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## Collateral Damage: How Can the Army Best Serve a Soldier With Post-Traumatic Stress Disorder?

Richard B. O'Connor

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**by**

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## **AN INSTITUTE OF LAND WARFARE PAPER**

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### **LAND WARFARE PAPER NO. 71, FEBRUARY 2009**

#### **Collateral Damage: How Can the Army Best Serve a Soldier With Post-Traumatic Stress Disorder**

**by Richard B. O'Connor**

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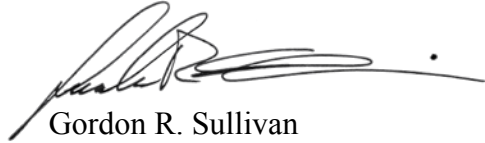


## Foreword

The number of Soldiers returning home from the wars in Iraq and Afghanistan suffering from Post-Traumatic Stress Disorder (PTSD) is staggering and frightening. The Army leadership is desperately trying to catch up with diagnosis, training and treatment of the compounding number of Soldiers suffering from PTSD. Throughout this study, the author posed the following question to Soldiers in the Warrior Transition Units: “How is the Army serving the Soldier with PTSD?”

This is an issue that concerns—or should concern—all of us. The impact of PTSD is felt not only by the Soldiers themselves but also by their families and friends, their fellow Soldiers, the Army in which they serve and the communities they return to. We as a nation owe it to these brave men and women to establish a comprehensive strategy for addressing PTSD—through thorough preparation before it occurs and identification of the symptoms and proper and immediate treatment.

Colonel O’Connor’s paper is a well-researched examination of an issue that is too often overlooked; it is also the thoughtful public expression of a father’s deep concern for the well-being of his Soldier son, and we are glad he brought it to us.



Gordon R. Sullivan  
General, U.S. Army Retired  
President, Association of the United States Army

February 2009



## Preface

As a squadron commander in the 3d Armored Cavalry Regiment during Operation Iraqi Freedom III from February 2005 to February 2006, I was responsible for the health and welfare of more than 1,000 Soldiers, over 50 percent of them on their second tour in Iraq. Unfortunately, the squadron was not provided any training on Post-Traumatic Stress Disorder (PTSD), and the Combat Support Team attached to the regiment during combat was not sufficiently effective or well integrated into the organization so that all Soldiers could receive mental health care.

As I entered my 32nd year of service, I decided it was time to reflect on my experiences and write this paper with three objectives in mind. First, as an officer, I needed to learn more about military mental health care and the impact PTSD and Traumatic Brain Injury (TBI) have had on the Soldiers and the Army. Two, as a colonel and a commander I need to understand how best to support the Soldiers suffering from TBI and PTSD and remove any stigma associated with PTSD. The third reason is personal.

My son Ryan joined the Army at the young age of 17 to serve his nation; he stepped eagerly onto the battlefield, highly trained and ready for the rigors of combat. What I believe the Army overlooked was the importance of training him and his leaders about combat stress. Ryan, a Cavalry Scout in the 4th Infantry Division's 3d Heavy Brigade Combat Team operating in the Diyala Province just north of Baghdad, experienced on a daily basis intense combat, the horror of death and, sadly, the loss of his fellow comrades in arms. On five occasions Ryan's vehicle hit improvised explosive devices (IEDs). Beyond the physical injuries with which he must cope, he is also recovering from TBI and PTSD. The constant daily flashbacks he experiences will not let him forget. He is also challenged by the loss of short-term memory, undoubtedly from the concussive force of the explosions. I am proud of his performance on the battlefield. I cannot put into words what it was like for me as a dad and a colonel in our Army to pin the Army Commendation for Valor on his chest. This paper is for him.



We are not only father and son, but also comrades in arms.

Colonel Richard B. O'Connor





## **Collateral Damage: How Can the Army Best Serve a Soldier with Post-Traumatic Stress Disorder?**

*The Army defines collateral damage as: “unintentional or incidental damage” occurring as a result of military actions.<sup>1</sup>*

*War means something different to those of us that have looked through the sights of a rifle at another human being’s face. Collateral damage means something different to those of us that have seen the lifeless body of a 9-year-old girl caught in the crossfire. Or for those of us that have struggled to save the life of a 7-year-old boy. I’ve only mentioned a fraction of what still haunts me from Iraq. I’ve been diagnosed with PTSD.*

An Iraq veteran from New Jersey<sup>2</sup>

### **Introduction**

On 19 March 2008, the Army marked the fifth anniversary of the invasion of Iraq. Since October 2001, approximately 1,640,000 U.S. troops have deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).<sup>3</sup> While advancements in medical care have saved numerous lives on the battlefield, we are faced with a growing number of Soldiers who are suffering with psychological injuries as a result of combat operations. Over 20 percent of the veterans returning from Iraq and Afghanistan have Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD) or both. A recent study by Rand Corporation determined that about one-third of returning servicemembers report symptoms of mental health problems or cognitive issues.<sup>4</sup> As the war wears on and these Soldiers continue to endure multiple combat tours without treatment, what is the impact on our Soldiers and their families? Are the Army and the Veterans Administration ready for the onslaught of Soldiers seeking mental health care in the near future?

PTSD is a wound the surgeon never sees, yet proper diagnosis and treatment are instrumental in helping Soldiers integrate back into their families and communities. According to the Mental Health Advisory Team IV (MHAT-IV) final report dated 17 November 2006, 20 percent of OIF 05–07 Soldiers and 15 percent of OIF 05–07 Marines screened positive for one or more mental health issues.<sup>5</sup> By December 2006, one in four Soldiers discharged after serving in OEF and/or OIF had filed disability claims, and more than 40,000 have been diagnosed with PTSD.<sup>6</sup> As multiple deployments have become the norm and Soldiers are seeking ways to deal with cumulative doses of combat, how effective is the Army in diagnosing and treating PTSD? What steps are unit leaders taking to ensure that their Soldiers are getting the treatment they need and to reduce barriers to care and dispel the stigma associated with PTSD? How confident is the Army leadership that everything has been done to prevent Soldiers with PTSD from returning to combat

without the proper medical care? As the war goes on and the number of Soldiers returning with mental health concerns continues to rise, is the Army being proactive to ensure that sufficient numbers of behavioral health professionals are available to diagnose and treat Soldiers with PTSD? Finally, is the Army support network standing by to assist Soldiers and their families before, during and after deployment?

While many assume the answer must be yes, there are Soldiers who are unable to find this network or count on their leadership to assist them with their psychological disorders. They end up dealing with the mental health situation alone. Case in point: A 31-year-old sergeant, father of two, who was undergoing treatment for excruciating headaches, died alone in his barracks room.<sup>7</sup> We cannot allow our sons and daughters who defended our nation in a time of war to suffer by themselves with personal tragedies such as domestic violence, homicide and suicide that emerge as they return to this great nation and reintegrate into society. PTSD is an injury that is hard to diagnose and more difficult to treat; as a result, most cases go untreated and will seriously impact the lives of our heroes for years to come. The global war on terrorism has brought to light the importance of the psychological health of military servicemembers, their families and survivors. The Department of Defense (DoD) created a Task Force on Mental Health with the mission to identify shortfalls, produce actionable recommendations and assist the military in rapidly developing and implementing a plan of action to identify, diagnose and treat servicemembers afflicted with PTSD.

This paper will examine the roots of PTSD and its historical significance; capture from Soldiers' testimonies the trials and tribulations of dealing with PTSD and how it affects them; examine what the Army studies have revealed; and recommend what the leadership should do to best serve Soldiers with PTSD now and in the future.

How does the Army best serve a Soldier with PTSD? Clearly, with the wars in Iraq and Afghanistan now in their sixth and eighth years, respectively, and expected to last well into the first quarter of the 21st century, it is paramount that we find the answer. We must not only properly diagnose and care for Soldiers with PTSD, but also develop preventive measures so that we do not send them back into combat. We begin by understanding the history of this condition now called *Post-Traumatic Stress Disorder*.

## **A Look in the Rearview Mirror**

Twenty-seven centuries ago, in *The Iliad*, Homer described two common events that occur as a result of heavy, continuous combat: "betrayal of 'what is right' by the commander and the onset of the 'berserk state.'"<sup>8</sup> A berserk state in this context applies to anyone who fights with reckless abandon and disregard for even his own life, a concept described during the Vietnam War and in Vietnam-inspired literature (Michael Herr's *Dispatches*) and film (Oliver Stone's *Platoon* and Adrian Lyne's *Jacob's Ladder*).

Modern theories of PTSD evolved from the 19th century concept of traumatic neurosis.<sup>9</sup> Sigmund Freud was intrigued by the post-combat psychological reactions Soldiers experienced.<sup>10</sup> Freud and Josef Breuer, in their classic work *Studies in Hysteria*, viewed neurosis as resulting from instinctual drives clashing with reality. Department of Veterans Affairs psychiatrist Jonathan Shay, scholar and author of the book *Achilles in Vietnam*,

draws a parallel between behaviors and symptoms of Greek heroes over 2,700 years ago with those of our Vietnam veterans.<sup>11</sup> Shay clearly implies that PTSD has been around as long as war itself. For centuries, thousands of Soldiers who went into harm's way to fight the nation's wars returned home with wounds no surgeon ever saw. So let's go back in time over several of our nation's wars and conflicts to identify what the military has done to properly diagnose, treat and care for Soldiers suffering with PTSD.

### **The American Revolution**

The Continental Army under the command of General George Washington understood the importance of morale and *esprit de corps* as a means of retaining Soldiers in combat and preventing desertion during long periods of inactivity, such as the winter at Valley Forge. The Army was plagued with combat psychological stress disorder that accounted for 50 percent of the deaths from 1817 to 1828.<sup>12</sup> Nostalgia, psychosis and chronic situational depression that led to severe alcohol abuse were some of the symptoms the Soldiers suffered as a result of combat operations. Clearly, similar symptoms of combat stress were prevalent then as today, though without the more elaborate definition.<sup>13</sup>

### **The American Civil War**

During the American Civil War, the Union Army documented more than 7,800 cases of "insanity" and "nostalgia."<sup>14</sup> Many Soldiers suffering from what are now recognized as symptoms of PTSD were released and sent home, which created a public outcry. The result was a War Department order in 1864 requiring the transfer of these Soldiers to government hospitals until their families could retrieve them.<sup>15</sup> The term "irritable heart" was applied to those Soldiers who experienced symptoms of chest pain, shortness of breath and anxiety—symptoms synonymous with those we currently associate with combat stress or PTSD.<sup>16</sup> Psychologists in the Union and Confederate armies did not have the requisite clinical or practical experience with combat-related stress. Thus, their understanding of combat stress symptoms and the means to treat them were inconsistent.

Battlefield commanders commonly referred to Soldiers suffering from symptoms of combat stress as malingerers or cowards. The commanders' lack of practical experience with proper identification of and prognosis for combat stress disorders resulted in the labeling of those Soldiers as deserters. The punishment for desertion was execution by a firing squad; deserters' bodies were buried where shot in an unmarked grave to erase their existence.<sup>17</sup> Medical discharge for psychological stress was virtually impossible.<sup>18</sup> Studies indicate that 10 percent of the Union and Confederate forces deserted, and it is hard to say how many of those desertions were due to traumatic stress.<sup>19</sup> However, Dr. Eric Dean analyzed the medical records of 291 Civil War veterans who had been committed to the Indiana hospital for the insane and determined that the symptoms those veterans experienced were similar to those of Soldiers diagnosed today with PTSD.<sup>20</sup>

### **World War I**

Soldiers who served in World War I were exposed to modern weaponry and a new battle environment called trench warfare. One can only imagine what goes on in the mind

of a Soldier trapped in a cold, muddy, rat-infested trench waiting for the next artillery shell to hit his location. Thousands of Soldiers who faced the horrors of trench warfare were traumatized and suffered serious injuries as a result of modern and sophisticated weaponry such as the machine gun and artillery. “Shell shock” was the term coined to denote the dazed, disoriented state Soldiers experienced on the battlefield.<sup>21</sup> World War I produced record numbers of post-traumatic stress casualties. In 1914, British Soldiers evacuated for combat-related stress numbered just under 2,000; the number grew to a staggering 20,000 by 1920. More than 50 percent of the Soldiers evacuated were psychiatric cases.<sup>22</sup> During World War I, British forces lost 80,000 Soldiers—one-seventh of all disability discharges—to shell shock.<sup>23</sup>

Those who suffered from shell shock felt they had received a literal shock to their central nervous system. They experienced symptoms such as staring eyes and violent tremors; many became deaf, blind or paralyzed even though they were not physically injured.<sup>24</sup> Dr. Charles Myer, a psychiatrist who coined the term “shell shock,” looked for a physical explanation, such as lesions on the head.<sup>25</sup> British and French psychiatrists began to treat shell shock by going forward on the battlefield and placing psychiatrists in forward hospitals.

In 1917 Thomas Salmon, an emissary for the U.S. Army Surgeon General, collected and analyzed this data and developed a comprehensive program for the prevention and treatment of shell shock, eventually renamed “war neuroses.”<sup>26</sup> Salmon’s initiative was accepted into Army doctrine because it was the first rational system of echelon psychiatry in the U.S. military.<sup>27</sup> Three guiding principles—proximity, immediacy and expectancy (collectively known as “PIE”)—became the cornerstone of military psychiatry. Proximity calls for treating Soldiers as close to the battle scene as possible. Immediacy means providing rest, food and a warm shower to rest body and mind and, most important, talking to the Soldiers and telling them that they are not ill and will soon be rejoining their comrades. Finally, expectancy is the central principle from which the others derive. Soldiers treated immediately near the unit have a higher probability of returning to their comrades in arms. The psychiatrist offers a diagnosis to the Soldier by stating something like this: “Understand you are not sick or a coward. You are just tired and will recover when rested.”<sup>28</sup>

Despite these advancements, commanders still viewed the symptoms as a sign of weakness, and stigma was associated with this condition. As Soldiers returned to the United States after the war, there was no health care system specifically dedicated to the returning veterans; the Public Health Service was responsible. By 1921, the number of patients seeking care was eight times higher than before the war. Many of the veterans found themselves sleeping on cots in the halls of the crowded hospitals and, not coincidentally, many just gave up seeking treatment. Furthermore, many of the veterans with mental illness believed they would get better since they were home with family and off the battlefield.

Colonel Albert Glass, a military psychiatrist who studied front-line psychiatry during World War I and implemented this concept in both World War II and the Korean War, discovered the following:

Neurotic war veterans, separated from dynamic elements of the combat situation, seemed to have combined or integrated battle trauma with the neurotic elements of personality to form a fixed psychological disorder which reacted to usual difficulties as if they were battle stimuli. In effect they fought the battle of civil life with the wartime symptoms of tension, noise sensitivity, and explosive outburst of rage, helplessness and battle nightmares.<sup>29</sup>

Colonel Glass reported that placing mental health professionals forward on the battlefield was very effective in treating combat-stressed Soldiers and returning them to their units by advising them to suppress their feelings and emotions; the extent of the damage to the mind of suppressing emotions until the Soldiers returned from war was not clearly understood. Years later, it was determined that combat stress is intractable, unpredictable and often irreparable. Of the 300,000 disabled veterans of World War I, about 50,000 were still hospitalized twenty years later for psychiatric illnesses.<sup>30</sup> By that time, America was on the brink of a second major conflict.

## **World War II**

When the U.S. military entered World War II, armed forces medical personnel were not prepared to implement the forward psychiatry that had been devised during World War I.<sup>31</sup> The progress made during World War I regarding post-traumatic stress—including the psychoanalytic notion of a prescreening process that would attempt to identify those individuals who could not withstand the horrors of combat, shell shock and battle fatigue—was lost.<sup>32</sup>

The lessons learned in combat psychiatry during the Spanish Civil War (1936–1939) were not available until after World War II. Most of that conflict's casualties were Germans, Italians and Spanish. A Spanish military psychiatrist, Dr. Emilio Mira, implemented the forward treatment concept as developed by Salmon's 1917 work and combined this with prescreening. Dr. Mira devised 17 questions for recruits to answer. When interpreted, these allowed the physician to assess motivation, intelligence and, it was believed, the probability that the recruits were likely to suffer from war neurosis. Among the questions asked were: "Do you ever faint?" "Do you suffer from dizziness?" and "How often would you like to have a seven-day pass and where would you go to spend the time?"<sup>33</sup>

As a result, psychiatrists were not assigned to combat divisions, and psychiatric treatment units were not formed and attached to tactical units to support forward treatment on the battlefield. Military physicians opted to utilize a psychological prescreening as a means to minimize casualties associated with combat stress. Any draft registrant with a history of psychiatric disturbance was not admitted to military service.<sup>34</sup> As a result, 15 million armed forces recruits were rejected because of psychiatric disorders.<sup>35</sup>

As the war continued, it became clear that—despite the efforts to identify and eliminate individuals unfit for military duty—all men, no matter how brave, are vulnerable to combat stress.<sup>36</sup> In other words, everyone has a breaking point, and the military needed to shift from just prescreening to treatment for combat stress forward on the battlefield.<sup>37</sup> A study conducted on a cohort of 1,000 Soldiers from the European Theater of Operations found

that the breaking point of the average rifleman was 88 days of continuous combat in which the unit sustained at least one casualty.<sup>38</sup> Understanding the relationship between combat exposure and combat effectiveness was instrumental in determining the importance of combat rest and recuperation (R&R) and, if necessary, rotation of troops or units.

Another critical finding during World War II was the importance of unit cohesion in preventing breakdowns and improving combat effectiveness. S. L. A. Marshall, in reviewing his experiences in World War I, World War II, Korea and various Arab-Israeli conflicts, noted:

When fire sweeps the field, be it in Sinai, Pork Chop Hill or along the Normandy coast, nothing keeps a man from running except a sense of honor, of bound obligation to people right around him, of fear of failure in their sight which might eternally disgrace him.<sup>39</sup>

Cohesion was one of the most important means of preventing and treating psychiatric casualties. Matthew D. Parrish, an eminent psychiatrist who served in combat air crews during World War II, observed that combat fatigue patients who had regular visits from their units and were encouraged to return were far more likely to do so.

Among the lessons learned from World War II regarding combat stress are:

- Psychiatric casualties are “an inevitable consequence of life-threatening hostilities.”
- Prescreening for psychological disorders will not prevent combat stress.
- Forward treatment is very effective in treating combat stress and quickly returning the Soldier back to the unit.
- Unit cohesion is instrumental in preventing and treating combat stress on the battlefield.

### **The Korean War**

At the onset of the Korean War, the military chose not to implement many of the lessons learned from World War II; as a result, psychological casualties were three times higher.<sup>40</sup> Instead of treating casualties forward on the battlefield and implementing the PIE treatment, the Army evacuated Soldiers to the rear and away from combat. This changed, however, when Colonel Glass became the theater neuropsychiatry consultant and quickly reinstated the U.S. combat psychiatric treatment program.<sup>41</sup> Combat stress casualties were treated forward by the battalion surgeon or an experienced medic. Glass also recommended a rotation system for troops, and the concept of R&R went into effect. The rotation system called for R&R after nine months for Soldiers in combat and after thirteen months for those in support units. If tactically feasible, whole units would go into R&R together to keep unit cohesion intact. As a result, psychiatric casualties accounted for only about 5 percent of medical out-of-country evacuations.

However, a new psychiatric problem soon arose among Soldiers in rear-echelon units. As the war progressed, more and more support units were deployed to theater and eventually

outnumbered the combat troops. In some cases, Soldiers in rear-echelon units that were not consistently on mission became bored; their morale was low, and they ultimately stressed over being homesick. They were also deprived of the enhancement of self-esteem provided by exposure to combat. As a result, some of the Soldiers sought relief through use and abuse of alcohol and drugs. While these Soldiers were disciplined appropriately, the root cause of their problems was not taken into account.

## **The Vietnam War**

American involvement began in 1955 with the arrival of the first U.S. military advisors. The first combat troops arrived in 1965, and the war raged on until the cease-fire of January 1973. The initial buildup of forces was slow, and psychological casualties were not easily identified or reported.<sup>42</sup> Most of the Soldiers serving in Vietnam were drafted and lacked recent combat experience. The morale, *esprit de corps* and unit cohesion ranged from low to high depending on the unit and the types of missions the unit accomplished.<sup>43</sup> The Vietnam War was a low-intensity guerrilla conflict fought without a front line. As in Iraq and Afghanistan, the enemy would hide amidst the civilian population. Most of the fighting took place at night in small-scale operations in a hostile, nearly impenetrable jungle.<sup>44</sup>

In some units, after a mission was complete, Soldiers returned to a fairly secure base camp to decompress and talk about the mission. This allowed for early diagnosis and treatment of some psychiatric casualties forward on the battlefield and contributed to the low number of combat-stressed Soldiers. Additionally, the Department of Defense implemented the 12-month rotation policy, which limited the amount of prolonged exposure to combat. Finally, advances in technology and the use of the helicopter were instrumental in quickly evacuating the wounded to nearby combat support hospitals.

Despite forward treatment and technological and other policy changes, approximately 19 percent of the more than three million servicemembers who served in Vietnam returned with PTSD.<sup>45</sup> The Vietnam War not only lasted longer than any previous war in which Americans fought, it was also the most unpopular. Fifty-eight thousand Americans lost their lives; for many of the more than two million American veterans of the war, the wounds of Vietnam will never heal. The toll in suffering and sorrow still lingers on and will never be fully appreciated.

## **Post-Vietnam War through the Gulf War**

It was not until after the Vietnam War concluded that the high number of returning veterans experiencing post-traumatic stress generated a significant amount of attention and concern from the American people and the U.S. government.<sup>46</sup> Moreover, it was not until 1980 that PTSD became a term for the combat stress disorder endured by Soldiers. As Dr. Matthew J. Friedman, a physician working in the Veterans Administration, recalled, "People were flooding the clinics, demanding that we do something for their distress. We had no clinical terminology for what we were seeing. Their suffering was so raw."<sup>47</sup> About three quarters of a million combat veterans from Vietnam are still alive today; some 250,000 of them still suffer from PTSD.<sup>48</sup>



In an interesting side note, not long after the Vietnam War, Israel was attacked by its neighbors in what became known as the Yom Kippur War.<sup>49</sup> Initially, the Israelis did not implement the psychiatric lessons that both the Americans and the British learned from previous wars, and their Soldiers suffered high rates of combat stress casualties. By 1982, the Israeli military changed their doctrine and implemented forward psychiatric care on the battlefield. During the invasion of Lebanon, they saw an improvement in the number of combat stress-related casualties. The Israelis still experienced a 25 percent rate of combat stress casualties among those wounded in action.<sup>50</sup>

In the 1991 Gulf War, it was reported that as many as 10 percent of U.S. military personnel suffered from PTSD.<sup>51</sup> The Millennium Cohort Study (July 2001–June 2003)—the largest prospective health project in military history—evaluated the long-term health effects of the military, including deployments. The Department of Defense recognized after the 1991 Gulf War that there was a need to collect more information about the long-term health of servicemembers. The study reported that of the 74,947 surveyed, 2 percent reported PTSD symptoms.<sup>52</sup> Self-reported exposure to chemical or biological warfare agents and protective countermeasures was associated with PTSD symptoms.<sup>53</sup> The lack of information and lessons learned on mental health care on the battlefield may have contributed to the U.S. military’s failure to recognize the importance of PTSD training and the use of Combat Support Teams.

## **Operation Enduring Freedom/Operation Iraqi Freedom**

Since October 2001, approximately 1.64 million U.S. troops have deployed to Operation Enduring Freedom (OEF) in Afghanistan and to Operation Iraqi Freedom (OIF), and many have been exposed to prolonged periods of combat-related stress or traumatic stress.<sup>54</sup> Rand Corporation recently completed a detailed report on PTSD, depression and TBI. The team surveyed a representative sample of current servicemembers and veterans about their current health situations as well as access to care. The survey of 1,965 recently returned servicemembers indicated that 18.5 percent of them meet the criteria for PTSD or depression. If the numbers are representative of the 1.64 million deployed to date, the study estimates that approximately 300,000 veterans who have deployed to OEF and OIF are currently suffering from PTSD.

Mental health care clinicians agree that “gaps” exist in understanding the full psychological effect of combat. Most studies have examined the effects of combat among veterans years after their exposure to combat operations, and little research exists today that examines a broader range of mental health outcomes closer to the time of deployment and redeployment.<sup>55</sup> Research and analysis are needed to systematically assess the mental health of members who have deployed to Iraq and Afghanistan and make the appropriate recommendations to doctrine, policy and procedures for optimal delivery of mental health care to returning veterans. With the high number of Soldiers returning with PTSD—and an even higher percentage for those with multiple deployments—it is imperative that we develop a system to quickly and effectively identify and treat returning Soldiers suffering from PTSD.

## Defining Post-Traumatic Stress Disorder

While historical and literary references regarding the aftereffects of psychological trauma date back to the third century, official recognition of PTSD occurred only 28 years ago.<sup>56</sup> The current diagnosis of PTSD actually begins with the 19th century concept of traumatic neurosis. As noted, the concept that PTSD produces physical disabilities was recognized from “shell shock” casualties during World War I.<sup>57</sup> Since World War II, there have been at least 80 different names for combat stress. It wasn’t until 1980 that Dr. Robert Jay Lifton and Dr. Chaim F. Shatun’s work on the treatment of combat stress paved the way for the American Psychiatric Association to refine the definition for combat stress reaction by placing the patient in either the Adjustment Disorder (depressed mood, anxious mood, etc.) or the Post-Traumatic Stress Disorder category. This revision, an addition to the third edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM-III), addresses the recognition that PTSD can evoke significant symptoms of distress in almost everyone.<sup>59</sup> It also stipulates that the disorder can be divided into acute (duration of symptoms less than six months), chronic (duration of symptoms six months or more) and delayed (onset at least six months after the traumatic event).<sup>60</sup> The current *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV), defines PTSD as follows:

The essential feature of Post-Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).<sup>61</sup>

The Defense Department’s Force Health Protection and Readiness website defines PTSD as:

. . . a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. Most survivors of trauma return to normal given a little time. However, some people will have

stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.<sup>62</sup>

The definition of PTSD in the DSM-IV includes a new category, Acute Stress Disorder, for symptoms that occur during or soon after the traumas, last for at least two days and cause clinically significant distress. If the symptoms persist beyond four weeks, the condition becomes acute PTSD. DSM-IV also identifies those individuals who need additional recuperation and treatment lasting from seven to 14 days. Finally, it also addresses individuals who experience stress but can remain in their unit and be given one to two days' recovery and then return to duty. This is a critical delineation and places the importance of forward mental health care on Combat Stress Teams embedded in the brigades in order to treat and release the Soldier back to his or her unit within a few days.

## **Soldier Testimonies**

In the course of my research, I conducted several interviews in a military treatment facility's Warrior Transition Unit (WTU) with Soldiers who were diagnosed with PTSD. The intent was to determine from the Soldiers themselves how the Army has responded to them. To protect their identities and also capture the true essence of their experiences without their experiencing any fear of reprisal, Soldiers are identified by pseudonyms, and I've disguised the Army post where the Warrior Transition Unit is located. What follows is a brief vignette of each Soldier, including what each would say if offered the opportunity to talk with the Army Chief of Staff about how best to take care of a Soldier with PTSD.

### **A Second-Generation Soldier**

Specialist Beltz, a 30-year-old combat infantryman from California, is suffering from extreme PTSD. His father was a Navy Seal and his mother was a Marine. Recently, his parents separated. He has two brothers to whom he looks for advice. After graduating from high school, he joined the Army. Deployed to Iraq from May 2005 to May 2006 with the 4th Infantry Division, Specialist Beltz was a model Soldier and received multiple combat awards during and after deployment. He was highly trained but did not receive any personal or unit training on PTSD prior to or during deployment, nor was he prescreened for PTSD. During his deployment, Specialist Beltz experienced day-to-day combat operations.

While he said little about his marriage, he did mention he was served divorce papers while in Iraq. What is now most important to him is his five-year-old daughter. Sadly, after redeployment he exhibited an extremely short temper (not the case before deployment) and found himself screaming at his daughter on a few occasions; he feared that he had PTSD. He has serious short-term memory problems and is taking five different drugs for all the symptoms he is experiencing. He believes that many of his comrades have PTSD as well, and that some do not even know it. He wants to stay in the Army and go back to

Iraq with his unit. As I talked with him, it was clear how passionate he was about the Army. Yet I could also tell that there were memory problems and that he seemed to have an axe to grind. So what would Specialist Beltz say to the Army Chief of Staff about Soldiers suffering from PTSD?

*I would tell him that I am a different person today than I was before I deployed to Iraq. I ask that [the Army leadership] please talk to us before judging us on who we are, what we do and what [they] can do to help. I want to stay in the Army, it is what I love, and I really appreciate people thanking me for what I do. All we ask is for some help and understanding.*

### **Following in Her Grandfathers' Footsteps**

Specialist O'Brien is a 22-year-old combat medic from Colorado suffering from PTSD. A high school graduate, she lettered in volleyball. She comes from a family with a military history; both grandfathers served in the Army. Her family's service is what motivated her to join the Army. Specialist O'Brien says that she received excellent training in preparation for combat. She was assigned to an Engineer Unit that deployed to Ramadi in support of a Marine division from 2005 to 2006.

I asked her about the best and worse experiences she encountered while deployed. She immediately talked about visiting the villages and spending time with the children, medically checking them out and talking with them. She then told me about a suicide vehicle-borne improvised explosive device (SVBIED) that was driven into a bus loaded with children while she was in the village. After the explosion, she went to treat the children. One girl (who looked like her niece) died in her arms, and the flashbacks of that experience, she says, come back to haunt her every time she sees a school-age girl.

Just before this experience she went home on R&R because her grandfather was dying. She recalled that the R&R was extremely stressful; at the time she felt closer to the Army family she'd left back in Ramadi. Her family, Specialist O'Brien said, just did not know what she was going through, and "it was too difficult to explain it to someone that can't understand." A month after her R&R, she was struck by shrapnel from a 122mm rocket that hit the base; the shrapnel injured her neck, and she suffered severe ear damage. She was flown first to the Army's Landstuhl Regional Medical Center in Germany and then back to a hospital in the continental United States (CONUS) for more advanced treatment.

Of the 50 Soldiers in her platoon, she reports, more than 50 percent have some degree of PTSD. While in Iraq many Soldiers came to her about PTSD and asked what she could do to help them. Soldiers do not want to talk openly about PTSD, she says; they think it is "something that happens when you go crazy," and they fear the associated stigma. She believes that the more often a Soldier goes on a mission, the more likely he has a more serious form of PTSD. When I asked Specialist O'Brien about the use of the Combat Stress Teams while deployed to Iraq, she dismissed them as "not helpful in treating PTSD. They were not familiar with the Soldiers' situation leading up to their symptoms and the Soldier was reluctant to repeat what he or she encountered."

SPC O'Brien was not tested for PTSD when she returned to CONUS in the summer of 2006; she received testing only after she was assigned to the WTU in June 2007. Before the WTU, she was assigned to the Medical Hold Unit and reported to a civilian once a day to go over her scheduled appointments. "It was a total waste of time." If she had the opportunity to tell the Chief of Staff of the Army how effectively the Army has responded to a Soldier with PTSD, she would say:

*In my opinion, I think the Army needs to do PTSD testing before deployment. When I did my PTSD testing, the doctors had nothing to compare my test results to. I have experienced that every Soldier handles PTSD differently. For example, I lost my hearing and suffer from neck injury and limited motion in my right arm from the rocket hitting near me. Another Soldier lost her right leg due to an IED. Neither of us suffers from extreme PTSD. I have also seen Soldiers who got whiplashes in an IED attack and had to be sent home early because they could not continue mentally. I believe in pre-deployment testing where you can accurately rate PTSD instead of using their own ideations of what PTSD rates are. I would suggest that the PTSD testing be conducted more than once . . . after redeployment. I would recommend three tests, one immediately after redeployment, again six months later and the third time a year after. I have witnessed Soldiers with PTSD at different times long after we redeploy. I experienced my worst time with PTSD long after my surgeries and about a year after redeployment.*

### **Frozen in the Moment**

Specialist James, a Transportation Specialist from California, suffers from extreme PTSD. He did not graduate from high school. He left a broken home when he was 14 years old and lived with friends until he was 17. He finally dropped out of school to find work and completed his GED when he was 18. He joined the Army and deployed to Iraq with the 101st Airborne Division from April 2005 to April 2006.

Upon arrival in theater, he was assigned to be the gunner on a gun truck that conducts convoy escort duty for support missions from Baghdad to Ramadi and back. For several months, he conducted a convoy escort mission every day. During the first few months he found eight IEDs. After about seven months of continuous "out of the wire" missions, Specialist James was given a "day off," while a fellow Soldier took his place. That evening, while on the mission, the gun truck hit an IED, and the Soldier who had taken his place was seriously wounded. SPC James realized that this incident and the continuous day-to-day missions were beginning to take a toll on him physically and mentally. He was not getting sleep. He would spend "a lot of time in the fitness center."

Then several days later, while out on a convoy escort mission as the gunner of the lead gun truck in the convoy, he saw a fast-moving car approaching straight at his vehicle. Instead of taking the appropriate and immediate actions he was trained to perform and had performed on many missions before, he just froze. The vehicle swerved around his truck and began to approach the convoy. The vehicle loaded with explosives was taken out by

another gun truck. He told me that he was not sure exactly what was going on with him and why he froze as opposed to doing what he was trained to do and what he had done previously.

At the nine-month mark in his tour and immediately after this mission, both Specialist James and the chain of command decided it was time for him to go home on R&R. Before leaving on R&R, “my squad leader told me to visit the Combat Stress Team. I went to see them, and they were all wearing clean white coats and did not appreciate what I had been through.” He left and did not return.

Upon arriving home, he quickly realized that his wife was constantly crying and that something was wrong. He recalled waking up in the middle of the night and having his wife in a chokehold. Sometime later, a friend told him that his wife was “sleeping around and that this guy was driving my car and sleeping at the house when I was deployed. I went to discuss it with my wife and it exploded into a bad situation.” The police arrived and Specialist James, uncontrollable, was Tasered by one of the officers. He went to the hospital, where a psychologist informed him that he needed to be treated for PTSD. Specialist James did not redeploy to Iraq and subsequently joined the WTU to be processed out of the Army.

When we spoke, Specialist James was in the process of integrating back into civilian life while finishing his last few months in the WTU. He spends much of his time talking to veterans at the local VFW post, and he believes that is great therapy for him. Specialist James said he had never heard of PTSD and had received no training, though he knew of other Soldiers in his unit who were experiencing similar symptoms of flashbacks and sleepless nights. Specialist James voiced the feeling that his leadership had failed him and should have realized what was going on with him and the number of missions he was on. He did not receive testing for PTSD upon deployment for R&R, as he came back separately and not with his unit. He hopes to leave the Army in a few months and land a job as a heavy equipment operator in Colorado. He told me that the WTU is an excellent unit and all the Soldiers understand and appreciate what he is going through. Given a chance to speak with the Army Chief of Staff about how the Army is supporting Soldiers with PTSD, Specialist James would:

*... tell him that the Army needs to conduct training on PTSD. I did not receive any training prior to deployment. I would also tell him that Soldiers need time to decompress between missions. Finally, I would recommend that all Soldiers returning from combat are tested for PTSD. I came home for R&R and did not return, and as a result, I did not take a test for PTSD. The only thing that saved me was seeing a psychologist before everything went bad.*

### **No Purple Heart for Rape**

Specialist Blane is a 23-year-old Oklahoman, a high school graduate who lettered in soccer. Like many young troops, she was motivated to join the service after 9/11. A supply specialist, she reports having received superb training in preparation for combat. She talked at length about the quality of the noncommissioned officers (NCOs) and how taking care

of Soldiers was their number one responsibility; not long into the conversation, it became apparent why that was a priority for her.

Specialist Blane suffers from PTSD as a result of being raped while in Iraq in 2005 during a nine-month deployment; her assailant was another Soldier. Some time after the assault, she went home for R&R and never returned to her unit. After returning to CONUS, she vividly recalls, she attended a mandatory training class on sexual harassment and “during the instruction I went crazy.” She was immediately tested and diagnosed with PTSD and began seeing a doctor for treatment. She began to experience flashbacks and attacked her husband. She soon realized that her mood swings went from depressed to emotional, especially after experiencing a flashback from Iraq. She was assigned to the Warrior Transition Unit after the unit was activated in 2007. She told me that her experiences at the WTU were excellent. The chain of command was responsive to her situation and made sure that she was receiving the care necessary for recovery. She indicated that she felt better and was looking forward to leaving the Army soon. Here is her message for the Army Chief of Staff:

*Soldiers must be trained on PTSD before deployment. They must know what symptoms to look for and how to diagnose. Every Soldier I saw experiences PTSD a little differently. Also, the Medical Evaluation Board paperwork is extremely cumbersome and takes way too long to process. I had to redo the paperwork four times and now it has been over a year. I also recommend that if the Soldier is going to leave the service and must wait for the paperwork, why not begin the process for transitioning out of the service while waiting on the paperwork. I have been doing menial tasks like working at the bowling alley, and I could have been going to school or starting a full-time job.*

## **A Psychologist’s Perspective**

After interviewing the Soldiers at the WTU, I decided to talk with Ms. Newman, a psychologist, to obtain insights regarding the diagnosis and treatment of PTSD in the Soldiers in the Warrior Transition Unit. Currently the chief of the psychology department, she has been practicing psychology and treating Soldiers suffering from combat stress for more than eleven years.

After completing her internship at Dwight David Eisenhower Medical Center, she entered active duty as a captain (psychologist) in the Medical Service Corps, serving her first assignment at Fort Drum, New York, with the 10th Mountain Division.

Not long after she arrived, she deployed to Somalia with the Combat Stress Team and saw several Soldiers with symptoms of deep depression, anxiety and extreme anger. She believed that the Soldiers who witnessed the horror of death, loss of life and extreme violence were experiencing symptoms closely associated with PTSD. She also witnessed the stigma associated with combat stress by the leadership. Some officers were also suffering from PTSD but chose to see her in the middle of the night so that no one would know that they were experiencing depression, flashbacks and sleepless nights. It was then that she began to realize the depths of the stigma associated with PTSD—the stigma that

leads to the suppression of emotions and the shame associated with sharing your feelings and is rooted in a Soldier's earliest days in the service. At the U.S. Military Academy at West Point, for example, new students are shouted at on day one: "You can't display emotion around here!"<sup>63</sup>

After returning from Somalia, Captain Newman deployed to Haiti, where again she began to see patients who were suffering from PTSD. Upon returning from Haiti, she was assigned to the National Training Center (NTC) staff at Fort Irwin, California. There she treated several Soldiers in the Observer Controller (OC) Group for depression, high stress, anxiety and pain management. She soon learned that after long hours spent working, sleeping and eating in their military vehicles, what the OCs need most is someone to talk to—someone who understands the Army life and can help them through the trials and tribulations of being in the field for weeks at a time training units preparing for combat.

Ms. Newman left Fort Irwin and active duty in 1995 and began working as a civilian psychologist at an Army hospital in the United States. Her experiences in the Army provide her with valuable insights into Soldiers' combat stress and how best to diagnose and treat it. Her understanding also instills confidence in the Soldiers. They open up to her, describing what they encountered and sharing their anxieties; as a result, they are quickly on the road to recovery.

Over the past few years, Ms. Newman has seen a steady increase in the number of Soldiers suffering from PTSD. The most troubling aspect is the associated stigma, which derives from the barriers to finding treatment imposed by the Soldiers' chain of command. Soldiers have recounted horrible experiences, such as harassment of those who have mental health issues. (One unit put all the Soldiers suffering from PTSD in an outfit called the "Yellow Platoon"; it doesn't take much imagination to figure out the implication.) In some units, the leadership makes it extremely difficult for the Soldiers to get treatment. For example, during daily formation, one senior NCO would call out loudly the names of Soldiers suffering from PTSD and embarrass them. Again, this speaks to the association of shame—whether an individual has what it takes to be the epitome of a seasoned combat Soldier. Another NCO would not allow his Soldiers to leave the unit to see a psychologist at the hospital. In short, Soldiers who fail the tests of "manhood" are publicly shamed, humiliated and made a negative example for others.<sup>64</sup> Ms. Newman believes that if a unit's leaders fail to recognize the symptoms of PTSD, they certainly cannot clearly understand what their Soldiers are going through. She strongly believes that if the leadership would take the time to talk with Soldiers suffering with PTSD, they would take the steps necessary to dispel the associated stigma.

Soldiers, Ms. Newman asserts, should be provided with the training and education about treatment capabilities immediately after redeployment. This is the first step to destigmatizing mental health treatment. She recalled specifically an example of a Soldier suffering with extreme anxiety and depression from a traumatic event during his deployment in Iraq. This Soldier, she reminisced, had entered the Army with his close friend from the same hometown. After completing basic and advanced individual training, they received assignments in the same unit and, shortly after arriving, each married. Clearly this Soldier's



life was closely bound to that of his friend and comrade. It was while both were deployed to Iraq and serving together on a mission that an SVBIED hit his buddy's vehicle. The Soldier immediately raced to apply first aid, putting tourniquets on all four limbs; his friend died a short time later en route to the combat support hospital. The blood on the surviving Soldier's uniform and on his body took weeks to fade, and the images from that horrific event will forever linger in his memory. Neither the Soldier nor his chain of command recognized immediately that he was going to need help to recover.

Ms. Newman has recently seen an increase in the number of female Soldiers suffering from PTSD. Most of the female Soldiers she has seen were combat medics who are experiencing anxiety disorders, depression, constant atrocious flashbacks and nightmares. She mentioned that, unlike the male Soldiers, females normally do not revert to alcohol or violence to relieve their stress. Nevertheless, they seek to keep the traumatic experiences to themselves, and it is hard for them to open up. Ms. Newman believes the first step to recovery is getting them to talk about their experiences, letting them know they are in good hands, and assuring them that their health will get better. Her biggest concern is that the Soldiers are not getting the treatment they need before they have to redeploy. *"By the time the Soldier begins his or her treatment, they are back in the training window for deployment."* She is very concerned that many Soldiers are not completing their treatment before they return to combat and will only get worse during their deployment. Additionally, with the increase in PTSD candidates and the requirements to deploy key staff members to OIF and OEF, the Behavior Health Department is unable to support all the Soldiers suffering with PTSD. Ms. Newman stated:

*The Combat Brigades have less than one year in between deployments to treat Soldiers with PTSD and it is therefore paramount the unit leadership work collectively to reduce the stigmatization and allow the Soldiers to obtain the treatment necessary to either return them back to their respective unit or be medically discharged and enrolled into the VA for follow-on treatment.*

## **Emerging Themes**

Based on the discussions with Soldiers suffering from PTSD and the psychologist who has treated hundreds of Soldiers over the past decade, several common trends have surfaced from this analysis:

- Soldiers who have experienced trauma and are having difficulty dealing with combat stress are continuing to experience organizational barriers to care. The barriers are established by the unit leadership either because they believe the Soldier is using PTSD as a mechanism to escape training or because they do not want to accept the fact that the Soldier has a mental health concern. This problem stems from the stigma that is associated with PTSD and other mental health illnesses.
- There appears to be a shortage of trained mental health personnel; it was clear from the interviews with Soldiers and the psychologist that there is an Army-wide shortage of trained psychologists and psychiatrists. With a higher number of Soldiers returning from deployment with PTSD and other mental health problems, it is imperative that

the situation be analyzed to determine what changes are necessary to address the shortages of mental health care professionals in both the Combat Support Teams and the hospitals.

- Soldiers should receive adequate training in PTSD before, during and after deployment. My interviews with Soldiers, coupled with my personal experience, indicate that there is a great deal to learn about PTSD, in particular how to identify the symptoms and how best to treat those suffering from combat stress. PTSD training must be integrated into the training plan before deployment. Forward treatment of combat stress is working, but if Soldiers do not know it is available or cannot get the care they need for whatever reason (location, stigma, etc.) the Army needs to reexamine ways to ensure forward treatment is available to all Soldiers. Upon redeployment, mental health should be given priority to ensure all Soldiers and their families are receiving adequate care and know what support systems are in place to address any questions or concerns.
- Testing for PTSD with the Pre/Post Deployment Health Assessment and Reassessment is not being conducted on all Soldiers either before or after deployment. Among those who fall through the cracks are Soldiers returning to CONUS for R&R and not going back to their units and Soldiers not tested when they are redeployed due to injury. To accurately assess the mental health of the units, it is paramount to test all Soldiers going to and returning from theater.
- The administrative procedures for the Medical Evaluation Board are too long; consequently, Soldiers are staying in the WTU too long and are frustrated with the process. Several Soldiers have been in the WTU for as long as a year working through the administrative process for transitioning out of the service and completing their Medical Evaluation.

Now that we have heard from the Soldiers, it is necessary to address not only what the military has been doing to take care of the Soldiers suffering from PTSD but what changes have made a difference to the Soldiers in the Warrior Transition Units suffering with PTSD.

## **What the Studies Found**

The signature wounds from the first major ground combat operation for the U.S. military since Vietnam are Post-Traumatic Stress Disorder and Traumatic Brain Injury. Despite advancements in medical care, improvements in body armor and the use of armored vehicles, one in five Soldiers suffers from PTSD.<sup>65</sup> The pace of the deployments into Iraq and Afghanistan is unprecedented in the history of the all-volunteer force.<sup>66</sup> A significant number of U.S. troops have deployed longer and have returned to combat with less than a year between deployments. A senior deployment health official, Colonel Elspeth Cameron Richie, indicated that “repeated deployments are making treatment efforts more challenging, particularly in reconnecting Soldiers to family and community after deployments.”<sup>67</sup> The troops are experiencing intense combat and threats from the emergence of improvised explosive devices, which have caused a significant number of deaths and injuries. The use of IEDs has been the primary method of terrorism used against U.S. forces in Operations

Iraqi Freedom and Enduring Freedom. Advances in medical technology, body armor and up-armored High-Mobility Multipurpose Wheeled Vehicles (HMMWVs) have led to higher survival rates than in previous conflicts.<sup>68</sup>

The studies and reports conducted since the start of OIF/OEF have identified gaps in the identification of PTSD and its proper diagnosis and treatment. The discussion of those studies that follows will highlight what the military mental health care clinicians and, most recently, the Rand Corporation have found regarding not only the magnitude of this illness and its impact on personnel readiness, but also policy and procedural recommendations for the armed forces to take in supporting servicemembers who are suffering from PTSD.

## **2001–2002**

A mental health assessment study conducted just before military operations in Iraq and Afghanistan determined that every year, at least 6 percent of all U.S. military servicemembers on active duty receive treatment for a mental health disorder.<sup>69</sup> Since combat operations commenced, most of the research on military mental health disorders has been conducted among veterans years after they retired or separated from the service. Only recently has there been research useful to guide U.S. policy and military regulations on how best to treat a serving Soldier with PTSD.<sup>70</sup>

As mentioned previously, the Army chose not to deploy Combat Stress Teams forward with the combat brigades for mental health care treatment. Then, in the summer of 2002, the Fort Bragg, North Carolina, community experienced a cluster of murder-suicides involving four military wives who were killed by husbands recently returned from combat operations in Afghanistan.<sup>71</sup> The military leadership began asking questions about whether PTSD was at the root of the tragedy. They quickly began looking into the types of programs and policies that were needed to take care of Soldiers returning from combat.

## **2003–2005**

The U.S. Army Office of the Surgeon General conducted a study of four U.S. combat infantry units (three Army and one Marine) from January through December 2003. A total of 6,201 Soldiers and Marines were interviewed using an anonymous survey that was administered to 2,530 Soldiers and Marines before deployment to Iraq and Afghanistan and to 3,671 three to four months after redeployment from combat.<sup>72</sup> The results of the interviews were startling.

First, the Soldiers and Marines who deployed to OIF (Iraq) experienced a greater degree of exposure to combat than those deployed to OEF (Afghanistan). Only 31 percent of the Soldiers deployed to OEF reported being in a firefight versus 71–86 percent for OIF. The percentage of Soldiers and Marines who met the screening criteria for PTSD following deployment was between 15.6 percent and 17.1 percent for OIF and 11.2 percent for OEF.<sup>73</sup> Nine percent of the Soldiers met the criteria for PTSD before their deployment to Iraq. Significantly, of the Soldiers and Marines who tested positive for PTSD, only 23–40 percent sought medical care. Still, the Soldiers and Marines returning from OIF were much more likely to seek mental health care than those returning from OEF.<sup>74</sup> The reasons cited for not seeking mental health care were stigmatization and barriers to obtaining such care.<sup>75</sup>

The study concluded that the baseline data for Soldiers and Marines who met the criteria for PTSD were similar to the percentage of Soldiers and Marines who were diagnosed with PTSD from Vietnam. Similarly, of those diagnosed with PTSD, only a very small percentage actually received mental health care. The major reasons cited in the findings for not seeking mental health care were the associated stigma and concerns about how they would be perceived by their peers and the leadership in their units.<sup>76</sup>

Finally, the report concluded that the military must address the twin issues of reducing the stigma associated with PTSD and removing the barriers to seeking mental health care. The military should consider developing an education program and revising the process for health care delivery both on and off the battlefield. Additionally, screening for PTSD prior to entrance into the military and for Soldiers and Marines returning to combat was highly recommended.<sup>77</sup>

In December 2003, the U.S. Army Office of the Surgeon General produced the first Mental Health Advisory Team (MHAT-I) report at the request of the Commanding General, Combined Joint Task Force-7, U.S. Central Command. The MHAT-I deployed to Kuwait and Iraq from 27 August through 7 October 2003, with the mission to assess OIF-related mental health issues and provide recommendations to medical personnel and commanders. This was the first time an assessment of mental health has been carried out in combat.<sup>78</sup>

The outcomes were as follows:

- The MHAT-I conducted a mental health survey of more than 750 Soldiers serving in Iraq in the summer of 2003. The assessment identified a significant proportion of Soldiers deployed to OIF who experienced and reported combat-related stress. Seven percent reported having a severe emotional or family problem, and 16 percent reported experiencing moderate stress and emotional or family problems. The team concluded there is an unmet requirement for mental health treatment. Soldiers also cited in the survey that barriers/obstacles exist that prohibit them from receiving behavioral health assistance. Of the Soldiers who screened positive for depression, anxiety or traumatic stress, 26 percent reported it was too difficult to get to the location of the Combat Stress Team. Other barriers included not getting time off to get help, and 24 percent reported not knowing where to go for help.
- Among Soldiers who left the theater for reasons of mental health, very few returned to duty. Of the 49 Soldiers evacuated for mental health reasons in 2003, 16 percent failed to receive follow-up care and 76 percent received six or fewer follow-up visits. Clinical charts were inconsistent and not maintained, and documentation did not reliably accompany patients through the evacuation plan.<sup>79</sup>

In January 2005, MHAT-II noted that improvements recommended by MHAT-I were either in place or in the process of implementation. The report noted some reduction in the number of Soldiers reporting mental health problems. A larger percentage of Soldiers with mental health issues reported receiving care; still, the report recommended improved awareness and emphasized the critical role of leaders.<sup>80</sup>

MHAT-III reported suicide rates similar to those of the first two reports, with about a 1 percent increase. Among its findings, MHAT-III (which deployed to Iraq in October and November 2005) stated that “the stigma concerning accessing behavioral health continued to decrease” from OIF-I to OIF-III (2004–2006). The report also stated that only 5 percent of Soldiers surveyed considered access to mental health care to be a problem.

*Note: These issues cited by the MHAT-I Team were consistent with the Soldier testimonies and, incidentally, the experience my son and I had while in Iraq in 2005–2007, the time of MHAT-II and -III. There was one Combat Stress team in Tall Afar, for example, and it was extremely difficult for the Soldiers in the regiment who were on a mission on the Syrian border or in the city of Tall Afar to obtain mental health care services. I recommend that the CSTs deploy out to the units rather than waiting for Soldiers to come to their location. My son operated in a remote location in Baqubah; not only was it dangerous to go back to the CST, he was not even sure where the team was located.*

## **2006–Present**

**Mental Health Advisory Team IV.** A fourth Mental Health Advisory Team from the Office of the Army Surgeon General deployed from 28 August to 3 October 2006 with the mission to:

- assess Soldier and, for the first time, Marine mental health;
- examine the delivery of behavioral health care in OIF; and
- provide recommendations for sustainment and improvement to command.<sup>81</sup>

MHAT-IV’s findings derived from a series of mental health assessment surveys with 1,320 Soldiers and 447 Marines, behavior health personnel, unit ministry teams and primary care clinicians and from personal observations.

The team determined that the level of combat is the main determinant of a Soldier’s or Marine’s mental health status, and not all Soldiers and Marines deployed to Iraq are at equal risk of screening positive for a mental health problem. More than three-quarters of Soldiers and Marines surveyed reported being in situations where they could be seriously injured or killed;<sup>82</sup> 62 percent of the Soldiers and 66 percent of the Marines surveyed indicated that they knew someone killed or seriously injured or had a member of their team become a casualty.<sup>83</sup>

Approximately 20 percent of the OIF 05–07 Soldiers and 15 percent of the 05–07 Marines screened positive for mental health illness. Of those who screened positive, only 42 percent of the Soldiers and 38 percent of the Marines sought help from a primary care provider, behavioral health provider or chaplain.<sup>84</sup> The primary reason for not seeking care was that the Soldier or Marine believed the leadership would treat them differently, seeing them as weak and consequently having less confidence in them. The secondary reason was the organizational barriers imposed by the unit leadership to getting the opportunity to seek mental health care. The survey reported that 40 percent of the Soldiers and 41 percent of the Marines indicated that there were organizational barriers to accessing mental health services.

The task force also reported that Soldiers who had experienced multiple deployments in Iraq or were deployed longer than six months were more likely to screen positive for a mental health problem than those deployed fewer than six months in theater or on their first deployment. There was also direct correlation between longer deployments and marital problems.

MHAT-IV identified that only 5 percent of Soldiers reported taking in-theater R&R, even though the average time deployed was nine months. The Soldiers who went to the in-theater (Qatar) R&R site reported frustration due to transportation difficulties and the length of time it took to get to and from the R&R site. More important, leaders of line units operating predominately outside the wire or off the forward operating base would often not allow Soldiers to get R&R due to resultant loss of combat power.<sup>85</sup>

Finally, the task force noted that good noncommissioned officer leadership was key to sustaining Soldier and Marine mental health and well-being. The Soldiers and Marines who reported their NCO leadership as doing a good or better job were less likely to screen positive for mental health problems. For example, for Soldiers in high combat conditions, only 20 percent of those screening positive for mental health issues viewed their leadership as good, while 40 percent viewed their leadership as poor.<sup>86</sup>

In summary, MHAT-IV recommended the following:

- Educate and train junior NCOs and officers in the important role they have in maintaining Soldier/Marine mental health and well-being.
- Include behavioral health awareness training in all junior leader development courses, beginning with the Warrior Leader Course and the Officer Basic Course.
- Reevaluate the in-theater R&R policy to ensure that all Soldiers and Marines who operate primarily off the forward operating base receive in-theater R&R and reduce the time it takes to get to and from the R&R site in Qatar.
- Establish and publish a command policy that ensures Soldiers and Marines are able to access mental health care professionals.

**Department of Defense Task Force on Mental Health.** From May 2006 to June 2007, the DoD Task Force on Mental Health conducted an assessment of the mental health services provided by the armed forces. The report commended the services for the investment made across all echelons to support the psychological health of military servicemembers and their families. The war on terrorism has challenged the mental health care system with respect to PTSD and TBI.

The task force deduced two critical findings:

- “. . . [T]he system of care for psychological health that has evolved over the decades is insufficient to meet the needs of today’s forces and their beneficiaries, and will not be sufficient to meet their needs in the future.”<sup>87</sup>
- “The Military Health System lacks the fiscal resources and the fully-trained personnel to fulfill its mission to support psychological health in peacetime or fulfill the requirements imposed during times of conflict.”<sup>88</sup>

As the military continues to be fully engaged in the war against terrorism, the mission to care for Soldiers' mental health must be restructured to meet the challenges facing the armed forces now and in the future, the task force concluded. DoD must provide the resource requirements necessary to increase mental health personnel requirements, expand the spectrum of mental health services, and improve resilience training, assessment and prevention. Critical to reducing the stigma associated with PTSD, the military must develop an easily-accessible program for servicemembers and their families suffering from mental illness in both active and reserve components.

The task force also stated that it is imperative to dispel the stigma associated with mental health illness and build a culture of support for servicemembers and their families. Throughout history, combat/traumatic stress has been stigmatized, interfering with access to care, quality of care and continuity of care. "Every military leader bears responsibility for addressing stigma; leaders who fail to do so reduce the effectiveness of the servicemembers they lead."<sup>89</sup>

**Rand Study.** In April 2008, the Rand Corporation published the latest report on the mental health and cognitive needs of America's returning veterans.<sup>90</sup> The focus of the Rand study was on the prevalence and magnitude of mental health and cognitive conditions that troops are experiencing when returning home from OIF and OEF II; the care system and existing programs to meet the health care needs of the redeploying troops; the societal costs of these conditions; and how much it would cost to deliver high-quality care to the servicemembers who need it.

The three key findings from the survey of 1,965 servicemembers are as follows:

- Approximately 18.5 percent of the servicemembers returning from Iraq and Afghanistan have PTSD, and 19.5 percent report experiencing Traumatic Brain Injury during deployment.
- Approximately 50 percent of the servicemembers who need treatment for PTSD seek it, and many of those receive less than adequate care.
- Improving access to care can be cost-effective and result in improved recovery rates.

Most of the findings from the recent Rand study are similar to and corroborate the findings of the MHAT studies, to include MHAT-V.<sup>91</sup>

## **Recommendations for Army Action**

The following are recommendations for action the Army should undertake to remove barriers to care and advance the treatment of mental health problems for Soldiers and their families:

- Establish the PTSD "gold standard" for diagnosing, treating and tracking PTSD. Currently, there is no standard for diagnosing and tracking PTSD within the Army, let alone across the services. Military mental health care clinicians should clarify the definition of the term "PTSD." Is it a "disorder" or an illness? Evidence from Soldiers and leaders I interviewed in compiling this study, coupled with discussions with mental

health personnel, indicates confusion. I would further recommend that the Army review the doctrine, policy and procedures for optimal delivery of mental health care on the battlefield and to veterans returning to home station. This information must become part of a formal Army Strategic Communication Plan.

- Continue to improve training programs such as “Battlemind” that aim to educate NCOs and officers on PTSD, the signs of combat stress and measures to take to support the Soldier suffering from this illness. Specifically, it is important to continue to reduce the stigma and remove barriers to seeking professional mental health care for those Soldiers who are suffering from combat stress.
- Based on Soldiers’ testimonies and the statements they would make to the Army Chief of Staff, it is clear that the Army can do more in training for understanding of PTSD and how best to identify someone suffering from mental illness. Pre- and post-deployment testing must be done on every Soldier, with appropriate time phases. For example, post-deployment testing should be done at least three times at scheduled intervals after the Soldiers redeploy from combat. This is imperative to get those Soldiers in need into mental health care quickly and make the determination whether they can stay on active duty and return to their unit before the next rotation.
- The Army should seek unique ways to provide mental health services, such as “tele-health” service. In this mode, a CONUS-based psychiatrist is paired with each CST to assist in diagnosing and treating PTSD on the battlefield or validating the need to return the Soldier to the United States for treatment.
- DoD and the Veterans Administration must formally encourage civilian mental health providers to work with returning Soldiers. A key weakness that exists includes the inability to track all Soldiers, particularly those who move from military health care to the VA system, to determine how each is progressing. DoD/military health service must develop a reliable method to track and document status of care. Establishing and maintaining such a tracking and documentation system that is consistent across all service components will help provide quality care.
- The Army should streamline the laborious administrative paperwork associated with out-processing Soldiers diagnosed with PTSD so they can transition quickly and efficiently from active duty into the Veterans Administration system for seamless follow-on treatment.

### **Recommendations for Army Follow-on Studies**

The signature wounds from the wars in Iraq and Afghanistan are Post-Traumatic Stress Disorder and Traumatic Brain Injury. Despite advancements in mental health care and body armor and improvements in combat equipment, one in four Soldiers returns from combat with PTSD, TBI or both. It is paramount that the Army continues to study, research and report on the issue of PTSD, particularly in the following areas:

- A meta-analysis of all MHAT studies to date is vital to compare/contrast what was identified as a major contributor to combat stress and what successes and or failures



we've had in treatment. For example, it would be useful to assess any difference in rates of combat stress between Soldiers in combat arms units and those Soldiers serving in combat service support units. While MHAT-V breaks out findings separately by combat theater, it still does not offer a comparative analysis to reveal significant trends.

- The Army should conduct a study of how best to reorganize mental health care in both combat and garrison operations to best support Soldiers suffering with PTSD. The system for mental health care should be easily accessible by all Soldiers and contain a process for documenting and recording mental health assessment electronically; this would allow the Soldier (whether in the active or reserve component of the Army or discharged into the VA system) and the mental health care professional to review the information. It is also paramount that forward mental health treatment be conducted on the battlefield; the process should be redesigned based on changes in doctrine and the likelihood that future conflicts will involve counterinsurgency operations.
- The Army should conduct a follow-on study to validate the financial costs it will incur to diagnose and treat properly the thousands of Soldiers suffering from PTSD. According to the recent Rand study, direct medical care and lost productivity from the wars in Iraq and Afghanistan could ultimately cost the nation between \$4 billion and \$6 billion.
- The Army should continue to conduct rigorous phenomenological research based on Soldier testimony, seeking common themes until analysis reaches the saturation point.
- The Army should study, compare and contrast the Vietnam War with Operations Iraqi Freedom and Enduring Freedom, as there is much more to be learned from our Vietnam veterans.

## **Conclusion**

Writing this research paper has exceeded my expectation for learning and understanding the significance of PTSD and what we as leaders and as an Army can do to support our Soldiers suffering from mental illness. The historical lessons from past wars and conflicts indicate that psychological casualties do occur and that the stigma associated with this has been the most significant barrier to seeking professional counseling or medical assistance. The use of forward Combat Stress Teams has been successful in diagnosing and reducing combat stress on the battlefield and is a critical combat multiplier that must be incorporated early on in military planning for combat operations.

An important element of supporting Soldiers suffering with PTSD is for them to know that they have a support network that will reach out to them, their entire family and the community in which they reside. Finally, it is the unit leadership that must embrace Soldiers who are suffering from combat stress and remove the stigma and barriers to seeking professional mental health care. Senior leaders in our armed forces have stated that until battalion commanders and command sergeants major accept the fact that psychiatric casualties are an inevitable consequence of combat and take the initiative to incorporate the importance of addressing combat trauma and stress in the training program, the Army will not dispel the existing organizational barriers that inhibit Soldiers from seeking mental health treatment.

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