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CHILD SOLDIERS: ARE U.S. MILITARY MEMBERS PREPARED TO DEAL WITH THE THREAT?

by

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Abstract

Child soldiers are not a new phenomena for U.S. military forces but they are an expanding problem with implications for training and the mental health of these troops and also global implications for the future. This paper begins by examining the problem of child soldiers throughout the world and assesses current U.S. military policy, strategy, and practices regarding child soldiers. Implications for U.S. forces are highlighted and analyzed. Specifically, this paper describes the impact of child soldiers on the effectiveness of combat forces, the potential for negative mental health consequences, the role media and public support may contribute to that outcome, and the effect on military populations beyond combat forces. Lastly, this paper recommends changes to military training and pre-deployment preparation, suggests specific mental health interventions and highlights areas additional research is needed. These recommendations are provided with the intent to mitigate some of the shortfalls identified and position the U.S. military to affirmatively respond to the question of whether or not they are prepared to manage the threat of child soldiers.

Chapter 1

Introduction

> *This is not just a problem for academia, but it is a problem that has clear policy implications that should concern us all...Our soldiers must deal with the complex dilemma of facing children on the battlefield without proper intelligence warnings or training to help prepare of guide them.*
>
> *P. W. Singer*[1]

The United States (U.S.) military is engaged in unprecedented locations around the globe. Child soldiers are pervasive around the globe as well. Sergeant Nathan Ross Chapman was the first U.S. military service member killed by hostile fire in Afghanistan and he was killed by a 14 year old child soldier after meeting with local tribal leaders on January 4, 2002.[2,3] U.S. Special Forces troops have faced armed children in Mogadishu in 1993, in Kosovo in 1999, and most recently in Afghanistan and Iraq.[4, 5]

Child soldiers are not a new phenomena for U.S. military forces but they are an expanding problem with many implications for the mental health of our troops in combat and also global implications for the future. Brookings Institute political scientist, P.W. Singer, refers to the common use of child soldiers as an "entirely new doctrine of warfare."[6] The ongoing conflicts in Afghanistan and Iraq represent the most sustained period of American military combat operations since the Vietnam War. Recent studies done with Army and Marine infantry troops returning from combat operations in Iraq and Afghanistan note an incidence of Post

Traumatic Stress Disorder (PTSD) similar to rates seen in Vietnam.[7] Soldiers fighting today face many of the same challenges that troops fighting in Vietnam faced. These universal psychological themes of combat include exposure to and involvement in killing and threat to their own lives. The National Center for PTSD cautions that despite combat similarities, it is essential to "appreciate the specific demands and context of these new wars in order to raise awareness of civilians back home…to estimate the need for clinical services, and to make other policy recommendations."[8] The increasing likelihood that U.S. troops will face child soldiers in combat more frequently and be required to kill these child combatants may be one of those unique differences.

This paper will begin by examining the problem of child soldiers throughout the world and then assess current U.S. military policy, strategy, and practices regarding child soldiers. Implications for U.S. forces will then be highlighted and analyzed; specifically, the impact of child soldiers on the effectiveness of combat forces, the potential for negative mental health consequences, the role media and public support may contribute to that outcome, and the effect on military populations beyond combat forces. Lastly, this paper will provide recommendations with the intent to mitigate some of the problems presented and position the U.S. military to affirmatively respond to the question of whether or not they are prepared to manage the threat of child soldiers.

Chapter 2

Child Soldiers-The Scope of the Problem

> *When one has no one left on the earth, neither father nor mother, neither brother nor sister, and when one is small, a little boy in a damned barbaric country where everyone slashes each other's throats, what does one do? Of course, one becomes a child soldier, a small soldier, to get one's fair share of eating and butchering as well. Only that remains.*
>
> - *Ahmadou Kourouma, African writer*[9]

The growing volume of literature on the subject of child soldiers may be the first hint that the problem is getting worse instead of better. The problem is not unique to one particular country or region of the globe. It has been reported that children are active soldiers in combat in over seventy-five percent of the world's conflicts. Figure 1 below depicts visually in the blackened areas the countries where children participated in armed combat between 1998-2001.

Figure 1: Countries children fought in armed conflict from 1998-2001.[10]

Australia and Antarctica are recognized as the only two continents where children are not engaged on the battlefields.[11]

The two simple words "child soldier" can have so many different meanings and connotations that this term must be defined. The United Nations classifies a child as those less than 18 years old. Child soldiers are commonly defined as "persons under 18 years of age engaged in deadly combat or combat support as part of an armed force or group."[12] The actual number of child soldiers is hard to quantify. Amnesty International cites research that estimates 300,000 child soldiers are exploited in over 30 countries but points out that efforts are underway to collect more reliable data on the actual number of children who are soldiering.[13] Current Human Rights Watch web sites also give the figure of 300,000 child soldiers but it is interesting to note that literature published in the late 1990s also estimated the same number of children.[14] The lack of change in these numbers may not represent a stagnant growth pattern but more likely the difficulty in getting true and accurate data on highly mobile, rapidly changing populations involved in conflict.[15] The Human Rights Watch group has published separate books describing the scope of the problem of child soldiers in Liberia, Sudan and Burma. Thirty-five to forty-five percent of the Burmese national army, or 70,000 soldiers are estimated to be children.[16] Much of the current literature on child soldiers does reference Africa and most notably, the Lord's Resistance Army (LRA) in Northern Uganda, which has become "infamous" for being composed of almost entirely children.[17] It is estimated that 30,000 children, both boys and girls, have been abducted into the LRA.[18]

In an address to the Naval Academy on November 30, 2005, President Bush stated U.S. troop strength in Iraq had increased to 160,000 personnel. In testimony to the House Armed Services Committee, the Joint Staff's Director of Operations, cited the number of troops in

Afghanistan at 17,900 and stated it would remain steady.[19] *The Global Report on Child Soldiers* published in 2004, confirmed that 8,000 child soldiers were estimated to be in Afghanistan, all recruited into factional armed groups and militaries including the Taliban and the Northern Alliance.[20] There were no reports of children serving officially in the armed forces but it was reported that young girls were often forced to marry armed group commanders. Similar to Afghanistan, research done in Iraq paints almost the identical picture. Although 18 is the minimum age for official military service, the 2004 Global Report documented that under the Ba'ath party government, there had been widespread military training of children citing the formation of the Ashbal Saddam (Saddam Lion Cubs) group. This group was formed after the 1991 Gulf War, specifically recruited children aged 10 to 15 years, and sent them to three weeks of training in fighting and infantry tactics. The U.S. Department of State estimated there were 8,000 members of this group in Baghdad alone and this was only one of several armed groups that recruited and employed child soldiers.[21]

Contributing Factors

Given the previous statistics, it is natural to question "why" or "how" this has happened. Several trends are reported to have impacted this phenomenon and made recruiting child soldiers that much easier. Poverty, persistent fighting, and demographics are only a few. Singer postulates that the decision to employ child soldiers is a deliberate and systematic choice:

> The reasons behind this conscious violation of international norms are complex, but involve three critical factors that form a causal chain: (1) generational disconnections caused by globalization, war, and disease create a pool of potential recruits; (2) efficiency improvements in small arms permit these recruits to be effective participants in warfare; which (3) results in the propensity to use children as a low-cost way to mobilize and generate force, particularly for individual goals in the context of failed or weak states.[22]

There are many specific facts that add credibility to his position. Consider the implication of demographics alone: half the people in sub-Saharan Africa are under the age of 18 and the Islamic world has one of the highest percentages of children in its population. Youth under the age of 24, make up fifty to sixty percent of the populations in Yemen, Saudi Arabia, Iraq and Pakistan.[23] There has also been a proliferation of small arms that are lighter and easier for children to operate. In addition, children are often less inhibited by the consequences of their actions and are therefore capable of even more violence than an adult soldier may be.

When considering the pressures from these negative global trends, it is not surprising that some children do join these groups 'voluntarily' but often when it is perceived as the only option for survival. Recent studies by the International Labour Organizations (ILO) credited "volunteers" for composing two thirds of the child soldiers in four Central African Countries. In Human Rights Watch reports and UNICEF sponsored studies, the following were identified as the common reasons children chose to become soldiers: to revenge family killings; protection from the warring group itself; regular meals and food; children are orphaned and in need of someone to care for them; and pressure from the peer group.[24,25,26]

Recruitment and Retention

The ultimate goal of organizations that employ child soldiers is to foster dependency so the child feels bound to the group.[27] Discipline is extremely important and often maintained by use of extreme and arbitrary violence. Several sources report that children are often forced to take part in ritualized killings soon after they have joined the group. They are forced to kill or be killed. The victims may be enemy prisoners, other children, or most offensive -- the child's own family or neighbors. Insisting on violence against their own family increases the child's isolation as they no longer have a place they feel they can ever safely return in the future.

Physical dependency is also encouraged. Alcohol, drugs and food are all used to control behavior and even to exploit children's natural tendency toward fearlessness.[28] Many children start out in support roles but that does not shield them from the harsh battle environment. Children are often used as porters but if they are too weak to carry their assigned load, they may be beaten, abandoned or killed. [29] Other support functions include cooks, spies, messengers and sexual service, the latter especially problematic for young girls pressed into service.

There is no doubt that U.S. military troops will continue to encounter child soldiers in many different environments. Has U.S. military policy, strategy or practice prepared our troops, and those responsible for keeping them fit to fight, for these encounters?

Chapter 3

U.S. Military Policy, Strategy and Practice

> *The lasting psychological consequences of causing destruction and perpetrating violence have been strikingly under-researched. For some, the shame and guilt induced by killing of any kind in combat can arguably be uniquely scarring.*
> *- PTSD Fact Sheet, 2005* [30]

Responsibility for Psychological Health of Military Troops

Joint doctrine publication JP 4-02, *Health Service Support in Joint Operations,* defines three pillars of force health protection: 1) healthy and fit force; 2) prevention and protection, and 3) taxonomy of medical care.[31] This doctrine incorporates a broad definition of health threats and includes 'psychological stressors that are not sufficiently countered' as one of the threats that can reduce the effectiveness of military forces. It stresses the importance of a robust health surveillance system and points out that it must also address psychological exposures and employ specific countermeasures to attempt to mitigate risk.

> Medical unit support for preventing DNBIs [disease and nonbattle injury] will include refined military medical surveillance and objective exposure measurements to identify threats, determine effective methods of threat assessment, and develop countermeasures to meet actual and potential threats. Prevention of DNBI casualties has historically focused on reducing or eliminating the risk of food-, water-, waste- and insect-borne illnesses, and heat and cold injuries during deployments. However, Operations Desert Shield/Desert Storm demonstrated the need to also place a much greater emphasis on…combat stress…and the prevention of DNBI.[32]

There is a DoD requirement for all deploying service members to participate in pre and post deployment screening. Military members complete a questionnaire that is reviewed by a medical professional. Almost half of the 18 questions on the post-deployment form query for contributing factors or symptoms of depression, anxiety and PTSD. One of the critiqued

limitations of this questionnaire is that it only seeks information on what happened to military members, not what the military members did. The post-deployment questionnaire does not ask if the member killed anyone.[33]

Another critique is related to the timing and administration of the post-deployment survey. Research done with returning Vietnam War veterans demonstrated that early distress and symptoms of PTSD were not always confirmed predictors of long-term mental health disorders.[34] The post-deployment survey was initially designed as a one-shot snapshot of a member's health at that moment which research has shown to be insufficient for an effective evaluation of a member's mental health status. The Department of Defense (DoD) appears to have attempted to correct this with the introduction of the Post-Deployment Health Reassessment (PDHRA) survey. Dr William Winkenwerder Jr., Assistant Secretary of Defense for Health Affairs, announced the implementation of the PDHRA with the goal of identifying health concerns from military members, 3-6 months after returning from deployment. According to Winkenwerder, the PDHRA focuses on "support to those needing assistance with post traumatic stress disorder, psychological and social readjustment issues" with compliance initiated by unit leadership.[35] The Army Medical Surveillance Activity (AMSA) collects PDHRA data from all the services. A February 2006 PDHRA update summarized data collected from pilot testing done in the latter half of 2005:

> --As of February 3, 2006, AMSA reported a total of 6,292 service members who had completed a PDHRA. .. Of these, 3,142 (49.9%) indicated no physical health, mental health, or adjustment concerns related to their deployment. By contrast, 3,150 (50.1%) reported at least one positive response for deployment-related symptoms or concerns…
> --Army service members represented 6,254 (99.4%) of these early PHDRA responders, and among Army service members, 664 (10.6%) were associated with the Reserve or National Guard components…
> --Physical health symptoms represented the dominant trend among those who have completed a PDHRA. Of the 6,292 members completing an assessment,

> 2,575 (40.9%) reported at least one physical health symptom, 879 (13.9%) reported at least one mental health symptom, and 627 (10%) indicated both physical and mental health symptoms. Among all responders, the two highest endorsements were 'sleep/fatigue problems,' [1,147 (18.2%)] and 'back pain' [1,116 (17.7%)].[36]

As of early February 2006, the Air Force was poised for full program execution but waiting on final direction from the Assistant Vice Chief of Staff and the Army has full program implementation.[37] No specific information on Navy progress was available on-line through the DoD Deployment Health Clinical Center.

The individual reassessment form, similar to the form completed immediately post-deployment, does attempt to assess for signs and symptoms of impaired psychological adjustments but once again does not attempt to garner specific information about any killing the military member may have had to do while they were deployed (refer to Appendix A). Question #7 asks: Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? Question #7a then asks them to select from an extensive list what exposure best describes their concern. The list includes specifics from the application of DEET insect repellent to exposure to lasers and depleted uranium but does not ask about exposure to killing or child soldiers. The lack of specificity about encountering or killing child soldiers may be a flaw in the medical community's threat surveillance assessment.

Policy and Strategy Specific to Child Soldiers

There is a dearth of published literature on the military's response to the threat of child soldiers, including lack of literature on troops' pre-deployment training needs and psychological response to encountering and killing children in combat. Despite the awareness of this emerging

problem, the majority of the U.S. military has not adopted any official policies or prepared doctrine specific to this issue. In June 2002, the Center for Emerging Threats and Opportunities (CETO), a U.S. Marine Corps think tank, sponsored a seminar that examined the implications of child soldiers for U.S. Forces. This seminar had representatives from each military service, the State Department, government and non-government organizations (NGOs). In addition to providing a synopsis of the problem of child soldiers and identifying several strategic level interventions targeted by the international community, the seminar and subsequent report highlighted several key points with specific tactical implications for the military.

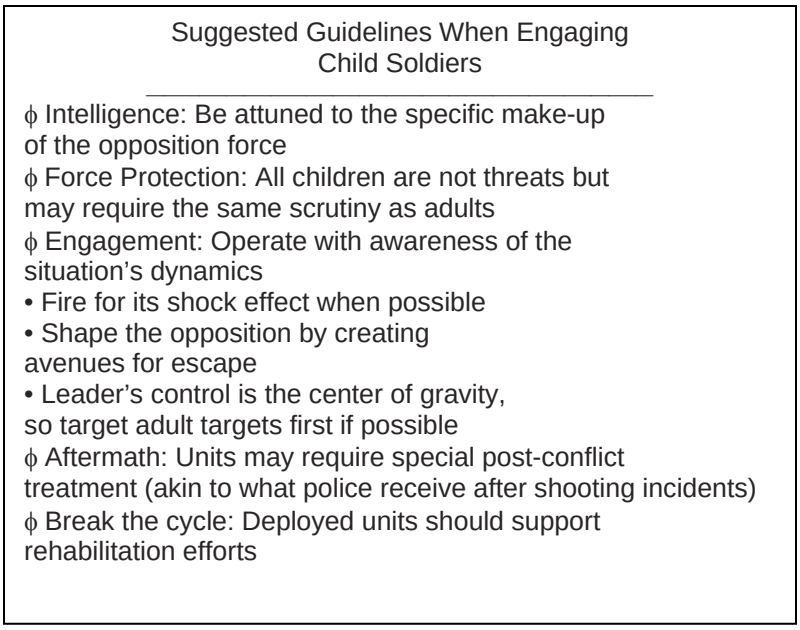

Figure 2. Guidelines from CETO Report, Child Soldiers: Implications for U.S. Forces[38]

The report also recommended that military doctrine describe the child soldier phenomenon and address specific ways to deal with it. Training was encouraged for all troops but especially before deployment and particularly to those groups likely to encounter child soldiers. The report concluded by recommending that war-game scenarios be modified to include child soldier issues.

Pursuant to the November 2002 report, there has not been much public evidence of adoption of the recommendations. This author questioned several Army, Marine and Air Force officers who have been in combat environments in the last 24 months about their deliberate preparation to face child soldiers. None reported knowledge of any specific intervention, pre or post conflict, to prepare them for this unique threat. War-game scenarios at the military senior service schools have not included or familiarized participants with any type of child soldier experience.[39] In P.W. Singer's book published in 2005, three years after the CETO child soldier seminar, he acknowledges that the Marines have begun to include some broad coverage on the issue of child soldiers in cultural intelligence seminars. He credits the Marine Corps Warfighting Lab and Marine Corps University for beginning to include info on a few war game scenarios, but he criticizes the other services for their lack of action.[40] Following the CETO seminar, two of the presenters were invited to brief the 11th Marine Expeditionary Unit (MEU) prior to a scheduled deployment to Iraq in January, 2004. One of the presenters, Rachel Stohl from the Center for Defense Intelligence, confirmed it was "an ad-hoc exercise, with no follow-up and no systematic training for other units."[41]

Not only is the combat community not focused on preparing for or mitigating the threat of child soldiers, but the military medical community does not appear to be leaning forward in those arenas either. Personal communication with Army and Air Force medical community senior officers substantiate that no specific preconflict interventions address child soldiers nor is it a problem the military medical community appears focused on right now.[42] The Center for Study of Traumatic Stress falls under the Department of Psychiatry at the Uniformed Services University of the Health Sciences (USUHS) and maintains an extensive web site with numerous linked resources and publications. There is an entire section dedicated to military psychiatry, but

it does not contain anything specific about the impact of child soldiers in combat. The center is internationally renowned for its work in the area of PTSD, the psychological effects of terrorism, bioterrorism, traumatic events and disaster and combat, yet does not address the psychology associated with encountering or killing child soldiers.

In April 2005, the National Center for PTSD published a PTSD Fact Sheet highlighting the unique circumstances and mental health impact of the wars in Afghanistan and Iraq. Despite the previously cited number of child soldiers documented to be operating in those countries, there is only reference to "ambiguous civilian threats" and no specific reference of child soldiers as a unique threat that may have a negative mental health impact. This report did reference the aftermath of violence, including killing, although it did not provide any specific information on the aftermath of killing children in combat.

Some mental health experts would argue there is no need to drill down to that level. Research in the arena of human resilience has summarized that although fifty to sixty percent of the U.S. population will be exposed to traumatic stress, only five to ten percent of the population develop PTSD.[43] The under-studied question that remains unanswered asks "What are the predisposing elements that promote resilience in the majority of the population?" In discussion with Col Carroll Greene, Air Force Special Operations Command (AFSOC) operational psychologist, regarding psychological trauma, Col Greene maintains: "[killing]child or not, may be an emotional issue for some soldiers-but, it is not the key to whether they will-or will not-develop a disorder." [44] Unfortunately, there has not been enough research conducted to determine if some military members may be more resilient to the trauma of killing a child, or if there are specific interventions that can foster this resilience and prevent negative psychological outcomes.

Policy and Strategy Specific to Killing in Combat

Despite the lack of specific information related to killing children in combat, there is research concerned with killing in combat. In 1947, S.L.A. Marshal, an Army Lt Col, claimed that only fifteen to twenty-five percent of American infantryman in World War II fired their weapons directly at the enemy soldiers stating "fear of killing, rather than fear of being killed, was the most common cause of battle failure in the individual."[45] Despite recent accusations that question Marshall's claim, the attempted discredit focuses on his data gathering methods and does not really attempt to dispute the claim that soldiers were reluctant to kill other soldiers. Marshall's declaration did appear to motivate the Army to change their training focus. In a Revised Program of Instruction, the focus was not only on teaching a man to shoot a target but also emphasized conditioning soldiers to kill.[46] Referred to as "operant conditioning," the U.S. Army began to use realistic, human shaped targets that would actually fall when hit. Use of this basic technique is attributed as the main reason for the increasing rate of fire in operations since WWII.[47] Most recently, the U.S. Armed Forces have incorporated the use of paint bullets, state-of-the-art video firearms simulators, and laser engagement simulators into training scenarios to help inoculate soldiers against combat stress.[48] Psychologist, Lt Col Dave Grossman, a retired Army ranger who specializes in training military units about the psychology and physiology of combat, emphasizes "in the end, it is not about the hardware, it is about the 'software'…training and mental readiness."[49]

Dr. Theodore Nadelson, an Army veteran, served as the Chief of Psychiatry at the Boston VA hospital for 20 years. He cautions that training does not "release all soldiers from their resistance to killing….training must remove conscripts from the framework of the inhibiting

force that civilization has raised against killing."[50] One method that helps to overcome this inhibition is the process of dehumanizing the enemy. Assigning a lower human value to an enemy helps overcome the moral hesitation that civilization has instilled against killing.[51] It is well documented that physical distance from the enemy may impact the success of dehumanization.[52,53] If a soldier is forced to kill the enemy in close combat, he may not be able to deny the element of humanity to his enemy. This becomes a more difficult task for westernized societies when the enemy is a child. A United Nations (U.N.) peacekeeper summarized this dilemma by asking; "Do you shoot a child that looks like he could be your son, even if it looks like they are going to shoot you?"[54]

Several military officers this author spoke to believed if they felt their life was threatened by a child soldier, they would not hesitate to kill them first regardless of their age, but none of them had actually killed a child soldier. In conversation with a Marine ground troop commander assigned to II Marine Expeditionary Forces (II MEF), headquartered at Camp Lejeune, North Carolina, it was clear that in his opinion he did have troops who would hesitate when it came to killing a child soldier, "even though they knew better."[55] Grossman postulates the following caution:

> Being able to identify your victim as a combatant is important to the rationalization that occurs after the kill. If a solider kills a child, a woman, or anyone who does not represent a potential threat, then he has entered the realm of murder (as opposed to a legitimate sanctioned combat kill), and the rationalization process becomes quite difficult. Even if he kills in self-defense, there is enormous resistance associated with killing an individual who is not normally associated with relevance or a payoff.[56]

Future training must take this natural resistance into account so troops can be prepared for the environments they may find themselves operating in.

Chapter 4

Implications for U.S. Forces

> *Anybody that can shoot a little kid and not have a problem with it, there is something wrong with them. Of course I had a problem with it. After being shot [at] all day, it didn't matter if you were a soldier or a kid, these RPGs… are meant to hurt us…I did what I had to do.*
>
> *-U.S. solider fighting in Iraq*[57]

There are several reasons that the threat of child soldiers should be on the U.S. military's radar scope. Being unprepared to encounter child soldiers has the potential to decrease the effectiveness of U.S. combat forces. Situations that require our military troops to kill child combatants could contribute to increased negative psychological outcomes. Additionally, populations other than just our combat troops may need to be prepared to interface with this growing threat as more of these children may be treated by our forward deployed medical troops, processed through detainee operations centers, or become part of media stories that may impact greater audiences than just our military public affairs personnel.

Effectiveness of U.S. Military Combat Forces

Morale is a factor that will contribute to the effectiveness of a deployed military unit. U.S. soldiers in WWII were forced to fight and kill children fighting as part of the Hitler Youth population. Although statistics confirm the death of large numbers of children, these combat kills lowered unit morale to the lowest point of their deployment despite the end of the war being near.[58] Another unexplored factor that may negatively impact unit effectiveness is the

consequence of guilt if a service member is unable to kill a child soldier, especially if this hesitation results in fellow soldiers being injured or killed.

In WWII, more German youth became combatants as the war continued over time and large numbers of regular troops were lost to attrition.[59] With a protracted war being fought in Iraq and Afghanistan, the probability also exists for U.S. troops to see an increase in the use of child soldiers in combat. Singer cautions that the potential exists for this demoralizing effect to be especially common in peacekeeping missions citing the example of the Indian army's peace intervention in Sri Lanka in the early 1980s. Pressure from the military leadership of the Indian army, who were "wore down by its experience against the child cadres," coerced political leaders to terminate the mission.[60]

There is a publicized account involving the capture of a six-man patrol of the Royal Irish Regiment and the British strike force mission, Operation Barras, that was sent to rescue them in 2000.[61,62,63] The patrol had been captured 16 days earlier by an armed group of child soldiers because the squad commander was not willing to give the order to fire on the armed children and was unclear about the Rules of Engagement (ROE) for this type of enemy. This account suggests that there is a difference for some between killing regular armed forces and killing armed children. It also highlights the importance of preparing soldiers for this encounter. Grossman's earlier analysis bears repeating, "in the end, it is about…training and mental readiness."[64]

Research has demonstrated that reliable information in advance reduces psychological vulnerability.[65] In 2001, the director of the Deployment Health Clinical Center at Walter Reed Army Medical Center confirmed the importance of keeping troops informed of risks they may face, commenting, "talking inoculates them to some degree."[66] Preparation may also include

visualization, re-enactments, and group discussions which often may be led by line officers in charge as opposed to mental health professionals.

> As a warrior it is your job to go into danger, but you can do something about how you respond to it. This is critical because if you do not feel a sense of intense fear, helplessness, or horror, there is no PTSD….If there is no sense of helplessness because your training has taught you what to do, there is no PTSD. If there is no horror because you have been inoculated against seeing blood, guts and brains, there is no PTSD.[67]

Although there is a renewed focus on psychological preparation for deployment, nothing in current pre-deployment training programs specifically addresses the child soldier threat or its potential impact on combat effectiveness.

Mental Health Consequences

Research has clearly demonstrated a relationship between war zone exposure and psychological effects in military members. PTSD, Acute Stress Disorder (ASD) and Combat Stress Reaction (CSR) are some of the more common psychological diagnoses and are closely related. CSR, defined as "any response to combat stress that renders a soldier combat ineffective," is type of ASD specifically centered on exposure to a combat environment.[68] PTSD and ASD have very similar defining characteristics listed in the *Diagnostic and Statistical Manual of Mental Disorders* but the timing of symptoms is a key difference.[69] Acute stress disorders by definition focus on the initial month after exposure to a traumatic event and for a PTSD diagnosis, symptoms must be present for longer than one month after a traumatic event. The most obvious common requirement for both diagnoses is for an individual "to have experienced or witnessed an event that has been threatening to either himself or herself or another person. Furthermore, it prescribes that the 'person's response involved intense fear, helplessness, or horror'."[70] The purpose here is not to dwell on specific differences in

psychological diagnoses but to make the point that killing child soldiers can be a combat exposure that may lead to an increase in negative psychological outcomes.

> In every war in which American soldiers have fought in this [twentieth] century, the chances of becoming a psychiatric casualty--of being debilitated for some period of time as a consequence of the stresses of military life, were greater than the chances of being killed by enemy fire. The only exception was the Vietnam War, in which the chances were almost equal.[71]

The majority of research on PTSD is related to the Vietnam War but it is not the only war studied. Studies as early as World War II highlight a contributory relationship between battlefield intensity and the number of psychological casualties.[72] Exposure to intense combat and more significantly, atrocity, were identified as major factors impacting the frequency of negative psychological outcomes in the Vietnam War.[73] Preexisting psychological illness has not been shown to be a necessary requirement for the development of psychiatric illness after exposure to combat.[74]

In addition to a psychological cost, PTSD has a monetary and societal cost. It is not uncommon for combat veterans, as well as individuals in the general population diagnosed with PTSD, to be diagnosed with major depression, anxiety disorders and alcoholism concurrently.[75,76] Vietnam War veterans diagnosed with PTSD are reported to have higher rates of additional psychiatric disorders as well as medical conditions, are heavy users of medical services, and also have higher unemployment rates. [77,78] Vietnam veterans with PTSD are twice as likely to develop cardiovascular disease, diabetes, and cancer and also have a higher death rate from accidents.[79]

In 2004, the Department of Psychiatry and Behavioral Sciences at Walter Reed Army Institute of Research, published results of research efforts that interviewed members of four U.S. combat infantry units before and after their deployments to Iraq or Afghanistan. The study

concluded that the military subjects were at significant risk for mental health problems, to include PTSD, major depression, substance abuse, social and employment impairment, and the increased use of health services.[80] Similar to Vietnam War studies, this research demonstrated a strong relationship between specific combat experiences and the prevalence of PTSD. Seventy-seven percent of troops in Iraq shot or fired at enemy, forty-eight percent were responsible for the death of an enemy combatant, and twenty-eight percent for the death of a non-combatant.[81] Seventeen percent of the troops returning from Iraq met the screening criteria for PTSD, major depression or generalized anxiety disorder.

There is no clear cut answer to the question of why some troops develop PTSD and others do not, although research has confirmed the existence of some potentially linked relationships. The OIF-II Mental Health Advisory Team report chartered by the U.S. Army Surgeon General, demonstrated that "lower perceptions of combat readiness, [lower] levels of training, and [lack of] confidence in the unit's ability to perform the mission," were linked to an increase in mental health problems.[82] Studies have demonstrated a connection between "indicators of global intelligence and the development of combat-related PTSD," citing research that proved lower pre-war intelligence predicted greater postwar PTSD in Vietnam veterans. [83] A 2005 RAND report examined CSRs to see if urban warfare had a significant impact on the rates of CSR. Interviews did confirm that the civilian threat in an urban environment may be a key risk factor for CSR. In particular, civilian casualties were identified as one of the major factors related to short and long term stress reactions.[84]

The report recommended that future research should examine the specific psychological impacts of operating in this environment. Child soldiers remain a part of this civilian threat that needs to be examined in more detail. Research done with Vietnam veterans also identified

killing as a "major factor leading to PTSD."[85,86] Although this author was unable to find any studies that specifically linked exposure to child soldiers with negative mental health outcomes in U.S. military troops, P.W. Singer interviewed British military officers who fought against groups composed largely of child soldiers in West Africa in 2001. These soldiers were challenged with "deep problems of clinical depression and post-traumatic stress disorder."[87]

Role of media and public support

Media coverage and public support are additional factors that may impact service members' psychological adaptation process. Nadelson postulates that the "difference in psychological casualties in a war is often said to be influenced by the degree of a nation's popular support for the war and its goal."[88] Research cited in the 2005 PTSD Fact Sheet confirms public opinion as a factor that impacts how troops view their deployment and their trauma exposure.[89]

Currently, public support and global support for the war in Iraq is waning.[90] Unlike in Vietnam however, that does not also equate to decreasing support for individual U.S. troops but it is too early to know if strong support of troops despite lack of support for the war effort will impact psychological outcomes. What can almost be assured however, is that media coverage of the threat of child soldiers has the potential to sway public opinion and global support. So what has the relationship been between the media and child soldier? Singer discloses the following information about the potential public-affairs nightmare:

> In the reports on the initial engagements with child soldiers, both the Arab and international press focused on the immediate act of U.S. soldiers shooting Iraqi children, rather than on the context that led them to be forced into such a terrible dilemma. The children were portrayed as heroic martyrs defending their homes, facing the American Goliath. This image obviously damages U.S. public information efforts to demonstrate the rightness of a cause or the special care U.S. and allied forces take to protect innocents. The potential backlash could imperil already tenuous support from regional allies and harden attitudes elsewhere against giving aid to the U.S. in the broader war on terrorism. Finally, the effect

> caused by seeing photographs of tiny bodies could become potent fodder for congressional criticism and antiwar protesters."[91]

With the known ripple effects of this type of media coverage, the U.S. military should be concerned about its impact on global and national public opinion and the psychological adaptation of individual military members.

Looking Beyond Combat Forces

Combat troops are not the only military members with the potential for interaction with child soldiers. Deployed military medics are often responsible for caring for casualties of combat, even enemy forces. Often these patients remain in their care for much longer periods of time than U.S. casualties who are quickly moved out of theater to more definitive care. With the increasing likelihood that U.S. troops will be engaged in combat against child soldiers, it is a very real possibility that military medics, in addition to treating these patients' physical wounds, should know what can be done to help these children begin the process of rehabilitation instead of just returning them to the control of their fighting units. Communication with Army medical leaders, Air Force Special Operations medical leaders, and recently deployed medical professionals confirm that there is neither current doctrine nor any training programs that address this issue.

Detainee operations is another arena outside of the battlefield where the potential exists for U.S. military forces to interact with child soldiers. A Human Rights Watch report published in April, 2003 as well as a letter to the Secretary of Defense, were written in response to the U.S. military's acknowledgement that children ranging in age from 13-15 years were included among the detainees at Guantanamo.[92,93] These documents do acknowledge that the children being held may have participated in armed conflict despite international law and human rights consensus

that stipulate that no children under age 15 can be recruited into armed forces or used to take part in hostilities. There are specific parts of Protocol I Additional to the Geneva Conventions that spell out the protections that should be afforded to children in this category. The U.S. is also a signer of the Optional Protocol to the Convention on the Rights of the Child.

> Under the protocol, the United States also has responsibilities to assist in the demobilization and rehabilitation of former child soldiers.…These standards recognize the frequent abuse of children as soldiers in armed conflicts around the world. Whether "voluntarily" or forcibly recruited, the use of children in armed conflict is now widely recognized as detrimental to the development and well-being of children, and a serious abuse of their rights. In responding to this phenomenon, the rehabilitation of former child soldiers is paramount, with appropriate assistance, including family reunification, counseling, educational and vocational training, to aid their reintegration into society. If the child detainees at Guantanamo have participated in armed conflict, the United States should facilitate such assistance without delay. [94]

In May 2005, the Office of the Surgeon General of the Army released the results of a report that examined detainee medical operations for Operation Enduring Freeedom (OEF), Operations Iraqi Freedom (OIF) and Guantanamo Bay (GTMO). The only mention of children falls under the section that reviews theater preparation for detainee medical care. A noted shortfall was lack of personnel, supplies and equipment to deal with specialty subsets of the Iraqi civilian and detainee population, and pediatrics was cited as one of those subsets.[95] A section of the report outlines recommendations for future training for those medics preparing to work in the arena of detainee care. There is no request for information or strategic or tactical policy guidance related to treatment or rehabilitation child soldiers. This author believes this reflects the military community's lack of focus on this population subset rather than the fact that the medics were already so well educated about child soldiers, they did not report a need for education and training.

In a 2003 article titled "*Fighting Child Soldiers,*" Singer makes several points about child soldiers that should be part of U.S. military predeployment education and training programs:

> Forces must also take measures to quickly welcome child-soldier escapees and enemy prisoners of war… Once soldiers ensure the child does not present a threat, they should provide any immediate needs of food, clothing or shelter. The child will have depended on the armed group for these things, so U.S. forces must fill the void. To help break the system of control that brought them into warfare, children should be kept separate from enemy POW. Then as soon as possible, soldiers should turn the child over to health-care or nongovernmental organizations professionals."[96]

Clearly, child soldiers have broad implications for many military populations in varied environments.

Chapter 5

Recommendations

To everything there is a season,
And a time for every purpose under the heaven.
There is a time to be born and a time to die.
A time to plant and a time to reap.
A time to kill and a time to heal.
- Ecclesiastes, Chapter 3

Training and Pre-Deployment Preparation

Revamping troop preparation and training is the area that has the potential for the most impact in mitigating potentially negative consequences of encounters with child soldiers. Grossman states: "When you are warned that something might happen, you can more easily control the amount of stress you receive. However, if you spend your life in denial and then something happens, it hurts you, and hurts you seriously."[97] The existence and potential for participation of child soldiers in combat should be a part of country-specific intelligence that is collected and reported in pre-deployment briefings. The intelligence and medical communities should identify the likelihood of encountering child soldiers, how they are used, and what the military members can expect. This threat assessment should be communicated not only to combat troops, but to all those preparing to deploy.

The RAND study that examined combat stress reactions and their implication for urban warfare concluded with thirteen recommendations for prevention that targeted commanders and NCOs. Tough and realistic training, intelligence, and rules of engagement were three of those

recommended areas of action.[98] The report suggests a three-tiered system of training, referred to as Stress Exposure Training. This training not only highlights the importance of identifying stressors in the operational environment ahead of time, but also emphasizes the individual's response, teaches the necessary skill sets, and stresses confidence building through realistic training. A briefing similar to the one presented to the 11th MEU (refer to Appendix B) should be mandatory for operational and strategic leaders so that tactical rules of engagement (ROE) can be decided upon and become part of the pre-deployment training scenarios.

Singer cautions that a "microsecond's hesitation" could cost U.S. troops their lives, so deliberate, preparatory efforts are essential to overcome individual shock towards our adversary's tactic of employing child soldiers and condition our forces to react quickly. [99] Child soldier scenarios should be added to wargames at all levels of training with consideration given to including child silhouettes in simulator training exercises. There are tactical as well as strategic implications and beneficial lessons to be taught and learned. Research has demonstrated the value of practicing skills under stressful training situations and established that the more realistic training is, the greater the chance the desired skill will be adopted.[100,101] There is literature on pretrauma training that cautions the evidence for such a strong relationship is tentative, noting that more controlled research needs to be done to determine the extent that training in advance can reduce negative psychological outcomes.[102]

Medics and personnel working in detention centers also need to have clear ROE outlined. They must understand the special needs of child soldiers and how they can help break the control that armed fighting groups can have on individual children. They should also be encouraged to establish relationships with NGO organizations who can assist with the immediate needs of child soldiers and encourage rehabilitation at the earliest opportunities.

Mental Health Interventions

With the responsibility for training and preparation allocated to unit commanders and NCOs, the medical community should focus on the aftermath of the inevitable engagements with child soldiers. The military medical community must develop programs to deal with the psychological aftermath of U.S. troops who must fire upon child soldiers in the course of warfare.[103] As there is no published research on the psychological implications of U. S. troops engaging child soldiers, there have been no studies that confirm the effectiveness of any specific interventions. Recommendations are inferred from research done on the stress of killing but the specific applicability in the child soldier killing subset is unknown. Research has questioned the impact of post-deployment psychological debriefings on the rates of PTSD.[104,105,106,107] Clear ROEs need to be established and incorporated into military clinical treatment guidelines. All military medical providers should be aware of the protocols for treating suspected combat stress reactions or PTSD and be prepared to engage early. Early intervention when symptoms are just beginning has been shown to prevent permanent psychological disorders in some cases.

Most medical interventions start with an accurate assessment, therefore adherence to the newly expanded PDHRA process must be encouraged and supported. This will be a test in a healthcare environment that is already challenged with limited access issues and overspending. With the end of the initial pilot testing, the quality and quantity of the information obtained must be analyzed by behavioral health specialists to see if any revisions to the survey should be adopted. Adding specific questions about exposure to killing and in particular, killing of women and children should be considered.

The biggest challenge for the medical community probably lies in solving the issues associated with military members' reluctance to seek out and receive mental health care.[108,109]

Research efforts indicate that there are still several organizational barriers and stigmas that contribute to this reluctance despite the following supposition: "no sane person would turn down antibiotics if the doctor prescribed them, and no reasonable warrior should turn away from psychological help if it is available and needed."[110] But mental health disorders are often much more difficult to recognize and there is a historical stigma associated with seeking out care for psychological illness that is not present with physiological illness. In the previously referenced 2004 study conducted with Army and Marine troops returning from tours of duty in Iraq and Afghanistan, only twenty-three to forty percent of the troops who screened positive for a mental disorder, sought out mental health care in theater or in the first year upon their return.[111] This is an area that definitely needs more attention from the medical community.

The Air Force should continue to formalize the operational psychologist program begun in AFSOC and promote its expansion into other populations and military services. The Army does employ combat stress teams and care should be taken to see that they are distributed appropriately in areas of combat operation. The Navy does employ psychologists on their aircraft carriers and psychologists have deployed with SEAL teams. Similar to the Army, the 'playing field' should be reexamined to see if the right medical assets are in place with the right Navy and Marine troops. Having mental health providers integrated into the "normal" or routine health care team may help to decrease some of the negativism and encourage early intervention and treatment of psychological symptoms and disorders. Energy must be dedicated towards identification and assessment of psychological threats, despite being hard to separate from physical threats. DoD should also support and participate in research that will contribute to the development of countermeasures to mitigate this risk. Clearly the complex threat of child

soldiers needs greater emphasis so that the military can continue to promote a fit and healthy force.

Armed with the knowledge that public support may impact troops' psychological adaptation, our Public Affairs Officers (PAOs) must also prepare now for the ramifications of American military encounters with child soldiers.

> In explaining events leading to the death of children, PAOs should stress the context under which the events occurred and the overall mission's importance. PAOs should inform the public that everything is being done to avoid and keep child soldiers from becoming casualties. At the same time, the public should be aware that child soldiers armed with AK-47s are just as lethal as are adults. Most important, PAOs must be proactive and seek to turn blame to where it should properly fall, on a regime that illegally and dishonorable pulls children into the military sphere to do its dirty work.[112]

There is an obvious need for the DoD to develop doctrine that addresses the many unique aspects of this growing threat.

Additional Research

This paper has highlighted some clear gaps in our existing knowledge base that have made it difficult to quantitatively establish the impact on U.S. soldiers of encountering child soldiers; therefore, several recommendations propose future research topics. A study should be conducted that identifies the mental health consequences among U.S. troops engaging with child soldiers. The study should also examine the impact of engaging child soldiers on combat effectiveness of U.S. troops. This study would ideally compare units that engaged with child soldiers against those that did not. The study would need to be designed in order to systematically interview troops to obtain self-reports of effectiveness and self-assessments of the impact of facing and killing child soldiers. The previously referenced RAND report recommended future research to evaluate the psychological consequences of operating in an

urban environment with a civilian population. Child soldiers are a large part of this new, emerging, civilian threat that definitely needs to be examined in more detail.

Studies should also be undertaken immediately that examine the effectiveness of current therapies and interventions for reducing mental health problems associated with engaging child soldiers. How do we know if interventions that minimize psychopathology associated with killing in general are working to help those who killed child soldiers and not doing more harm than good? The military community should not assume that all killing in combat is the same without some type of empirical evidence to help support that assumption and dictate treatment modality. Closely related is a need for more research on resilience and attempts to identify what makes some individuals more resilient to long term psychological conditions after exposure to traumatic events. The military population must be careful not too formulate too many assumptions from studies on combat killing in general that have not included experiences of facing and killing child soldiers.

Additional attention should also be invested into identifying interventions that would decrease the negative stigma of mental health care. Although well cited as an obstacle to care, not much guidance exists in the current literature that helps providers and patients alike overcome this barrier. Lastly, consideration should be given to establishing surveillance or monitoring systems that systematically collect data over time to monitor trends and other key factors related to the problem of child soldiers.[113] Similar to what the public health community uses to monitor infectious disease, this data could be used to help units anticipate the involvement of child soldiers and the extent to which the problem is getting better or worse in a region. This information could be essential for military planning and helpful in future research attempts.

Chapter 6

Conclusion

> *Children with AKs are a new feature of the modern battlefield, and U.S. forces will have to deal with the dilemmas they present at some point...For U.S. military planners, now is the time to pay greater attention to the phenomenon's unique particularities, so that appropriate responses can be designed. Child soldier incidents will come sooner or later. The pertinent question is whether American troops will be prepared.* *P.W. Singer*[114]

The increased global presence of the U.S. military is a trend that will continue for the foreseeable future. The use of child soldiers in combat environments around the globe also appears to be a trend growing in the same direction. This paper attempted to ascertain the military's readiness to encounter this unique threat. By examining the scope of the problem of child soldiers, by assessing U.S. military policy, strategy and practice, and by highlighting the implications for U.S. forces, it has drawn the conclusion that U.S. military members have <u>not</u> been properly prepared to face the threat of child soldiers.

The DoD has not been proactive in preparing personnel who may come in contact with this evolving dimension of warfare or taking measures to mitigate potential mental health problems from encounters with child soldiers. The U.S. military, with cooperation between the line and medical community, must come to terms with the inevitability of facing this type of enemy in current and future conflicts. Continuing to ignore this threat has implications for the effectiveness of combat forces and the mental health of military members working in many

different environments. These include strategic implications as well as specific tactical repercussions.

Contrary to initial assumptions, many of the recommendations are aimed directly at non-medical populations—the line side of the military needs to engage. This is not a threat that will be negated by mental health intervention alone. Mental health programs that treat the consequences of killing child soldiers only partially address the threat. The DoD must establish appropriate training and education programs to proactively prepare U.S. troops for scenarios involving child soldiers. The intelligence community must engage proactively in data gathering and threat assessment scenarios that involve child soldiers and then communicate that information to the right populations. The medical community should be acutely aware that preventive measures are often more effective for protecting individual mental health and also more cost-effective than post-exposure mental health treatments.

Singer advocates that countries around the globe must pay more attention to the child soldier phenomenon in peace and postwar planning and ensure specific provisions to address child soldiers. Ignoring this responsibility leaves the children ready to begin the same cycle all over again and continue a cycle of violence into future generations.[115] Ignoring the child soldier phenomenon may also perpetuate negative psychological outcomes in future generations of U.S. military members.

Appendix A

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POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA)

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment in support of military operations and to assist military healthcare providers, including behavioral health providers, in identifying present and future medical care needs you may have. The information you provide may result in a referral for additional healthcare that may include behavioral healthcare.

Routine Use: To other Federal and State agencies and civilian healthcare providers as necessary in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

Disclosure: Disclosure is voluntary.

INSTRUCTIONS: Please read each question completely and carefully before making your selections. Provide a response for each question. If you do not understand a question, ask the administrator. Please respond based on your MOST RECENT DEPLOYMENT.

Demographics

Last Name

First Name MI

Today's Date (dd/mm/yyyy) / /

DOB (dd/mm/yyyy) / /

Date arrived theater (mm/yyyy) /

Date departed theater (mm/yyyy) /

Social Security Number — —

Gender
- ○ Male
- ○ Female

Marital Status
- ○ Never Married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

Service Branch
- ○ Air Force
- ○ Army
- ○ Navy
- ○ Marine Corps
- ○ Coast Guard
- ○ Other

Status Prior to Deployment
- ○ Active Duty
- ○ Selected Reserves - Reserve - Unit
- ○ Selected Reserves - Reserve - AGR
- ○ Selected Reserves - Reserve - IMA
- ○ Selected Reserves - National Guard - Unit
- ○ Selected Reserves - National Guard - AGR
- ○ Ready Reserves - IRR
- ○ Ready Reserves - ING
- ○ Civilian Government Employee
- ○ Other

Pay Grade

○ E1	○ O01	○ W1
○ E2	○ O02	○ W2
○ E3	○ O03	○ W3
○ E4	○ O04	○ W4
○ E5	○ O05	○ W5
○ E6	○ O06	
○ E7	○ O07	○ Other
○ E8	○ O08	
○ E9	○ O09	
	○ O10	

Location of Operation
- ○ Iraq
- ○ Afghanistan
- ○ Kuwait
- ○ Qatar
- ○ Bosnia/Kosovo
- ○ SW Asia - other
- ○ Africa
- ○ South America
- ○ North America
- ○ Australia
- ○ Europe
- ○ On a ship
- ○ Other: _____

Since return from deployment I have:
- ○ Maintained/returned to previous status
- ○ Transitioned to Selected Reserves: _____
- ○ Transitioned to Ready Reserves: _____
- ○ Retired from Military Service
- ○ Separated from Military Service

Current Contact Information:

Phone: _____
Cell: _____
DSN: _____
Email: _____
Address: _____

Total Deployments in Past 5 Years:

OIF	OEF	Other
○ 1	○ 1	○ 1
○ 2	○ 2	○ 2
○ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5 or more	○ 5 or more	○ 5 or more

Current Unit of Assignment

_____

Current Assignment Location

_____

_____

Point of Contact who can always reach you:

Name: _____
Phone: _____
Email: _____
Mailing Address: _____

Reset

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1. Overall, how would you rate your health during the PAST MONTH?
   ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. Compared to before your most recent deployment, how would you rate your health in general now?
   ○ Much better now than before I deployed
   ○ Somewhat better now than before I deployed
   ○ About the same as before I deployed
   ○ Somewhat worse now than before I deployed
   ○ Much worse now than before I deployed

3. Since you returned from deployment, about how many times have you seen a healthcare provider for any reason, such as in sick call, emergency room, primary care, family doctor, or mental health provider?
   ○ No visits ○ 1 visit ○ 2-3 visits ○ 4-5 visits ○ Over 6 visits

4. Since you returned from deployment, have you been hospitalized? ○ Yes ○ No

5. During your deployment, were you wounded, injured, assaulted or otherwise physically hurt? ○ Yes ○ No
   If NO, skip to Question 6.

   5a. **IF YES**, are you still having problems related to this wound, assault, or injury? ○ Yes ○ No ○ Unsure

6. Other than wounds or injuries, do you currently have a health concern or condition that you feel is related to your deployment? ○ Yes ○ No ○ Unsure
   IF NO, skip to Question 7.

   6a. **IF YES**, please mark the item(s) that best describe your deployment-related condition or concern:

   ○ Chronic cough
   ○ Runny nose
   ○ Fever
   ○ Weakness
   ○ Headaches
   ○ Swollen, stiff or painful joints
   ○ Back pain
   ○ Muscle aches
   ○ Numbness or tingling in hands or feet
   ○ Skin diseases or rashes
   ○ Ringing of the ears
   ○ Redness of eyes with tearing
   ○ Dimming of vision, like the lights were going out
   ○ Chest pain or pressure
   ○ Dizziness, fainting, light headedness
   ○ Difficulty breathing
   ○ Diarrhea, vomiting, or frequent indigestion
   ○ Problems sleeping or still feeling tired after sleeping
   ○ Difficulty remembering
   ○ Increased irritability
   ○ Taking more risks such as driving faster
   ○ Other: _____

7. Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed? ○ Yes ○ No
   IF NO, skip to Question 8.

   7a. **IF YES**, please mark the item(s) that best describe your concern:

   ○ DEET insect repellent applied to skin
   ○ Pesticide-treated uniforms
   ○ Environmental pesticides (like area fogging)
   ○ Flea or tick collars
   ○ Pesticide strips
   ○ Smoke from oil fire
   ○ Smoke from burning trash or feces
   ○ Vehicle or truck exhaust fumes
   ○ Tent heater smoke
   ○ JP8 or other fuels
   ○ Fog oils (smoke screen)
   ○ Solvents
   ○ Paints
   ○ Radiation
   ○ Radar/microwaves
   ○ Lasers
   ○ Loud noises
   ○ Excessive vibration
   ○ Industrial pollution
   ○ Sand/dust
   ○ Blast or motor vehicle accident
   ○ Depleted Uranium (if yes, explain)
   _____
   ○ Other: _____

8. Since return from your deployment, have you had serious conflicts with your spouse, family members, close friends, or at work that continue to cause you worry or concern? ○ Yes ○ No ○ Unsure

9. Have you had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you ....

   a. Have had any nightmares about it or thought about it when you did not want to ○ Yes ○ No

   b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it ○ Yes ○ No

   c. Were constantly on guard, watchful, or easily startled ○ Yes ○ No

   d. Felt numb or detached from others, activities, or your surroundings ○ Yes ○ No

10. a. In the PAST MONTH, did you use alcohol more than you meant to? ○ Yes ○ No

    b. In the PAST MONTH, have you felt that you wanted to or needed to cut down on your drinking? ○ Yes ○ No

11. Over the PAST MONTH, have you been bothered by the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○

12. If you checked off any problems or concerns on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

13. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ○ Yes ○ No

14. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ Yes ○ No

15. Are you currently interested in receiving assistance for a family or relationship concern? ○ Yes ○ No

16. Would you like to schedule a visit with a chaplain or a community support counselor? ○ Yes ○ No

[redacted] DD FORM 2900, JUN 2005 Reset 33348 [redacted]

Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY # ___ – ___ – ____

DATE (dd/mm/yyyy) __ / __ / ____

Provider Review and Interview

1. Review symptoms and deployment concerns identified on form:
   - ○ Confirmed screening results as reported
   - ○ Screening results modified, amended, clarified during interview: _____
2. Ask behavioral risk questions.
   a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? ○ Yes ○ No
      IF YES, about how often have you been bothered by these thoughts? ○ Very few days ○ More than half of the time ○ Nearly every day
   b. Since return from your deployment, have you had thoughts or concerns that you might hurt or lose control with someone? ○ Yes ○ No ○ Unsure
3. **IF YES OR UNSURE** to behavioral risk questions, conduct risk assessment.
   a. Does member pose a current risk for harm to self or others? ○ No, not a current risk ○ Yes, poses a current risk ○ Unsure, referred
   b. Outcome of assessment ○ Immediate referral ○ Routine follow-up referra ○ Referral not indicated
4. Record additional questions or concerns identified by patient during interview: _____

Assessment and Referral: After my interview with the service member and review of this form, there is a need for further evaluation and follow-up as indicated below. (More than one may be noted for patients with multiple concerns.)

5. Identified Concerns

	Minor Concern	Major Concern	Already Under Care: Yes	Already Under Care: No
○ Physical Symptom	○	○	○	○
○ Exposure Concern	○	○	○	○
○ Depression Symptoms	○	○	○	○
○ PTSD Symptoms	○	○	○	○
○ Anger/Aggression	○	○	○	○
○ Suicidal Ideation	○	○	○	○
○ Social/Family Conflict	○	○	○	○
○ Alcohol Use	○	○	○	○
○ Other: _____	○	○	○	○
○ None				

6. Referral Information
   - ○ a. No referral made
   - ○ b. Immediate/emergent care
   - ○ c. Primary Care, Family Practice
   - ○ d. Specialty Care: _____
   - ○ e. Behavioral Health in Primary Care
   - ○ f. Mental Health Specialty Care
   - ○ g. Case Manager, Care Manager
   - ○ h. Substance Abuse Program
   - ○ i. Health Promotion, Health Education
   - ○ j. Other Healthcare Service
   - ○ k. Chaplain
   - ○ l. Family Support, Community Service
   - ○ m. Military OneSource
   - ○ n. Other: _____
7. Comments: _____
8. Provider
   a. Name (Last, First) _____
   b. Signature and stamp: _____

ICD-9 Code for this visit: V70.5_6

Ancillary Staff/Administrative Section

9. Member was provided the following:
   - ○ Health Education and Information
   - ○ Health Care Benefits and Resources Information
   - ○ Appointment Assistance
   - ○ Service member declined to complete form
   - ○ Service member declined to complete interview/assessment
   - ○ Service member declined referral for services
   - ○ Other: _____
10. Referral made to the following healthcare or support system:
    - ○ Military Treatment Facility
    - ○ Division/Line-Based Medical Resource
    - ○ VA Medical Center or Community Clinic
    - ○ Vet Center
    - ○ TRICARE Provider
    - ○ Contract Support: _____
    - ○ Community Service: _____
    - ○ Other: _____
    - ○ None

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Appendix B

Child Soldiers

Rachel Stohl
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Center for Defense Information
and
Charlie Borchini
Colonel, U.S. Army Retired
Research Fellow
Center for Emerging Threats and Opportunities

June 23, 2003

The Impact of Conflict on Children

In the last decade:
- More than 20 million children have been displaced
- Two million killed
- One million orphaned
- Six million seriously injured or disabled
- Twelve million have become homeless

Child Soldiers
- Over 300,000 children in over 30 countries around the world
- Over 50 countries recruit children into the military forces

Definition of Child Soldier

- "Any person under the age of 18 that is engaged in deadly violence non-criminal or combat support as part of an armed force/group."
- Child soldiers are in government forces, rebel opposition groups, and guerrilla armies.
- Both boys and girls serve as child soldiers.

International Law

- Geneva Conventions
- UN Convention on the Rights of the Child (CRC)
- International Criminal Court (ICC) Rome Statute
- International Labor Organization (ILO) Convention 182
- Optional Protocol

Optional Protocol

- Requires states to "take all feasible measures" to ensure that members of their armed forces under the age of 18 years do not participate in hostilities;
- Prohibits the conscription of anyone under the age of 18 into the armed forces;
- Requires states to raise the age of voluntary recruitment from 15 and to deposit a binding declaration of the minimum age for recruitment into its armed forces; and
- Prohibits the recruitment or use in hostilities of children under the age of 18 by rebel or other non-governmental armed groups, and requires states to criminalize such practices.

Optional Protocol

- Signed by President Clinton in July 2000
- Entered into force on February 12, 2002
- Ratified by the Senate on June 18, 2002
- May 2003 – signed by 111 countries and ratified by 51

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UN Policy

- May 1999 – governments should not send military observers and civilian police younger than 25 to participate in UN operations.
- Other types of peacekeeping troops should preferably be 21, but definitely not younger than 18.
- Impacts the United Nation's 17 peacekeeping forces currently fielded, involving over 14,000 troops, military observers, and police from 76 countries.

Child Soldiers in the Democratic Republic of Congo (DRC)

- Tens of thousands child soldiers
- Both boys and girls used as child soldiers
- Government of DRC has ratified the Optional Protocol
- Children systematically abducted
- Children used on the front lines and support positions
- Children from other countries pressed into ranks of warring parties

Child Soldiers in the Democratic Republic of Congo (DRC)

- Child soldiers are believed to be 35 percent of troops in Congo
- 10 parties to the conflict believed to use child soldiers at end of 2002

  DRC government, MLC, RCD-G, RCD-N, RCD-K/ML, UPC, Masunzu's forces, Lendu militias, Ex-FAR/Inerahamwe, Mai Mai
- Former child soldiers face terrible hardships if they manage to leave armed forces

What Can Be Done?

- Create a central office within DoD with staff cognizance, responsibility, and expertise concerning U.S. policy on child soldiers,
- Develop capacity to interface with the Services, Joint Staff, NGOs/IOs, and the media on U.S. policies and the steps the U.S. military is taking to address the issue of child soldiers.
- Develop appropriate tactics, techniques, and procedures to deal with child soldiers

What Can Be Done?

- Define Rules of engagement
- Develop strategies to minimize casualties
- Process child POW's separately
- Develop child DDR programs
- Identify non-governmental organizations and UN agencies to assist
- Return child combatants to their families ASAP

For More Information

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Preparation

- Know the threat and focus intelligence collection
- Understand impact child soldiers will have upon our own forces
- Harmonize doctrine, training, and rules of engagement

Consider All Possible Actions

- Hold threat at a distance
- Fire for shock
- Break-up the threat
- Shape the battlefield -- create avenues for escape
- Exploit non-lethal weapons possibilities

Think Strategically

- Target adult leadership, center of gravity
- Eliminate recruitment zones and protect at-risk groups
- Use Psychological Operations
- Welcome and process prisoners and escapees

Deal with the Aftermath

- Attuned Public Affairs programs
- Familiarization with demobilization and reintegration programs
- Psychological needs of own forces

Future Efforts

- Training
  - Classes for students in training base and units in training or preparing to deploy
  - Seminars, panels, and other forums
  - Familiarize with the issue, examine countries and regions where phenomenon exists, discuss possible tactics, techniques, and procedures, highlight international law and rules of engagement
- Incorporate into exercise and wargame scenarios
- Foreign military training

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BIBLIOGRAPHY

Africa, Human Rights Watch, and Human Right Watch Children's Rights Project. *Easy Prey. Child Soldiers in Liberia*. 1-80. New York: Human Rights Watch, 1994.

Ambrose, Stephen E. *Citizen Soldiers: The U.S. Army from the Normandy Beaches to the Bulge to the Surrender of Germany, June 7, 1944-May 7, 1945*. New York: Simon and Schuster, 1997.

Amnesty International. 2005. Child Soldiers: A Global Issue. In, http://web.amnesty.org/pages/childsoldiers-background-eng. (accessed September 12, 2005).

Army Medical Surveillance Activity (AMSA). *Update and Review: Post Deployment Health Reassessment (PDHRA)*. 2: Department of Defense, 2006.

Baum, Dan. 2004. The Price of Valor. In, 2004-07-12, The New Yorker, http://www.newyorker.com/printables/fact/040712fa_fact. (accessed Nov 8, 2005, 2005).

Bonanno, George A. "Loss, Trauma, and Human Resilience. Have We Underestimated the Human Capacity to Thrive after Extremely Adverse Events?" *American Psychologist* 59, no. 1 (January 2004): 20-28.

Borchini, Charles, Stephanie Lanz, and Erin O'Connell. *Child Soldiers: Implications for U.S. Forces*. edited by Center for Emerging Threats and Opportunities (CETO), 1-30: Marine Corps Warfighting Laboratory, Quantico, VA, November 2002.

Brett, Rachel, and Irma Specht. *Young Soldiers. They Choose to Fight*. Bolder, CO: Lynne Rienner Publishers, 2004.

Bryant, Richard A., and Allison G. Harvey. *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*. Washington, DC: American Psychological Association, 2000.

Burgess, Lisa. 2004. U.S. Troop Presence in Afghanistan at 17,900 and Expected to Hold Steady. In, Stars and Stripes, http://www.globalsecurity.org/org/news/2004/040709-afghan-presence.htm. (accessed November 30, 2005).

Center for Defense Information. 1997. The Invisible Soldiers: Child Combatants. In, ed. The Defense Monitor. Volume XXVI, Number 4, The Defense Monitor, http://www.cdi.org/dm/1997/issue4/. (accessed 20 September, 2005).

Chairman of the Joint Chiefs of Staff. *Joint Publication 4-02. Health Service Support in Joint Operations*. I-8 through F-10. Washington, DC: Department of Defense, DRAFT 17 October 2005.

Coalition to Stop the Use of Child Soldiers. November 17, 2004. Child Soldiers Global Report 2004. In, http://www.child-soldiers.org/resources/global-reports?root_id=159&category_id=165. (accessed October 10, 2005).

Dod Expands Health Assessment Program Following Deployments. Spring 2005. In, 1056, Military Medicine, http://proquest.umi.com/pqdweb?index=0&did=821950721&SrchMode=1&sid=1&Fmt=4&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1134008547&clientId=417. (accessed October 28, 2005).

Favret, Lt Col James. E-mail communication outlining status of PDHRA program, January 30 2006.

Fuller, Graham E. *The Youth Factor: The New Demographics of the Middle East and the Implications for U.S. Policy*. edited by The Saban Center for Middle East Policy, 1-42: Brookings Institution, June 2003.

Greene, Col Carroll, A.F. Special Operations Command Psychologist, Col Charles W. Hoge, Walter Reed Army Institute of Research, Department of Psychiatry and Behavioral Sciences, and Col Elspeth Ritchie, U.S. Army Psychological Consultant to the Army Surgeon General. Telephone and e-mail conversations with author Nov 2005-Jan 2006.

Greene, Col Carroll, AFSOC Psychologist. Telephone Interview by the author, November 23, 2005.

Grossman, Dave. *On Killing: The Psychological Cost of Learning to Kill in War and Society*. Boston: Little, Brown and Company, 1995.

Grossman, Lt Col Dave. *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*: PPCT Research Publications, 2004.

Gurganus, Col Charles, 2nd Marine Division. Personal Interview by the author, November 17, 2005.

Helmus, Todd, and Russell Glen. *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*. Santa Monica, CA: Rand Corporation, 2005.

Higby, Col Charley, US Army War College Asst Dean for Academic Affairs, CAPT Mark Seaman, US Naval War College, Col Olsen S. Key, Air War College Faculty, Department of Joint Warfighting, and Col Stephen Holts, National Defense University. E-mail communication that attempted to ascertain if any of the services Senior Service Schools included child soldiers in any of its' wargaming scenarios., September 2005-January 2006 2005.

Hoge, Charles W., Carl A Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert Koffman. "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care." *The New England Journal of Medicine* 351, no. 1 (2004): 13-22.

Human Rights Watch. *My Gun Was as Tall as Me. Child Soldiers in Burma*. 1-213. New York: Human Rights Watch, 2002.

———. 2005. New Video, Photo Essay Tell Story of Uganda's Child "Night Commuters". In, Human Rights Watch, http://www.hrw.org/english/docs/2005/08/21/uganda11647.htm. (accessed September 10, 2005).

———. April 24, 2004. U.S.: Guantanamo Kids at Risk. In, Human Rights Watch, http://hrw.org/english/docs/2003/04/24/usint5782.htm. (accessed.

Jegen, Mary Evelyn. *Casualties of Warfare: Children and Childhood*. National Catholic Reporter, 1997.

"Kalashnikov Kids.(Tackling the Problem of Child Soldiers)." *The Economist* (1999).

Kilner, Major Peter G. Draft, 3 Jan 2005. The Military Ethicist's Role in Preventing and Treating Combat-Related, Perpetration-Induced Psychological Trauma. In, The Joint Services Conference on Professional Ethics (JSCOPE), http://atlas.usafa.af.mil/jscope/JSCOPE05/jscope05.html. (accessed Nov 11, 2005.

Litz, Brett T. 2005. The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq. In, National Center for Post Traumatic Stress Disorder (PTSD), http://www.ncptsd.va.gov/facts/veterans/fs_Iraq-Afghanistan_wars.html. (accessed November 8, 2005).

Machel, Graca. *The Impact of War on Children*. Edited by UNICEF. New York: PALGRAVE, 2001.

Mackenzie, Debora. "Trauma of War Hits Troops Years Later." *NewScientist* (2005): 6-7.
MacNair, Rachel M. *Perpetration-Induced Traumatic Stress*. Edited by Harvey Langholtz, *Psychological Dimensions to War and Peace*. Westport, CT: Praeger Publishers, 2002.
Maier, Timothy. 2002. Children Are Being Used as Soldiers; Third World Countries Increasingly Are Coercing Child Soldiers into Military Action, Raising Moral Dilemmas That Can Be Matters of Life and Death for Western Troops. In *Insight on the News*, 30 (2), News World Communications, Inc, http://find.galegroup.com/itx/infomark.do?type=retrieve&tabID=T002&prodId=SPJ.SP00&docId=A95150325&retrieveFormat=PDF&isAcrobatAvailable=true&userGroupName=maxw30823&version=1.0&isMultiPage=false&noOfPages=2&source=gale. (accessed Sep 20, 2005, 2005).
Marshall, S.L.A. *Men against Fire*. New York: William Morrow, 1947.
Mercy, James. E-mail communication with author Nov 30, 2005.
Nadelson, Theodore. *Trained to Kill: Soldiers at War*. Baltimore, MD: The John Hopkins University Press, 2005.
Nichols, Bill, and Mona Mahmoud. "Support for Iraq War at Lowest Level." *USA Today*, May 4, 2005.
Office of the Surgeon General Army. *Assessment of Detainee Medical Operations for OEF, GTMO, and OIF*. Department of the Army, 13 April, 2005.
Operation Iraqi Freedom Mental Health Advisory Team. *Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report*. edited by The U.S. Army Surgeon General, 1-A31: The U.S. Army Surgeon General, 30 January 2005.
Orsillo, Susan M., Frank W. Weathers, Brett T. Litz, Howard R. Steinberg, Jennifer A. Huska, and Terrence M. Keane. "Current and Lifetime Psychiatric Disorders among Veterans with War Zone-Related Posttraumatic Stress Disorder." *The Journal of Nervous and Mental Disease* 184, no. 5 (1996): 307-13.
Price, Johann. 2002. Operation Enduring Freedom: Coalition Casualties in Afghan Operations. In, v. 2.0 June 16, 2002, http://orbat.com/site/agtwopen/casualties2.html. (accessed Nov 11, 2005).
Singer, P.W. 2001-2002. Caution: Children at War. In *Parameters*, 4, Winter, U.S. Army War College, http://carlisle-www.army.mil/usawc/Parameters/01winter/singer.htm. (accessed September 20, 2005.
———. *Children at War*. New York: Pantheon Books, 2005.
———. 2003. Fighting Child Soldiers. In *Military Review*, Vol 83; Issue 3, Department of the Army Headquarters, http://proquest.umi.com/pqdweb?index=4&did=411111941&SrchMode=1&sid=3&Fmt=4&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1133641676&clientId=417. (accessed September 16, 2005).
Special Operations. 2000. Operation Barras. Sierra Leone. In, Special Operations.Com, http://www.specialoperations.com/Counterterrorism/Barras.htm. (accessed 20 September, 2005).
Stohl, Rachel. E-mail communication with author, September 23, 2005.
Szegedy-Maszak, Marianne. "The War of Emotions; Soldiers' Mental Disorder Were Once Dismissed as 'Shell Shock.' No Longer." *U.S. News & World Report*, Dec 17 2001, 46.

Ursano, Robert J., Brian G. McCaughey, and Carol S. Fullerton, eds. *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos*. Cambridge: Cambridge University Press, 1994.

Whitman, Lois. April 24, 2003. Letter to Secretary Rumsfeld on Child Detainees at Guantanamo: Human Rights Watch Urges Child Protections. In, Human Rights News, http://www.hrw.org/press/2003/04/us042403ltr.htm. (accessed January 27, 2006).

Zwi, AB, R Garfield, and A Loretti. "Collective Violence." In *World Report on Violence and Health*, edited by EG Krug, LL Dahlberg, JA Mercy, AB Zwi and R Lozano, 213-39. Geneva: World Health Organization, 2002.

ENDNOTES

[1] P.W. Singer, *Children at War* (New York: Pantheon Books, 2005), x.

[2] Timothy Maier, *Children Are Being Used as Soldiers; Third World Countries Increasingly Are Coercing Child Soldiers into Military Action, Raising Moral Dilemmas That Can Be Matters of Life and Death for Western Troops* (30 (2)) (News World Communications, Inc, 2002 [cited Sep 20, 2005 2005]); available from http://find.galegroup.com/itx/infomark.do?type=retrieve&tabID=T002&prodId=SPJ.SP00&docId=A95150325&retrieveFormat=PDF&isAcrobatAvailable=true&userGroupName=maxw30823&version=1.0&isMultiPage=false&noOfPages=2&source=gale.

[3] Johann Price, *Operation Enduring Freedom: Coalition Casualties in Afghan Operations* (v. 2.0 June 16, 2002) (2002 [cited Nov 11 2005]); available from http://orbat.com/site/agtwopen/casualties2.html.

[4] Singer, *Children at War*. 162-3.

[5] P.W. Singer, *Fighting Child Soldiers* (Vol 83; Issue 3) (Department of the Army Headquarters, 2003 [cited September 16 2005]); available from http://proquest.umi.com/pqdweb?index=4&did=411111941&SrchMode=1&sid=3&Fmt=4&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1133641676&clientId=417.

[6] Singer, *Children at War*.

[7] Charles W. Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *The New England Journal of Medicine* 351, no. 1 (2004), 14.

[8] Brett T. Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* (National Center for Post Traumatic Stress Disorder (PTSD), 2005 [cited November 8 2005]); available from http://www.ncptsd.va.gov/facts/veterans/fs_Iraq-Afghanistan_wars.html.

[9] Singer, *Children at War*. *v*.

[10] Charles Borchini, Stephanie Lanz, and Erin O'Connell, *Child Soldiers: Implications for U.S. Forces*, ed. Center for Emerging Threats and Opportunities (CETO) (Marine Corps Warfighting Laboratory, Quantico, VA, November 2002), 8.

[11] P.W. Singer, *Caution: Children at War* (4, Winter) (U.S. Army War College, 2001-2002 [cited September 20, 2005); available from http://carlisle-www.army.mil/usawc/Parameters/01winter/singer.htm.

[12] Singer, *Children at War*. 7.

[13] Amnesty International, *Child Soldiers: A Global Issue* (2005 [cited September 12 2005]); available from http://web.amnesty.org/pages/childsoldiers-background-eng.

[14] "Kalashnikov Kids.(Tackling the Problem of Child Soldiers)," *The Economist* (1999), 19.

[15] AB Zwi, R Garfield, and A Loretti, "Collective Violence," in *World Report on Violence and Health*, ed. EG Krug, et al. (Geneva: World Health Organization, 2002). 217.

[16] Human Rights Watch, *My Gun Was as Tall as Me. Child Soldiers in Burma*, (New York: Human Rights Watch, 2002).

[17] Singer, *Caution: Children at War* ([cited).

[18] Human Rights Watch, *New Video, Photo Essay Tell Story of Uganda's Child "Night Commuters"* (Human Rights Watch, 2005 [cited September 10 2005]); available from http://www.hrw.org/english/docs/2005/08/21/uganda11647.htm.

[19] Lisa Burgess, *U.S. Troop Presence in Afghanistan at 17,900 and Expected to Hold Steady* (Stars and Stripes, 2004 [cited November 30 2005]); available from http://www.globalsecurity.org/org/news/2004/040709-afghan-presence.htm.

[20] Coalition to Stop the Use of Child Soldiers, *Child Soldiers Global Report 2004* (November 17, 2004 [cited October 10, 2005]); available from http://www.child-soldiers.org/resources/global-reports?root_id=159&category_id=165.

[21] Ibid.([cited).

[22] Singer, *Caution: Children at War* ([cited).

[23] Graham E. Fuller, *The Youth Factor: The New Demographics of the Middle East and the Implications for U.S. Policy*, ed. The Saban Center for Middle East Policy (Brookings Institution, June 2003), 2.

[24] Human Rights Watch Africa and Human Right Watch Children's Rights Project, *Easy Prey. Child Soldiers in Liberia*, (New York: Human Rights Watch, 1994).

[25] Graca Machel, *The Impact of War on Children*, ed. UNICEF (New York: PALGRAVE, 2001), 11.

[26] Rachel Brett and Irma Specht, *Young Soldiers. They Choose to Fight* (Bolder, CO: Lynne Rienner Publishers, 2004), 123.

[27] Singer, *Caution: Children at War* ([cited).6.

[28] Ibid.([cited). 8.

[29] Mary Evelyn Jegen, *Casualties of Warfare: Children and Childhood*, (National Catholic Reporter, 1997).http://find.galegroup.com/itx/infomark.do?type=retrieve&tabID=T002&prodId=SPJ.SP00&docId=A19136141&userGroupName=maxw30823&version=1.0&source=gale

[30] Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* ([cited).

[31] Chairman of the Joint Chiefs of Staff, *Joint Publication 4-02. Health Service Support in Joint Operations*, (Washington, DC: Department of Defense, DRAFT 17 October 2005), I-9.

[32] Ibid., F-1.

[33] Major Peter G. Kilner, *The Military Ethicist's Role in Preventing and Treating Combat-Related, Perpetration-Induced Psychological Trauma* (The Joint Services Conference on Professional Ethics (JSCOPE), Draft, 3 Jan 2005 [cited Nov 11, 2005); available from http://atlas.usafa.af.mil/jscope/JSCOPE05/jscope05.html.

[34] Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* ([cited).

[35] *Dod Expands Health Assessment Program Following Deployments* (1056) (Military Medicine, Spring 2005 [cited October 28, 2005]); available from http://proquest.umi.com/pqdweb?index=0&did=821950721&SrchMode=1&sid=1&Fmt=4&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1134008547&clientId=417.

[36] Army Medical Surveillance Activity (AMSA), *Update and Review: Post Deployment Health Reassessment (PDHRA)*, (Department of Defense, 2006).

[37] Lt Col James Favret, E-mail communication outlining status of PDHRA program, January 30 2006.

[38] Borchini, Lanz, and O'Connell, *Child Soldiers: Implications for U.S. Forces*, 26.

[39] Col Charley Higby, US Army War College Asst Dean for Academic Affairs et al., E-mail communication that attempted to ascertain if any of the services Senior Service Schools included child soldiers in any of its' wargaming scenarios., September 2005-January 2006 2005.

[40] Singer, *Children at War*, 166.

[41] Rachel Stohl, E-mail communication with author, September 23, 2005.

[42] Col Carroll Greene, A.F. Special Operations Command Psychologist, Col Charles W. Hoge, Walter Reed Army Institute of Research, Department of Psychiatry and Behavioral Sciences, and Col Elspeth Ritchie, U.S. Army Psychological Consultant to the Army Surgeon General, Telephone and e-mail conversations with author Nov 2005-Jan 2006.

[43] George A. Bonanno, "Loss, Trauma, and Human Resilience. Have We Underestimated the Human Capacity to Thrive after Extremely Adverse Events?" *American Psychologist* 59, no. 1 (January 2004), 24.

[44] Col Carroll Greene, AFSOC Psychologist, Telephone Interview by the author, November 23, 2005.

[45] S.L.A. Marshall, *Men against Fire* (New York: William Morrow, 1947).

[46] Dan Baum, *The Price of Valor* (2004-07-12) (The New Yorker, 2004 [cited Nov 8, 2005 2005]); available from http://www.newyorker.com/printables/fact/040712fa_fact.

[47] Lt Col Dave Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace* (PPCT Research Publications, 2004), 205.

[48] Ibid., 207.

[49] Ibid., 208.

[50] Theodore Nadelson, *Trained to Kill: Soldiers at War*
(Baltimore, MD: The John Hopkins University Press, 2005), 42.

[51] Ibid., 43-44.

[52] Ibid., 48.

[53] Dave Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society*
(Boston: Little, Brown and Company, 1995), 99-130.

[54] Singer, *Children at War*, 162.

[55] Col Charles Gurganus, 2nd Marine Division, Personal Interview by the author, November 17, 2005.

[56] Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society*, 174.

[57] Singer, *Children at War*, 170.

[58] Stephen E. Ambrose, *Citizen Soldiers: The U.S. Army from the Normandy Beaches to the Bulge to the Surrender of Germany, June 7, 1944-May 7, 1945* (New York: Simon and Schuster, 1997), C. 19.

[59] Ibid.

[60] Singer, *Children at War*, 170.

[61] Special Operations, *Operation Barras. Sierra Leone* (Special Operations.Com, 2000 [cited 20 September 2005]); available from http://www.specialoperations.com/Counterterrorism/Barras.htm.

[62] Singer, *Children at War*. 163-4.

[63] Singer, *Caution: Children at War* ([cited).

[64] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*. 208

[65] Todd Helmus and Russell Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare* (Santa Monica, CA: Rand Corporation, 2005), 99.

[66] Marianne Szegedy-Maszak, "The War of Emotions; Soldiers' Mental Disorder Were Once Dismissed as 'Shell Shock.' No Longer," *U.S. News & World Report*, Dec 17 2001, 46.

[67] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, 274.

[68] Helmus and Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, xiii.

[69] Richard A. Bryant and Allison G. Harvey, *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment* (Washington, DC: American Psychological Association, 2000), 6-7.

[70] Ibid., 7.

[71] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, 11.

[72] Robert J. Ursano, Brian G. McCaughey, and Carol S. Fullerton, eds., *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos* (Cambridge: Cambridge University Press, 1994), 9.

[73] Nadelson, *Trained to Kill: Soldiers at War*, 90.

[74] Ursano, McCaughey, and Fullerton, eds., *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos*, 10.

[75] Ibid., 12.

[76] Bryant and Harvey, *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*, 140.

[77] Susan M. Orsillo et al., "Current and Lifetime Psychiatric Disorders among Veterans with War Zone-Related Posttraumatic Stress Disorder," *The Journal of Nervous and Mental Disease* 184, no. 5 (1996), 307.

[78] Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* ([cited).

[79] Debora Mackenzie, "Trauma of War Hits Troops Years Later," *NewScientist* (2005), 6.

[80] Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," 14.

[81] Ibid., 18.

[82] Operation Iraqi Freedom Mental Health Advisory Team, *Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report*, ed. The U.S. Army Surgeon General (The U.S. Army Surgeon General, 30 January 2005).

[83] Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* ([cited), Operation Iraqi Freedom Mental Health Advisory Team, *Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report*.

[84] Helmus and Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 128.

[85] Rachel M. MacNair, *Perpetration-Induced Traumatic Stress*, ed. Harvey Langholtz, *Psychological Dimensions to War and Peace* (Westport, CT: Praeger Publishers, 2002), 13-20.

[86] Kilner, *The Military Ethicist's Role in Preventing and Treating Combat-Related, Perpetration-Induced Psychological Trauma* ([cited).

[87] Singer, *Children at War*, 170.

[88] Nadelson, *Trained to Kill: Soldiers at War*, 89.

[89] Litz, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq* ([cited).

[90] Bill Nichols and Mona Mahmoud, "Support for Iraq War at Lowest Level.," *USA Today*, May 4, 2005.

[91] Singer, *Fighting Child Soldiers* ([cited).

[92] Lois Whitman, *Letter to Secretary Rumsfeld on Child Detainees at Guantanamo: Human Rights Watch Urges Child Protections* (Human Rights News, April 24, 2003 [cited January 27, 2006]); available from http://www.hrw.org/press/2003/04/us042403ltr.htm.

[93] Human Rights Watch, *U.S.: Guantanamo Kids at Risk* (Human Rights Watch, April 24, 2004 [cited); available from http://hrw.org/english/docs/2003/04/24/usint5782.htm.

[94] Whitman, *Letter to Secretary Rumsfeld on Child Detainees at Guantanamo: Human Rights Watch Urges Child Protections* ([cited).

[95] Office of the Surgeon General Army, *Assessment of Detainee Medical Operations for OEF, GTMO, and OIF*, (Department of the Army, 13 April, 2005), 18-4.

[96] Singer, *Fighting Child Soldiers* ([cited).

[97] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, 268.

[98] Helmus and Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 127-31.

[99] Singer, *Fighting Child Soldiers* ([cited).

[100] Grossman, *On Killing: The Psychological Cost of Learning to Kill in War and Society*, 48, 76.

[101] Helmus and Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 99-102.

[102] Bryant and Harvey, *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*, 167-68.

[103] Maier, *Children Are Being Used as Soldiers; Third World Countries Increasingly Are Coercing Child Soldiers into Military Action, Raising Moral Dilemmas That Can Be Matters of Life and Death for Western Troops* ([cited).

[104] Greene.

[105] Helmus and Glen, *Steeling the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 121-24.

[106] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, 311-12.

[107] Bryant and Harvey, *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*, 170-73.

[108] Operation Iraqi Freedom Mental Health Advisory Team, *Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report*.

[109] Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," 13, 16.

[110] Grossman, *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, 290.

[111] Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," 16.

[112] Singer, *Fighting Child Soldiers* ([cited).

[113] James Mercy, E-mail communication with author Nov 30, 2005.

[114] Singer, *Caution: Children at War* ([cited).

[115] Center for Defense Information, *The Invisible Soldiers: Child Combatants* (Volume XXVI, Number 4) (The Defense Monitor, 1997 [cited 20 September 2005]); available from http://www.cdi.org/dm/1997/issue4/.