward that goal: ducking, checking, digging, covering, looking, and listening with utter vigilance. This can mean needing to shut off any emotion, even shut out any perception" (650). Contrary to a belief that people should be compassionate towards others, the military teaches its warriors to pride themselves on completing the mission. When I went through Fallujah, my battalion lost thirty-three marines in two weeks. I never stopped to mourn their deaths; I never stopped to reflect on my feelings. Instead, I performed my duties to the best of my abilities even if it meant that I could possibly be a number added to that

list. Even though this sentiment is seen as troublesome outside of combat, the action of numbing emotions is not only for self-preservation but for the protection of others.

When I was in the Marine Corps, I was trained to view my environment with a 360-degree consideration. When on patrol in Iraq, we were often situated in an urban environment: small city streets, sometimes with large buildings, and people walking around everywhere (especially in the market place). When on patrol, our job was to not only seek out and destroy the enemy but to be present within the population in order to deter any terrorist activity. In order for our patrol to be successful, we (the marines on patrol) had to watch every corner of the buildings; we had to be cognizant of the movements of the people around us; we had to be aware when people were reaching into their pockets (danger of weapons, grenades, or triggers to IEDs); we had to pay attention when a car was riding too low or a motorcycle was left unattended (both possibilities of an IED). Our hypervigilance is what kept us alive; we were trained to be this way, so that we could be efficient enough to complete the mission (when you are dead, you cannot complete the mission).

I was mentally prepared for any situation that might occur. In “The Importance of Understanding the Military Culture,” Lynn K. Hall addresses the mental-health community, explaining the need for behavior that might be deemed as abnormal by outside (civilian) cultures. The aggressive mental state, in Hall’s terms, provides “service members with security, identity, and a sense of purpose” (7). The identity of a marine is based upon the success of the mission, which is always placed above the selfish concerns of the individual service member. Hall explains, “It is also these concepts of honor and sacrifice that helps us understand the inherent stigma that is so predominant in the military. Military personnel are expected to ‘soldier up’ and get through the rough times on their own” (15). Because the mission is so important, the success of the team and the individual service member determines the preservation of an identity. When labeled as having a mental disorder (PTSD), veterans who are no longer in a team environment could not only view themselves as deficient but risk being viewed by the public as mentally deficient as well—a fact that perpetuates the feeling of failure and the avoidance of needed counseling. The veteran will not accept failure as a part of his or her identity; when failure is not an option, the identity and the safety of veterans are at risk.

When I was a young marine, I was training with my company in the field. We were training at night. While on the patrol in the hills of Camp Pendleton, I fell into a six-foot hole, my chest landing on my M249 SAW; I bounced off my weapon and lay motionless for a while. I was out of breath and dazed after the fall. My fellow marines helped me out of the hole, and we continued on the patrol. Upon returning to our patrol base, I noticed a large bruise on my chest, and I started to become short of breath. I asked

for help from the Corpsman (Doc) and was immediately chastised for recognizing the pain. Caplan explains how military training “involves not only hard-driving physical exercise but also, as virtually every vet brings up in interviews, the order to take a gun outfitted with a bayonet and run around in a field, jabbing the bayonet and screaming ‘Kill! Kill! Kill!’ Hundreds of thousand of moments and tasks are aimed to train soldiers to commit acts of violence as well as of self protection” (535). Although Caplan’s description may not be completely accurate—I don’t think running around in a field is an adequate way of detailing military training—the purpose of her explanation is compelling: the military trains its war fighters to act in a certain way; they are trained to be hypervigilant and to kill the enemy without hesitation. When I recognized the pain from my fall, I was admitting a weakness to my fellow marines. Although this idea may seem crass to a civilian, the reasoning behind this behavior is considered to be a tool in the completion of combat missions. Combat requires a high tolerance for pain; physical and mental emotions are numbed to create warriors who habitually act on the training they have received. This is how wars are won.

When the civilian culture requests that the veteran transitions, or changes his or her behaviors to match new norms, the traits that were once used to win wars are now used as a talking point in a therapist’s office. Caplan discusses the misconceptions of military veterans as being mentally ill: “Unfortunately, most Americans, including those in the military and the VA, believe that all the vets need once diagnosed, is to be sent behind therapists’ closed doors, to be cured through psychotropic drugs or both” (281). As a combat veteran, I have experienced the push for psychotropic alternatives to my “mental illness.” Unfortunately, I have never been able to eliminate my need to check the corners of buildings, or to check the people around me for possible weapons.

Veterans may not see mental health counseling as a viable solution. Caplan, sharing my sentiments, considers the current use of not only the term PTSD, but also the treatments that are offered, to be antiquated. She posits, “that did not work for vets of earlier wars, and it will not work this time” (281). Caplan continues, “If ‘mental health problems’ result from war’s intensity, should we really be calling them ‘mental health problems,’ as though they were medically caused or brain based disorders” (168). Although the term PTSD is perpetuated by the government entities that treat it, the VA hasn’t always been happy with the use of the term. In “New Name for PTSD could mean less stigma,” Greg Jaffe, a writer for the *Washington Post*, discusses the government’s plan to erase the word “disorder” from Post Traumatic Stress Disorder: “Military Officers and some psychiatrists say dropping the word ‘disorder’ in favor of injury will reduce the stigma that stops troops from seeking treatment.” By erasing the word disorder from PTSD, the government hopes to match the term rhetorically to a physical wound. This, in the eyes of the government officials who are for the change,

would erase the stigma attached to the term. Unfortunately, the stigma and negativity attached to the diagnosis PTSD is rooted well below the topical aspects of the term; it is the motivation of the term and the use of the term that promotes the perpetuation of mentally defective images of our veterans.

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The issues with being labeled with PTSD stem from the use of language and its persuasive markers. In the *Rhetoric of Motives*, Kenneth Burke discusses the different rhetorical markers in language and the motives they represent. The danger in Burke's view is that the motives push against the principle of autonomy: "Though rhetorical considerations may carry us far afield, leading us to violate the principle of autonomy separating the various disciplines, there is an intrinsically rhetorical motive, situated in the persuasive use of language" (1338). This motive is to label the hypervigilance and emotional repression that are utilized in a combat environment as elements of a mental defect. If these characteristics (hypervigilance and emotional numbing) are drilled into a service member's head during training for the purposes of completing a mission, then the mission should be changed so that the training can be redirected to reflect the need to disassociate one's self from hypervigilance and emotional numbing.

Because the term PTSD relates to a need for mental health counseling, the mission becomes an individual action. However, if the term is eradicated and the military and the civilian population consider that what returning veterans need is a *re-training*, the stigma attached to the now mental health based identity can be changed back to what was effective in a military setting: a warrior who completes missions. Burke compares identity to grammar, a specific set of rules that governs a past structure: "The grammar was at peace insofar as it contemplated the paradoxes common to all men, the universal resources of verbal placement" (1326). The identity of a veteran is the grammar; hypervigilance and emotional numbing can also be seen as a grammar that assists the veteran in combat action. Burke refers to the change that occurs as a Rhetoric: "But insofar as the individual is involved in conflict with other individuals or groups, the study of this same individual would fall under the head of Rhetoric" (1327). The language of the dominant civilian class, or more precisely, the utilization of the term PTSD, creates a new rhetoric, which would then disturb the peace of the grammar thus leaving the veteran in danger of losing a very important identity. By changing the rhetoric of mental health back to mission-based language, the stigma can be erased and the mission can be continued.

In *The Nature of Identity and its Role in Social Problems*, Mark Bracher argues that identity is partly based upon the roles one plays in certain social situations and the ideologies that drive certain actions: "In the linguistic register alone, our sense of self is also heavily dependent on

certain systems or belief or knowledge that we have invested in, and on certain identity-bearing scripts or narratives that we have adopted" (27). The point of changing the term PTSD to reflect a re-training is evident in Bracher's concepts of identity. A veteran's "sense of self" can be determined by how the dominant belief system (civilian world) utilizes the ideologies the veteran has been "invested" in. The mental health terms that are readily associated with mental diseases only push the veteran further into the realms of isolation.

Although pushing veterans into isolation may not be the motive of the dominant civilian culture, the action does show the need of the majority to make a world where everybody follows the same types of norms. Bracher utilizes Freud's work with transference: "Freud observed the power of such scripts in what he called transference, the tendency of individuals to perceive or manipulate people and situations in order to repeat early, formative relationships and interactions with significant others" (38). Although Freud's theory, in Bracher's case, is being used to represent the power struggles in relationships, the commonalities at the macro level are vast. Veterans, especially those who are labeled as having PTSD, are in a power struggle with their civilian counterparts; Freud's theory posits that the dominant one (the civilian) is transferring certain beliefs onto the less dominant (the veteran). The identity that has kept the service member safe and was seen as the norm in the military is now categorized as defective and abnormal. Now that the veteran's identity lingers in liminality, the use of the term PTSD perpetuates the problem.

Bracher continues to describe not only the different elements of identity, but he also explains that when one's identity is put into question, there is conflict: "While having a multiplicity and diversity of identity contents renders identity more inclusive and more secure, it also introduces a new type of identity threat: an internal threat, in the form of conflict between different identity contents" (52). To clarify, Bracher describes this concept in more detail: "For example, many adults experience time conflicts between their familial and professional identity contents: time spent working often reduces the amount of time one can spend with one's family, and vice versa" (52). Relating to Bracher's argument, veterans have two broad (both identities have sub-identities that are not being discussed here: parent, husband, wife, etc.) conflicting identity contents: civilian and veteran. Both have two different sets of ideologies that call for two different plans of action in certain situations. Diagnosing a veteran places him in a social situation that is reserved for the mentally ill; however, *re-training* veterans how to use their skills (leadership, integrity, dedication, drive) in a new non-combat social situation where hypervigilance and emotional numbing are not needed, will allow them to remobilize the warrior mentality: it will give them a new mission. Bracher explains, "The most direct way of maintaining one's identity or sense of self is to engage in behaviors that

are themselves enactments of one's identity contents" (40). Veterans are hypervigilant and emotionally numb not because they have a psychological disorder but because they have not been trained to be anything else — they were not adequately prepared for their new mission.

The point of this paper is to promote self-reflexivity for the practitioners who are engaged in helping our veterans remobilize into the civilian world. The language being used, especially the term PTSD, reflects a need to treat behaviors that are seen as aberrant outside the military culture. Only through an understanding of the military culture and the linguistic markers that promote specific mental faculties will practitioners be able to create an environment that is conducive to the idea of re-training. If the civilian and the veteran collaborate, retraining becomes a team concept that could result in "a more honest acknowledgement of the emotional effects of war and wider repertoire of responses—beyond drugs, pathologizing, and shaming—to those who are suffering" (Caplan 3098).◆

#### Works Cited

- Burke, Kenneth. "A Rhetoric of Motives," in *The Rhetorical Tradition: Readings from Classical times to the Present*. Ed. Patricia Bizzell and Bruce Herzberg. Boston: Bedford/St.Martin's, 2001. 1324-339. Print.
- Caplan, Paula J. *When Johnny and Jane Come Marching Home: How All of Us Can Help Veterans*. Cambridge, MA: MIT, 2011. Print.
- Hall, Lynn K. "The Importance of Understanding Military Culture." *Social Work in Health Care* 50.4 (2011): 4-19. Web.
- Jaffe, Greg. "New Name for PTSD could mean less stigma." *Washington Post*. N.p., 05 May 2012. Web.
- "VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress." *Management of Post-Traumatic Stress Disorder and Acute Stress Reaction (2010) – VA/DoD Clinical Practice Guidelines*. Department of Veterans Affairs, 2012. Web.