

**Arming Commanders to Combat PTSD:
A Time For Change – Attacking the Stressors Vice the
Symptoms**

**A Monograph
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Abstract

Arming Commanders to Combat Posttraumatic Stress Disorder by COL Robert D. Haycock, US Army, 53 pages.

Just as war is not a new phenomenon, neither are the issues associated with the mental and emotional scars combat brings to those who fight a nation's wars. Historically, the United States has assumed a reactive vice proactive posture as it relates to coping with the fiscal, and humanistic challenges that manifest within a nation at war, and those who experience the trauma of combat. The Army has proven slow to respond to the need to train and educate its leaders and instead has devoted vast capital on the assessment and treatment of posttraumatic stress disorder (PTSD), attacking the symptoms as they arise, vice attacking the stressors which cause the affliction. The invasions of Iraq and Afghanistan and the deployment of forces throughout the world to combat terror, however, have created conditions whereby PTSD is again in the lime-light.

This monograph examines PTSD from a historical perspective reviewing the manner in which the Army viewed, assessed, and treated those afflicted with PTSD as well its methods for training and educating those honored with the opportunity to lead these warriors in battle. This monograph highlights existing shortfalls in assessment, training, doctrine, and education as it relates to those commanding at the battalion-level.

The Army does not properly prepare battalion commanders for the complexities of coping with PTSD in their units nor arm them with the tactics, techniques, and procedures necessary to mitigate the effects of PTSD on the combat effectiveness of their units and the soldiers that fill the ranks.

The Army should implement more rigorous assessment programs for units deployed to identify those at risk of PTSD or demonstrating stress-related symptoms before the mental well-being of the soldier is dramatically affected and treatment becomes more difficult. Further, the Army should review and update existing doctrine and training techniques (*Battlemind* training) to focus specifically on commanders at the battalion level. The Army must demonstrate a linkage between doctrine, training and education, enhance efforts to consolidate PTSD resources for ease of access, and revise strategic communications procedures to reduce stigmas associated with PTSD. The Army must arm its tactical commanders with the tools to address the stressors associated with PTSD in order to preserve the force and ensure its effectiveness in the ambiguous and complex environment which appears to best characterize the way ahead.

Almost 200 years ago, Carl Von Clausewitz described war as, “This tremendous friction, which cannot, as in mechanics, be reduced to a few points, is everywhere in contact with chance, and brings about effects that cannot be measured, just because they are largely due to chance”¹ He states further that the dangers which are inseparable from war and the physical exertions associated with it can add to the friction of combat and as such, “The good general must know friction in order to overcome it whenever possible and in order not to expect a standard of achievement in his operations which this very friction makes impossible”² If one applies Clausewitz’s view of war to the nearly 400 armed conflicts which countries have waged since 1800, one can easily see the truth in his words and what it indicates for commanders.

Nations throughout history glorified the warrior on the battlefield and committed much of their national treasure to equipping, manning, and deploying armies. Nations often measured success and defeat by the acquisition or loss of territory and treasure, and the number of soldiers killed and physically wounded. Arguably, nations and their militaries glorified and simplified armed conflict in an attempt to make the war more palatable to the respective populations.

Recent deployments in support of the Global War on Terror (GWOT), best characterized by counterinsurgency (COIN) operations, arguably reflect the type of operations this nation is likely to engage in for the foreseeable future. The current and future operating environment is as Field Manual (FM) 3-0 describes, an era of persistent conflict which is complex, multidimensional, and increasingly fought among the people.³ In other words, current and future operations emphasize that which most military officers clearly recognize: Asymmetrical and

¹ Carl Von Clausewitz, *On War* (Princeton, New Jersey: Princeton University Press, 1984), 120.

² Ibid., 19-120.

³ Headquarters, Department of the Army, *FM 3-0: Operations (United States: United States Government, 2008)*, Foreward.

non-contiguous battlefields are anything but simple and the fog of war and friction which Clausewitz describes is arguably more prevalent than any time in history. In light of the fact that few countries currently possess the resources to wage war for extended periods, careful application of force in a manner which preserves their national treasure becomes essential.

National treasure, however, is not defined in terms of fiscal or monetary terms alone and instead must also emphasize the preservation of the very people sent to fight the wars-the Soldiers. Clausewitz's statements above imply that good leaders are responsible for clearly understanding the operating environment and the effects friction has not only on operations, but also on those who execute them. Current operations across the globe highlight the fact that the emotional and mental stability of soldiers in a complex operating environment is essential. "A battalion is made up of individuals, the least important of whom may chance to delay things or somehow make them go wrong. The dangers inseparable from war and the physical exertions war demands can aggravate the problem to such an extent that they must be ranked among its principal causes."⁴ This statement implies that a unit is only as strong as its weakest link. In light of this, it seems feasible to recognize that Post Traumatic Stress Disorder (PTSD) is not only part of the friction of combat as described by Clausewitz, but is also the result of friction(s) associated with battle. "As with safeguarding physical health, safeguarding mental health is an integral component of the United States' national responsibilities to recruit, prepare, and sustain military force..."⁵ As such, commanders and leaders are responsible for understanding the impact PTSD has on the combat effectiveness of each soldier, and subsequently upon the

⁴ Clausewitz, *On War*, 119.

⁵ The RAND Corporation, Center for Military Health Policy Research, *Invisible Wounds of War,- Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery*, edited by Terri Tanielian and Lisa H. Jaycox (Santa Monica, Arlington, Pittsburgh, RAND Corporation, 2008), xix.

collective unit, and take measures to ensure mental and emotional stability within the ranks. Clearly, a failure in this regard inhibits combat effectiveness and can create long term emotional and mental scars on those who served. These mental and emotional scars come in many forms and have assumed many different names over time. Currently, however, experts refer to the mental and emotional scars carried by combat veterans as PTSD.

Post Traumatic Stress Disorder hit the national spotlight for the first time since the Vietnam Conflict as U.S. forces became engaged in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). During this recent conflict, PTSD befuddled commanders in the field as they struggled to balance mission accomplishment with the necessity of sustaining the force, and maintaining the health, morale, and welfare of assigned troops. This officer, as an infantry battalion commander fighting in Southwest Baghdad in 2005-2006, was no exception. He also grappled with the challenges associated with PTSD in his unit and identified it as the “unseen enemy” which unexpectedly mandated the dedication of great amounts of physical, emotional, and mental energy to defeat. In retrospect, the battalion received only cursory pre-deployment PTSD training in the form of suicide prevention training and PTSD pre-screening. Due to the limited command emphasis on this topic, the focus remained on the tactical and technical aspects of war fighting during pre-deployment and deployment operations. The assumption that PTSD related issues would likely prove minimal and within the capabilities of the mental health and medical community both during and after deployment, led to a lack of command emphasis which later created numerous challenges for the battalion.⁶

⁶ The battalion commander became engrossed with the complexities associated with fighting an insurgency, managing a 300 square kilometer area of operation, and the administrative actions to support 800-1400 soldiers deployed and in the rear detachment as well as their families. As such, he was slow to recognize the emotional, mental, and physical strains combat took on his battalion until one company went from 130 men to 85 after only 60

In early October, 2005, two hours after assuming command of the area of responsibility (AOR), the battalion suffered its first casualties: Four soldiers (to include a company First Sergeant) were killed by an Improvised Explosive Device (IED) blast. Thus began a pitched battle for control of the AOR, between the battalion and a very determined enemy characterized by a feverish Operational Tempo, extreme environmental conditions, and daily contact with enemy forces. Over the next twelve months, the effects of physical and emotional fatigue and PTSD⁷ gradually reduced the unit's combat effectiveness as casualties continued to rise. A summary of battalion operations during the twelve month deployment is as follows: The battalion conducted nearly 8000 combat patrols, 1400 cordon and search missions, forty-nine air assault operations, 380 search and attack missions, established over 2000 blocking positions and 5600 observation posts, conducted hundreds of convoy security operations, and built six company-patrol bases. Additionally, the battalion lost forty-four M1114/M1151 vehicles as a result of enemy engagements, discovered over 600 IEDs, suffered 123 wounded and had nineteen soldiers killed during combat operations (four of which were suicides).⁸

Throughout the deployment, the battalion commander repeatedly sought advice from other commanders and medical staff regarding means and measures to combat the effects of PTSD but was left to his own devices to determine measures to mitigate PTSD. These challenges with PTSD highlighted unit-level educational and training shortfalls associated with

days of fighting. In retrospect, the commander should have implemented measures to mitigate strains on the soldiers prior to deployment. Late recognition resulted in a tremendous reduction of unit combat effectiveness.

⁷ The author uses the term combat operational stress and PTSD interchangeably but recognizes that although-symptoms are similar the difference is primarily one of symptom duration. Few would diagnose soldiers with PTSD in theater at the time of his deployment so the author is unclear as to whether his soldiers suffered from combat operational stress or PTSD.

⁸ All statistics are based upon the commander's personal notes updated during the conduct of daily battlefield update briefs.

PTSD and emphasized the role that battalion and company grade commanders play in *identifying* and *mitigating* PTSD. Clearly, the battalion commander and his subordinate leaders were ill-prepared to cope with the challenges associated with PTSD which served to identify a problem which is the premise for this paper: The United States military proactively assesses and treats soldiers with PTSD but neither adequately trains nor educates battalion commanders to apply tactical measures on the battlefield to prevent or mitigate PTSD.

Material regarding combat related PTSD is abundant and available to include books, professional journals, internet sites, independent studies, Army Field Manuals (FMs), research articles and longitudinal studies. While U.S. involvement in the GWOT brought the issue of PTSD to the forefront and has mandated additional research, almost all research, however, still focuses on the Vietnam era. This comes as no surprise since the public outcry for answers following that conflict mandated extensive research, and it was during this time period that the term “PTSD” first came to fruition. Review of active duty military unit After Action Reviews (AARs), operations orders, and training plans address issues associated with PTSD proved helpful, but in most cases exceeded the classification of this paper and as such, can only be referenced in general terms. As a result, reliance on a careful review of existing literature combined with interviews with mental health care providers, PTSD program managers, individuals at the Center for Army Lessons Learned, and behavioral scientists at the United States Army PTSD Training Program within the Army Medical Department (AMEDD) Center and School, and personal experience serve as the basis for this research and will help answer several questions to include: What is the historical significance of PTSD? What is PTSD? What are its causes and symptoms? How are soldiers affected? Is the Army proactive or reactive in assessment, mitigation, treatment, and prevention and what education and training

does it mandate? Does the Army need to adjust current training methods and does the training focus need to change to support tactical leaders in combat? What are the strategic implications of PTSD?

An initial survey (Tactical Commander PTSD Survey) distributed to 265 current and former battalion commanders from combat, combat support and combat service support branches, addresses these questions; 65 officers responded to the request for information.⁹ This survey also addresses the question as to whether these commanders felt prepared to cope with challenges associated with PTSD during deployment and what could the Army do to better to prepare its leaders to prevent and mitigate PTSD on the battlefield?¹⁰ As a result of the feedback from throughout the Army, the author distributed a second survey (Combat Arms Tactical PTSD Survey) specifically addressing tactical prevention considerations was distributed to only fifty officers from the Fires, Maneuver and Effects branch in order to gain their insight as to what tactical measures were employed successfully or should have been considered. The author refers to the results of the general survey periodically throughout this paper but the study focuses predominately on those officers who participated in both.¹¹ This paper is framed and outlined in sections to address the questions as depicted above.

PTSD, as it is now formally recognized, did not exist until the American Psychological Association (APA) defined it in 1980 in the Diagnostic and Statistical Manual of Mental

⁹ 45 of the 65 officers who responded to the Tactical Commander PTSD Survey were from the Fires, Maneuver and Effects Branch).

¹⁰ Selection of participants for both surveys came from a list provided by SCP, CGSC and from the author's personal knowledge of those who commanded.

¹¹ The author recognizes the importance of feedback from non-combat arms commanders; however this study will focus on those most likely to engage the enemy in the close fight.

Disorders Volume III (DSMIII).¹² One can, however, trace the roots of its evolution back through history. Just as war is not a new phenomenon, neither are the issues associated with the mental and emotional stress combat brings to those who fight a nation's wars. Regardless of its current name, scholars refer to the trauma of combat in many factual and fictional accounts of battle dating back centuries. In fact, *The Iliad* by Homer, written twenty-seven centuries ago, is parallel to posttraumatic stress of today. Achilles, the hero of the *Iliad*, (circa 700 B.C.) was undergoing traumatic battle experiences and suffering stress reactions similar to documented combat stress victims of the Civil War, World War I, World War II, Korean War, Vietnam War and the Gulf War. Also, Homer's epic poem, *The Odyssey*, (circa 700 B. C.) describes the psychological travels of Odysseus, a recent veteran of the Trojan Wars who was returning home. His problems, like many modern soldiers, included flashbacks and survivor's guilt.¹³

Throughout history, many military leaders recognized the psychological and emotional impact that the carnage of battle placed upon the soldiers that participated in combat. Countless examples exist that demonstrate commanders' attempts to mitigate its impact. As early as the Middle Ages, commanders used military bands and tight formations of men to instill confidence in the soldiers, promote cohesion, and mitigate the effects of trauma on the soldiers within their formations. History demonstrates that friction especially that of mental stress in combat remains constant. What has changed over time, however, is the manner in which leaders and medical professionals view the soldiers' reactions to it, how they have defined the condition, and subsequently prescribed treatment. Reviewing the evolution of PTSD brings to light an alarming

¹² Alastair M. Hull, Patricia M. Doherty and Linda J. Bowes. "What is the Profile of Post-Traumatic Reactions Within Medical Literature?" *The Irish Journal of Psychological Medicine* 19, no. 4 (2002), 125-127, <http://www.ijpm.org/index.html?level=e&artid=164> (accessed January 18, 2009).

¹³ Kevin Roberts, PhD., "Post traumatic Stress Disorders: A Chronological Account," <http://www.militaryconnection.com/articles/health/ptsd-chronological-account.html> (accessed January 18, 2009).

trend characterized by a failure to acknowledge the existence of mental and emotional trauma related injuries and scorn towards those who suffered from it.

During the Revolutionary War, mental health disorders that are recognizably similar to those seen in modern armies of today plagued George Washington's Continental Army.¹⁴ Unfortunately his leaders did not the fully understand the complexities associated with the soldiers' reactions to trauma and placed little emphasis on assessment, diagnosis or treatment. Instead of seeking aid for those soldiers who suffered from what was called "melancholia" and "insanity", they instead questioned the character and honor of those demonstrating an aversion to combat and shamed them into fighting.¹⁵

Likewise during the Civil War, soldiers experiencing mental and emotional injuries were diagnosed as having "Soldier's Heart" or "Soldier's Melancholy"¹⁶ In 1871, doctor Jacob Mendes DeCosta, an American physician, began studying those Civil War veterans who demonstrated stress-related heart palpitations, increased breathing and headaches as a result of the mental and emotional stressors they experienced during the war. Dr. DeCosta concluded that the patients did not have heart disease; their condition was instead a disturbance with their nervous system that he labeled "Irritable Heart" or "DeCosta's Syndrome"¹⁷ Many, however, still questioned the validity of such a condition and treatment of veterans usually continued to be one of scorn. In fact, Civil War veterans had to prove "irritable heart" to claim disability and in most cases their claims were rejected on the basis that acknowledgment of any form of "self-

¹⁴ Penny Coleman, *Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War* (Boston: Beacon Press, 2006), 19.

¹⁵ Ibid.

¹⁶ James Le Fanu, "The Irritable Heart of Soldiers and the Origins of Anglo American Cardiology: The US Civil War (1861 to World War I (1918)," *Journal of the Royal Society of Medicine* 96, no. 3 (March 2003), 151-152.

¹⁷ Roberts, "Post Traumatic Stress Disorders: A Chronological Account."

pollution” was unworthy of official support.¹⁸ The most important aspect of this era from an evolutionary standpoint is the fact that leaders and physicians had come to grips with the fact that soldiers were emotionally and psychologically affected by the horrors of war. This acknowledgment, therefore, led to a period of increased psychological study.

Despite this increased recognition that trauma had adverse affects on soldiers and increased period of study, the assessment, diagnosis, and treatment of soldiers suffering from emotional and mental trauma hardly fared better in the years immediately following the Civil War. In fact, at the outbreak of World War I, no country was prepared to cope with the massive influx of stress-related casualties associated with this “new” kind of war. In no previous conflict had men, been pinned into place by the stasis of trench warfare, or experienced the trauma and devastation inflicted by new weapons such as the machine gun, gas, and tank, nor had any soldier been subjected to artillery exchanges of such regularity, intensity and magnitude.¹⁹

During this war, therefore, military and medical professionals implemented a diagnosis and treatment procedures characterized by prompt, forward and simplified treatment where the goal was simply to give the afflicted soldiers rest so that they could rapidly return those who suffered from “shell shock” to duty. The U.S. Army Surgeon, General, Major General Raymond Whitcomb Bliss, implemented a three-echelon system for prevention, triage, treatment, and

¹⁸ Coleman, *Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War*, 24.

¹⁹ Franklin D. Jones, M.D., F.A.P.A., *War Psychiatry* (2008, May –Updated), http://www.bordeninstitute.army.mil/published_volumes/war_psychiatry/war_psychiatry.html (accessed January 20, 2009), 8.

return to duty of stress casualties which integrated trained psychiatrists into each division and also established neurological hospitals to assist afflicted soldiers.²⁰

Regrettably, these lessons of WWI were lost and the Army was again ill-prepared to diagnose or treat the massive number of psychiatric casualties during World War II. Instead, the Army had to rediscover the experiences of the previous war and implement procedures to treat an estimated 504,000 trauma-based casualties.²¹ The Army, however, was more proactive in determining the cause of “battle fatigue”, and subsequent diagnosis and treatment techniques than ever before. Numerous studies of the time focused on the epidemiology of combat stress casualties. That is, the direct relationship to intensity of combat, modified by physical and morale factors, and the relationship between stress-related casualties and unit cohesion, morale, leadership, and combat intensity.²² These studies taught combat psychiatrists several important lessons to include: psychiatric casualties are inevitable, pre-induction screening is ineffective, combat stress casualty numbers depended on individual, unit, and combat environmental factors, appropriate interventions can return the majority to combat duty, units with good morale and leadership had fewer combat stress casualties, and increases in cumulative stress and increases in the intensity of the fighting increased the likelihood that a soldier became a combat stress casualty.²³

Typically, the United States military was again ill-prepared to meet the needs of its psychiatric casualties at the outbreak of the Korean War. Fortunately, only five years had

²⁰ Headquarters Department of the Army, FM 22-51: *Leaders' Manual for Combat Stress Control* (United States: United States Government, 1994), 1-4.

²¹ Dave Grossman and Loren Christensen, *On Combat: Psychology and Physiology of Deadly Conflict in War and Peace*, 2nd ed. (United States of America: PPCT Research Publications, 2007), 12.

²² Jones, M.D., F.A.P.A., *War Psychiatry*, 14-15.

²³ *Ibid.*, 14-15.

elapsed, and the lessons of World War II were still well known and the principles learned during that war were applied appropriately: combat stress casualties were treated forward, usually by battalion surgeons, experienced aid man or another soldier and returned to duty in such a manner that psychiatric casualties accounted for only about five percent of medical out-of-country evacuations.²⁴ Psychiatric studies during this conflict built upon lessons learned from the World War I and World War II, and progress was made in terms of diagnosis, treatment, and assessment. One study conducted by the Operations Research Office from John Hopkins University entitled, *A Study of Combat Stress-Korea 1952*, studied the effects of combat stress on the infantryman.

In this study, the psychiatrist and medical doctors analyzed the psychological and physiological effects of combat on infantryman and concluded that: soldiers need an adjustment period prior to going into combat (as a replacement) and all soldiers need time away from the front, medical and company officers require joint training on stress related injuries, early return of neuropsychiatric casualties to combat from the lowest echelon possible saves manpower and gives the individual additional opportunity to prove himself, and effective leadership and unit cohesion reduces mental and emotional injuries.²⁵ These findings were significant for three reasons: First, they demonstrated a change in attitude, treatment diagnosis, and assessment which serve as the bases by which current Army combat stress doctrine is founded.²⁶ Second, psychologists and military leaders finally recognized that “shell shock”, as the affliction was

²⁴ Ibid., 16.

²⁵ Stanley Davis, et al., *A Study of Combat Stress: Korea 1952*, (Baltimore: Operations Research Office, John Hopkins University, 1952), 137-156. (The control group consisted of four groups of infantryman to include soldiers diagnosed with stress disorders, soldiers who had recently conducted offensive operations, soldiers who had recently conducted defensive operations, and soldiers who had served in the rear area).

²⁶ Lisa S. Beall, “Post-Traumatic Stress Disorder: A Bibliographic Essay.” (1997), <http://www.lib.auburn.edu/socsci/docs/ptsd.html> (accessed January 17, 2008)

called during World War I, or “combat fatigue” as it was called in World War II and Korea did not represent an inborn mental illness or an individual character flaw but instead, were indicative of a psychological disease due to psychic shock, terror, and over-exposure to the friction of war. Finally, the outcome of the psychiatric studies conducted during this era was the formal acknowledgement by the American Psychological Association (APA) in 1952 that combat related psychological disorders actually existed and its subsequent inclusion in the DSM-I in the form of “Stress Response Syndrome” under the heading “Gross Stress Reactions”.²⁷ As the United States became embroiled in the Vietnam Conflict, the number of combat stress related casualties rose to a point where neuropsychiatric cases accounted for over sixty percent of all medical evacuations from the theater by war’s end.²⁸ During this era, “battle fatigue” casualty rates rarely exceeded one per ten wounded in action (WIA) due to the sporadic nature of fighting, U.S. military air and artillery superiority, scheduled rest and recuperation (R&R), and a fixed combat tour.²⁹ Other behavioral problems related to combat stress, however, became more prevalent. Drug abuse, alcoholism, “fragging” and other behavioral anomalies rose dramatically.³⁰ As such, the military and medical professionals again reviewed existing procedures for assessment, diagnosis, and treatment of soldiers afflicted with mental and emotional disorders associated with combat.

²⁷ Ibid., (In 1968, the APA revised the DSM I and produced the DSM II which did little to impact treatment or diagnosis but instead, merely categorized all trauma related disorders under the category “situational disorders”).

²⁸ Headquarters Department of the Army, FM 22-51: *Leaders’ Manual for Combat Stress Control* (United States: United States Government, September 29, 1994), 1-6.

²⁹ Ibid., 1-5 and 1-6.

³⁰ “Fragging” is a term which became popular during the Vietnam War and refers to a soldier killing his superior officer. Normally, “fragging” took place during actual combat operations where evidence identifying the attacker proved difficult to ascertain.

In 1980, the APA published the DSM-III which listed PTSD as a subcategory of anxiety disorders. The inclusion of PTSD in the DSM proved controversial for although it legitimized this psychological disorder, many debated as to whether PTSD was an anxiety or a dissociative disorder. Others argued that the inclusion was merely re-labeling what had already been described as "shell shock," "war neurosis," "traumatic neurosis," "combat trauma," or "combat fatigue."³¹ Public outcry for help from veterans and their families ultimately led Congress to mandate The National Vietnam Veterans' Readjustment Study (NVVRS) in 1983 which focused on obtaining accurate prevalence rates of postwar psychological problems in order to serve the needs of the nation's veterans.³² This study concluded that although the "majority" of the 830,000 Vietnam veterans appeared to have successfully readjusted to postwar life, between twenty six and thirty percent exhibited some symptoms of PTSD and were experiencing a wide range of adjustment challenges.³³

The United States involvement in the Persian Gulf War of 1990-1991, though brief in duration, brought the issue of PTSD to the forefront again as veterans struggled with issues associated with possible exposure to chemical weapons, and Gulf War Syndrome. Research on PTSD continued following the war and in 1994, the APA published DSM-IV which further legitimized PTSD by classifying it as a new stress response category.³⁴ Then in 2005, the Department of Veterans Affairs published its annual report, as mandated by Congress, which

³¹ Beall, "Post-Traumatic Stress Disorder: A Bibliographic Essay."

³² Jennifer L. Price, "PTSD Fact Sheet-Findings From the National Vietnam Veterans' Readjustment Study", United States Department of Veterans Affairs National Center for PTSD, http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_nvvr.html?opm=1&rr=rr45&srt=d&echorr=true (accessed January 14, 2009).

³³ Ibid.

³⁴ Beall, "Post-Traumatic Stress Disorder: A Bibliographic Essay."

outlined the results of research projects conducted during a period of January 2003 to December 2003.³⁵ These research projects focused on symptoms and general health status, brain and nervous system function, diagnosis, reproduction, treatment, prevention, chemical weapons, pyridostigmine bromide and interactions of exposures for Vietnam veterans.³⁶ These studies were thorough and the conclusions addressed issues that are well beyond the scope of this paper. However, the report also indicated that the rate of PTSD among Gulf War veterans was 10.1% and ruled out a connection between PTSD and Gulf War Syndrome.³⁷

The United States now faces similar challenges with PTSD as it wages the GWOT in Iraq and Afghanistan. The nature of this conflict, characterized by multiple, and in many cases back to back deployments, tour extensions, challenging and complex environmental factors, and an elusive enemy, foster conditions whereby the number of PTSD cases is likely to increase. As of April, 2008 over 59,000 veterans of OIF and OEF had been diagnosed with PTSD.³⁸ This number, however, is likely low and does not include the countless service members who did not seek care as a result of limited access to treatment facilities and concern for the stigma attached to diagnosis. Granted, the government is devoting extensive resources to enhance capabilities to more accurately identify, assess, and treat PTSD. However, the gap between treatment and prevention which has existed since the 1800s does not appear to be narrowing.

³⁵ Deployment Health Working Group Research Subcommittee, Department of Veterans Affairs. *Annual Report to Congress-Federally Sponsored Research on Gulf War Veterans' Illness for 2003*, 1, (February 2005), <http://www1.va.gov/resdev/resources/pubs/docs/GulfWarRpt03.pdf> (accessed January 10, 2009).

³⁶ Ibid., 1.

³⁷ Ibid.

³⁸ Kelly Kennedy, "Many Troops With PTSD Aren't Treated-Advocates Blame Stigma, Lack of Access," *Military Times*, Apr 14, 2008.

“In an area of operations characterized by continuous action and high danger, our forces may experience high rates of stress casualties unless small-unit leaders are trained and prepared to manage stress.”³⁹ Leaders, however, can only manage stress as directed by FM 6-22.5 if they understand what causes it and understand the symptoms associated with it. Throughout history, many psychiatric professionals debated as to what type of injury PTSD represents: Is it an emotional, physical, or anxiety-based injury? Research appears to indicate that PTSD represents aspects of all three. There are several definitions of PTSD but arguably, the most authoritative reference, The Diagnostic and Statistical Manual of Mental Disorders Volume IV (DSM-IV TR), defines PTSD as:

The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.⁴⁰

One challenge that leaders face as they attempt to mitigate PTSD on the battlefield is the fact that every soldier reacts differently to the same stressor. This said, the leader must remain cognizant that traumatic experiences can create changes in the soldiers' brain that may immediately, or over time, result in PTSD. The physiological reactions to stress are very complex and difficult to explain. In basic terms, the traumatic event triggers a biological response, or innate “fight or flight” reaction in the soldier's brain. More specifically, when the body is exposed to a stressful

³⁹ Headquarters, Department of the Army, *FM 6-22.5: Combat Stress* (United States: United States Government, 2000), preface).

⁴⁰ American Psychiatric Publishing Inc. “Posttraumatic Stress Disorder.” *Diagnostic and Statistical Manual For Mental Disorder*, 4th ed. <http://www.psychiatryonline.com/content.aspx?aID=3357&searchStr=post-traumatic+stress+disorder> (accessed 19 January 2009).

condition, the hypothalamus situated in the brain, secretes hormones which activate the adrenal or the suprarenal glands which are responsible for the physiological effects of stress through the “fight or flight response.”⁴¹ Most psychiatrists agree that this “fight or flight” response to danger is normal and that most who experience mental or emotional challenges as a result of exposure to a traumatic event overcome these challenges without a need for assistance from mental health professionals. If this is the case, however, what constitutes a person getting diagnosed with PTSD? The DSM-IV-TR articulates five diagnostic or symptomatic criteria which serve as the basis for diagnosis (A-F) as depicted below:

The first criteria, Criterion A-Stressor, dictates that the soldier was exposed to a traumatic event in which he experienced, witnessed, or was confronted with an event/events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others; and the soldier’s response involved intense fear, helplessness, or horror. If the soldier does not meet these criteria, then he cannot be diagnosed with PTSD.⁴²

The second criteria, Criterion B-Intrusive Recollection, prescribes that the soldier persistently re-experiences the event in at least one of the following ways: The soldier experiences recurrent and intrusive distressing recollections of the event; experiences recurrent distressing dreams of the event; acts or feels as if the traumatic event was recurring; exhibits intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event he experienced; exhibits physiologic reactivity upon exposure to

⁴¹ Stressfocus.com, “Physiological Stress Response: Its Effects on the Body,” http://www.stressfocus.com/stress_focus_article/physiological-stress-effects.htm (accessed January 18, 2009).

⁴² United States Department of Veterans Affairs National Center for PTSD, “Fact Sheet-DSM-IV-TR Criteria for PTSD,” http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_dsm_iv_tr.html (accessed January 17, 2009). The “and” qualifier is significant because many face traumatic experiences in combat but what is most important is how they respond to it. However, a detailed explanation as to how psychologists determined the criteria and specifics for diagnosis as outlined in the DSM-IV-TR is beyond the scope of this paper.

internal or external cues that symbolize or resemble an aspect of the traumatic event.⁴³ Soldiers that exhibit the symptoms as described in this criteria may find themselves constantly thinking about the traumatic event, having nightmares about the experience, or experience other physiological reactions such as rapid heart rate, hyper-ventilation, or sweating when they reflect upon the event, or find themselves in an environment where the stimulus reminds them of the event.

The third criteria as depicted in the DSM-IV-TR, Criterion C-Avoidant/numbing, mandates that the soldier demonstrates a persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness,(not present before the trauma), as indicated by at least three of the following: The soldier avoids thoughts, feelings, or conversations associated with the trauma; attempts to avoid activities, places, or people that arouse recollections of the trauma; demonstrates an inability to recall important aspects of the traumatic experience; exhibits diminished interest or participation in significant activities, displays a detachment or estrangement from others; demonstrates a restricted range of affect (no loving feelings); exhibits a sense of foreshortened future.⁴⁴ Soldiers who meet this criteria may startle easily, have difficulty remember certain aspects associated with the traumatic event, may distance themselves from others or events that remind them of the event, and have difficulty maintaining personal relationships.

The fourth criteria outlined in the DSM-IV-TR, Criterion D- Hyper-Arousal, dictates that the soldier must display persistent symptoms of increased arousal which were not present before the trauma, indicated by at least two of the following: difficulty falling or staying asleep;

⁴³ Ibid.

⁴⁴ Ibid.

irritability or outbursts of anger; difficulty concentrating; hyper-vigilance; exaggerated startle response. Soldiers meeting this criterion may demonstrate a constant state of alert, or get easily frustrated with those around them or the environment.⁴⁵

The fifth criteria for PTSD, Criterion E- Duration, specifies that the duration of the disturbance, as outlined in the criteria/symptoms B, C, and D, must exceed one month.⁴⁶ Interestingly, the Army does not agree with the fifth criteria for diagnosing PTSD. Instead, the Army uses three months as the threshold as opposed to thirty days with the view that anyone who exhibits a failure to recover naturally from stress, after having been removed from the stressor for less than ninety days is suffering from combat operational stress, and not PTSD.⁴⁷

Recognizing that the symptoms of combat operational stress are similar to PTSD, with the duration of symptoms as the major difference, one cannot help but wonder if the Army should modify its current position to ensure soldiers receive applicable care before combat operational stress evolves into PTSD? It remains unclear as to why the Army deviates from the DSM-IV-TR in this regard, however, it may be that the DMS-IV-TR as a document lends itself to ambiguity and makes diagnosis and treatment complex. This document provides a definition of PTSD, however, the multiplicity of conditions and symptoms that each soldier experiences and the fact that no single approach for diagnosis or treatment is adequate for all cases, limits the utility of the DSM-IV-TR.

The final criteria for PTSD diagnosis, Criterion F-Functional Significance, dictates that the disturbance causes the soldier clinically significant distress or impairment in social,

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Gerry Grace, PhD. Team Leader, PTSD Training Section of the AMEDD Center and School, interview by author (telephonic), January 22, 2009.

occupational, or other important areas of functioning. This criteria determines whether the soldier is suffering from Acute PTSD (symptoms for one to three months) or chronic PTSD (symptoms for more than three months) and determines whether the soldier is experiencing PTSD with or without delay onset (onset of symptoms at least six months after exposed to the stressor).⁴⁸

Most people exhibit some of the symptoms/criteria as outlined in the DSM-IV-TR following a traumatic experience but will not likely develop PTSD. Why then do some become afflicted while others do not? There is no clear answer to this question, however, experts believe that the likelihood that a person will get PTSD is based on several factors to include: the intensity and duration of the trauma, how close the individual was to the event, how strongly they reacted to the event, how much in control the individual felt he or she was, whether the individual was injured, whether the individual lost someone they were close to, the amount of help and support the individual received, and the timeliness of the help received.⁴⁹ In the final analysis, however, it is logical to conclude that the discriminator between those who develop PTSD and those who do not is dependent upon the soldiers' individual ability to disassociate between stimuli which caused stress in the past, and stimuli associated with current, safe conditions.

The DSM-IV-TR further defines two stress-induced disorders closely related to PTSD. The first disorder, Acute Stress Disorder (ASD), was introduced into the DSM-IV-TR in 1994. Although the current diagnostic criteria for ASD are similar to the criteria for PTSD, they differ

⁴⁸ NCPTSD, "Fact Sheet-DSM-IV-TR Criteria for PTSD."

⁴⁹ United States Department of Veterans Affairs National Center for PTSD, "PTSD Fact Sheet-What is Posttraumatic Stress Disorder (PTSD)?" http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_what_is_ptsd.html?opm=1&rr=rr13&srt=d&echorr=true, (accessed January 19, 2009).

in the duration of the symptoms and the amount of emphasis placed on dissociative symptoms. ASD symptoms normally occur in a soldier between two and four days following the traumatic incident and can last up to four weeks: ASD diagnosis mandates additional emphasis on dissociative symptoms which include; a lack of emotional responsiveness, a sense of numbing or detachment, a reduced sense of surroundings, an inability to remember certain aspects of the trauma, a sense of not being real, trouble experiencing pleasure, purposeful avoidance of exposure to thoughts, emotions, conversations, places or people that remind them of the trauma and an increased state of anxiety and arousal such as a difficulty staying awake or falling asleep.⁵⁰ Soldiers that experience these symptoms for a period exceeding four weeks are diagnosed with either chronic or acute PTSD as described above. If symptoms exceed four weeks but are not considered severe enough for a diagnosis of PTSD, then the soldier is diagnosed with the second type of stress disorder called adjustment disorder⁵¹

As defined by the DSM IV TR, Adjustment Disorder is a temporary maladaptive reaction of a person to identifiable psychosocial pressures, with its reaction response emerging within three months after the initiation of the stressors and persists no longer than six months.⁵² Diagnostic criteria for adjustment disorders are similar to the criteria for PTSD and ASD. Again, where they differ, however, is in the duration of the symptoms, the amount of emphasis placed on the dissociative symptoms and treatment techniques.

⁵⁰ NCPTSD, "Fact Sheet-DSM-IV-TR Criteria for PTSD."

⁵¹ Rebecca Frey, PhD., "Acute Stress Disorder," *Psychology Today* (2007), Acute Stress Disorder: *Psychology Today*, <http://www.psychologytoday.com/conditons/acutestress.html>, (accessed January 18, 2009).

⁵² PSYweb.com, "Adjustment Disorders," <http://psyweb.come/Mdisord/jsp/adjd.jsp#cd> (accessed January 18, 2009).

A careful review of the emotional, behavioral, cognitive, and physical symptoms of PTSD as depicted in the DSM-IV-TR, or analysis of subsequent manifestations such as substance abuse, suicide, unemployment, spousal abuse, or divorce, may lead one to debate as to whether these represent symptoms of PTSD or are the result of having PTSD. There is without a doubt, however, a correlation between these symptoms and manifestations and PTSD. Research indicates that two-thirds of all servicemen diagnosed with PTSD also have major depression while statistically, those with PTSD are also at greater risk for behavioral conditions such as substance abuse, unemployment, divorce, suicide, homelessness, and spousal abuse.⁵³

The suicide rate within the active duty Army, for example, increased at an alarming rate over the past 20 years; 102 soldiers committed suicide in 1991 and sixty-seven committed suicide in 2004. Since then, the numbers steadily increased over the next three years to eighty-five, 102, and 115, respectively.⁵⁴ The exact suicide figures for 2008 are still forthcoming, but according to the Army, 143 soldiers committed suicide (including fifteen still pending final determination) during this year alone.⁵⁵ The number of suicides among veterans is also staggering. Veterans Affairs statistics indicate that 144 soldiers committed suicide from among the 500,000 veterans who have left the military between 2002-2005.⁵⁶ This alarming trend captured the attention of military and civilian leaders alike and led military and civilian mental

⁵³ The RAND Corporation, Center for Military Health Policy Research, *Invisible Wounds of War- Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery*, ed. Terri Tanjelian and Lisa H. Jaycox (Santa Monica, Arlington, Pittsburgh: RAND Corporation, 2008), 128-141.

⁵⁴ Pauline Jelinek, AP., "Army suicides on the Rise Again," Editor and Publisher Journal (May 29, 2008), http://www.editorandpublisher.com/eandp/news/article_display.jsp?vnu_content_id=1003809654 (accessed January 22, 2009). She highlights that the military did not even start keeping records on PTSD until 1980.

⁵⁵ Peter W. Chiarelli, VCSA, Email to all senior leaders concerning suicides, dtd January 29, 2009, <https://webmail.us.army.mil/en/mail.html?lang=en&laurel=on&cal=1> (accessed January 29, 2009).

⁵⁶ Jelinek, "Army Suicides on the Rise Again."

health professionals to conduct several additional studies to examine the linkage between PTSD and suicide and the cause of the alarming trend.

Collectively, these studies demonstrated that although statistics indicate an increase in suicides in the Army, they all call into question the validity of the statistics. Ultimately, one must recognize that these statistics may be skewed for several reasons: First, most statistics provide insight into the number of soldiers that either attempted or committed suicide but fail to link these statistics specifically with PTSD. Perhaps the soldier that committed suicide had not been diagnosed with PTSD? Second, suicide statistics are difficult to validate because suicide attempts are only included in the statistical summary if they are reported as such to the government or organization conducting the study. How do you record an attempted suicide if the soldier who attempted suicide did so without anyone's knowledge or did so but the cause of his death was not listed as suicide? Finally, it appears as though statistical reporting of suicides within the military is viewed with suspicion as a result of misleading or fraudulent reporting by some within military or governmental agencies.

In May 2008, for example, the House Committee on Veterans' Affairs, led by Chairman Bob Filner (D-CA), held a hearing to learn the truth about veterans' suicides and determine whether some within the Department of Veterans Affairs (VA) had attempted to manipulate suicide data to portray a lesser problem. During this hearing Ira Katz, MD, PhD, the Veterans Affairs' Deputy Chief Patient Care Services Officer for Mental Health, contradicted earlier reports which indicated that there was a low suicide rate among veterans and admitted that Veterans Administration prevention coordinators were identifying about 1000 suicide attempts

per month among the veterans seen in VA medical facilities.⁵⁷ If true, this number represents a staggering number of veterans and makes one wonder how many soldiers actually attempt to commit suicide a year as a result of PTSD and what if any connection exists between these suicides and PTSD? In the final analysis, the true number of warriors who committed suicide as a result of PTSD and its linkage between PTSD and each individual case may never be known. This does not however, relinquish the government from its responsibility to continue research, establish linkages between PTSD and suicide, and assist those afflicted with PTSD.

Likewise, substance abuse and divorce rates among OIF and OEF soldiers also continues to rise with some estimates indicating that the substance abuse rate of veterans after only the four years of the war was at nearly twenty-one percent, while nearly fifteen percent of veterans at least contemplated divorce during this same time period.⁵⁸ This indicates that PTSD can create conditions whereby a soldier who went to combat “without” emotional or mental disorders can develop them as a result of the trauma he experienced in combat. In light of the fact that research indicates that exposure to trauma can profoundly influence initiation, continuation, and relapse of drug, alcohol, and tobacco use⁵⁹ how will trauma affect the estimated 1.6 million soldiers who deployed to OIF and/or OEF and had suffered from emotional and mental challenges prior to deployment? These types of questions have caused the senior leadership of the Army to react and initiate programs to stem the tide of stress on our soldiers. On January 30, 2009, the Vice Chief of Staff of the Army sent out an email to all senior leaders addressing this

⁵⁷ “The Truth About Veterans’ Suicides,” *House Committee On Veterans’ Affairs*, May 6, 2008, <http://veterans.house.gov/news/PRArticle.aspx?NewsID=242> (accessed January 4, 2009).

⁵⁸ Leo Shane III, “Researchers: Alcohol misuse, divorce rates higher among returning troops,” *Stars and Stripes*, *Mideast edition*, December 9, 2005, <http://www.stripes.com/article.asp?section=104&article=32730&archive=true> (accessed January 5, 2009).

⁵⁹ Nora Volkow, M.D., *National Institute on Drug Abuse (NIDA) Community Drug Alert Bulletin-Stress and Substance Abuse*, <http://www.nida.nih.gov/StressAlert/StressAlert.html> (accessed January 14, 2009).

issue. In his email, he stressed several key points which highlighted the additional emphasis the leadership of the Army is placing on this sensitive topic to include: suicides are occurring across every segment of the force at an alarming rate; this is not business as usual and is a leader responsibility.⁶⁰

This email, in conjunction with recent additional research, appears to validate the view that the Army has only begun to scratch the tip of the proverbial iceberg as it relates to defining the serious nature of this problem, and the impacts that the horror of war are having on the soldiers individually and society collectively

How then does the Army assess or diagnose PTSD in the soldiers who serve? Military psychologists, in conjunction with civilian psychiatric agencies, developed three primary assessment tools using the DSM-IV as a point of departure which include: pre-deployment assessment (DD2795), post-deployment health assessment (PDHA, DD2796), and the post-deployment health assessment-repeat (PDHA-R, DD2900). Army Directive 2007-02 (Deployment Cycle Support Directive), dated 26 March 2007, dictates the implementation of these health assessment surveys within the force. Although several officers that participated in both surveys distributed by the author indicated that their unit did not receive PTSD pre-deployment screening using the DD2795, the Deployment Cycle Support Directive does mandate that medical care providers administer this assessment to all soldiers prior to deployment. One can conclude, however, that the reason that these officers did not receive a DD2795 prior to deployment, is because they deployed prior to the publication of this directive. Further, this directive mandates that medical care providers administer “behavioral health assessments” to all

⁶⁰ Chiarelli, Email to all senior leaders concerning suicides.

soldiers prior to deployment “as necessary”.⁶¹ It fails, however, to define “behavioral health assessments” and differentiate between these assessments and the DD2795, DD2796, or DD2900. Additionally, this directive mandates the use of “behavioral health assessments” on an “as necessary” basis without specifying what conditions warrant its use.⁶² Although it is unclear as to why the directive does not clarify the difference between the three existing health assessment tools and the “behavioral health assessments, one can conclude that the reference to “as necessary” simply provides flexibility to exercise command and self referrals any time a soldier demonstrates behavioral symptoms indicative of emotional stress.

Review of Army Directive 2007-02 also indicates that the Army fails to mandate 100% screening of soldiers at any time during a deployment. Instead, it directs that all soldiers receive the PDHA and PDHA-R at the conclusion of the deployment.⁶³ The first post-deployment assessment, the PDHA, is administered to each soldier as part of redeployment activities in theater or within 30 days of redeployment. Each soldier fills out the PDHA and conducts a face-to-face interview with a trained health care provider where each service member's current health, mental health or psycho-social issues such as special medications taken during the deployment, possible deployment-related occupational/environmental exposures, and deployment-related health concerns are addressed.⁶⁴ The PDHA-R, though similar to the PDHA, is administered 90-180 days following redeployment and is a proven assessment technique because most symptoms

⁶¹ Department of the Army, “Policy Guidance-Deployment Cycle Support,” *Army Directive 2007-02*, 26 March 2007: 13.

⁶² Ibid.

⁶³ Ibid., 14-15.

⁶⁴ Department of Defense Deployment Health Clinical Center, “Deployment Support,” <http://www.pdhealth.mil/dcs/default.asp> (accessed January 20, 2009).

of PTSD occur within six months of the traumatic experience.⁶⁵ At the conclusion of the PDHA and PDHA-R, mental health and medical care providers provide feedback to the soldier both discuss and document all health concerns and provide resource options to the soldier. If during the course of the PDHA or PDHA-R process a soldier displays symptoms of PTSD, the mental health community administers follow-on supplemental assessment tools and provides referrals for medical consultation to validate the existence of emotional, cognitive, or anxiety type disorders.

There are a few problems with this diagnosis and assessment approach and philosophy, however, which are worthy of discussion. First, the failure to conduct any type of screening during a deployment prevents the chain of command and mental health care providers from establishing a baseline on the soldier to determine how he or she is affected by stress and the degree to which he or she are affected during the deployment. Second, both the PDHA and PDHA-R rely on honest and forthright answers on behalf of those soldiers taking them. Fear of an attached stigma of weakness or cowardice, in conjunction with the fear that diagnosis may mandate separation from the service, may influence a soldier's responses in a manner which does not accurately reflect the true state of his medical and mental condition. Finally, despite the fact that an overwhelming number of battalion commanders indicated that they encouraged soldiers to seek care providers as necessary and did not believe a stigma existed within their unit, health care providers are not in full agreement.⁶⁶ In fact, the issue of diagnosing PTSD in the current conflict is a very contentious and sensitive issue; in most cases, those with anxiety, emotional,

⁶⁵ Grace, January 22, 2009 Interview.

⁶⁶ Information acquired from Tactical Commander PTSD Survey, distributed to battalion commanders (branch immaterial) by the author.

and stress disorders are classified as combat operational stress casualties for treatment purposes to both prevent afflicted soldiers from being redeployed and alleviate friction with tactical commanders who are trying to preserve combat power.⁶⁷ Despite this challenge, the health assessment tools currently in use by mental health and medical care providers appear to accurately identify those soldiers who are challenged with emotional and anxiety stress disorders when they are forthright, and allow for prompt diagnosis and treatment of PTSD.

Over the past two years, military and civilian psychiatrists have changed the focus of treatment for soldiers afflicted with stress disorders. According to Dr. John Fortunato, a clinical psychologist from Fort Bliss, Texas, pre-2007 treatment for soldiers suffering from emotional and anxiety based afflictions "...consisted of medication and group counseling and very little individual counseling because of insufficient staff."⁶⁸ He stated further, that if soldiers were not found fit for duty after 3 months of treatment, psychologists had to sign documentation stating that these soldiers had received maximum benefit from inpatient and outpatient treatment and had to be medically discharged even though he and other psychologists knew that the Army simply had not done enough to rehabilitate them.⁶⁹ Fortunately his view, and his innovative treatment facility at Fort Bliss drew the attention of the Army Chief of Staff, General George Casey, and thus more command emphasis and resources concerning diagnosis and treatment resulted. In light of the fact that each soldier experiences stress differently, and there a multitude of combinations of symptoms by which PTSD can be diagnosed, it becomes easy for one to see why treatment is so complex. However, additional command emphasis and continued study now

⁶⁷ Grace, January 22, 2009 Interview.

⁶⁸ Virginia Reze, "PTSD and Soldier Suicide," The Fort Leavenworth Lamp, July 24, 2008. A4

⁶⁹ Ibid.

make a wide variety of treatment options available for afflicted soldiers. Psychiatrists now recognize that these treatment options or combination of treatment options are dependent upon the type of symptoms the soldier demonstrates, the duration of the symptoms, and where the soldier goes for treatment. Treatment techniques implemented to support deployed soldiers are similar to those used to support soldiers at home station; the major difference, however, is that there are generally fewer mental health specialists available on deployments than within the continental United States and thus, more emphasis is placed on the use of chaplains to facilitate critical-debriefings both individually and collectively.⁷⁰

Currently, mental health professionals treat soldiers using psychiatric, developmental, psychodynamic, family support, cognitive-behavioral, and existential-humanistic approaches either individually or in combination with varying degrees of success. The Army, however, has the highest success rate using one or a combination of the following three treatment techniques; Eye Movement Desensitization And Reprocessing (EMDR), Prolonged Exposure Therapy (PE), and Cognitive Processing Therapy (CPT).⁷¹

The EMDR therapy program focuses on the way the brain processes information: Psychiatrist believe that unresolved traumatic experiences inhibit the manner in which the mind processes information and that involuntary eye movement can reduce negative thoughts, facilitate cognitive thought, and reduce PTSD. During EMDR, the therapist works with the soldier to identify a specific problem and focuses the efforts of the session on getting the soldier

⁷⁰ This assumption is based upon the author's personal experience as a battalion commander prior to, during, and following OIF. In this capacity, he spent hundreds of hours consulting mental health care providers on behalf of his soldiers both at home station and abroad.

⁷¹ Grace, January 22, 2009 Interview.

to recall the event that caused him anxiety and stress. Throughout the session, the therapist facilitates the directional movement of the eyes while the soldier focuses on the disturbing material. Although the effectiveness of this therapy is questionable, many believe that at the conclusion of the therapy, the soldier no longer relives the images, sounds and emotions when the traumatic event comes to mind.⁷²

Another treatment technique currently in use by Army and civilian psychiatrists to treat anxiety based disorders is PE. This therapeutic treatment is the most empirically validated treatment for PTSD, and it is based upon the premise that avoidance strategies used to avoid anxiety provoking stimuli become the primary problem during treatment.⁷³ As such, the psychiatrist uses role-playing and situationally-based scenarios to encourage the soldier to talk about the traumatic experience. Many therapists hesitate to use exposure therapy however, because it can cause distress and possibly drive patients away from therapy. But a rigorous review of treatments for PTSD conducted by the U.S. Institute of Medicine in the Fall of 2007, concluded that the only treatment for PTSD supported by a strong evidence base was exposure therapy.⁷⁴ Again, the success of any treatment varies by individual and as such, psychiatrists must vary or combine treatments to maximize effectiveness.

The third primary treatment technique currently used to help soldiers afflicted with anxiety or emotional challenges is CPT. CPT is based upon social cognitive theory and emphasizes addressing aspects of the mind where fear and shame have impeded normal

⁷² Boulware, Carol MFT, Ph.D. "EMDR offers New Hope!," *Psychotherapist.net*. (2006), <http://www.psychotherapist.net/emdr-faq.html#anchor452196> (accessed January 22, 2009).

⁷³ Aaron Levin, "Prolonged Exposure Therapy Helps Ward Off PTSD," *American Psychiatric Association* 43, no. 13, page 13.

⁷⁴ *Ibid.*

processing functions; it differs from EMDR and PE in that it uses didactic and role-play scenarios to stimulate the natural recovery associated with psychological trauma.⁷⁵ The military and psychiatric communities continue to make great strides in refining treatment techniques associated with PTSD but continue to struggle with effective educational and training techniques to combat this affliction.

Historically, the Army has used field manuals and briefings as a means of educating and training those within its ranks. The effectiveness of these techniques, however, is arguably in question and represent challenges for military leaders. The Combat Stress Field Manual 6-22.5, for example, was designed to educate soldiers and leaders as to the genesis of combat stress and PTSD. It states, “The same leadership skills that apply to troop welfare and war fighting can effectively reduce or prevent combat stress reactions. Leaders should take preventive actions and address stress symptoms as they appear.”⁷⁶ This statement clearly demonstrated the significance that both the Army and Marine Corps placed on understanding the causes, effects, and symptoms of PTSD but specifically stated that leaders must take preventive actions to address stress symptoms as they appear. Herein lies the problem; this view encouraged reactive leadership aimed at addressing symptoms as they appear vice proactive leadership addressing the stressors which create the symptoms. This statement amplified the sentiment that doctrine reflected the same reactive view towards combat stress which has pervaded since the Revolutionary War era. One might argue that if a leader waits to act until he or she recognizes combat operational stress or PTSD symptoms as described in the DSM-IV and FM 22-6.5, the

⁷⁵ Candice Monson et al., “Cognitive Processing Therapy for Veterans With Military-related Posttraumatic Stress Disorder,” *Journal of Consulting and Clinical Psychology* 74, no. 5, 898-907. (April 26, 2006). http://www.ncptsd.va.gov/ncmain/nc_archives/nc_articles/id28862.pdf (accessed January 21, 2009).

⁷⁶ Headquarters, Department of the Army, FM 6-22.5: Combat Stress, 17.

soldier(s) is already progressing towards PTSD and a problem within the command already exists. Although FM 6-22.5 is an informative document which addresses both symptoms and stressors, it addresses them as separate entities and fails to establish a connection between the two. This in turn makes translation of knowledge and understanding of PTSD into actions on the ground prior to, during, or after deployment difficult for leaders. This recognition led to the publication of FM 4- 02.51, *Combat and Operational Stress Control*, in 2006. This document represents a paradigm shift from traditional thinking in that it emphasizes the commanders' role as it relates to combat operational stress mitigation, and stresses the correlation between stressors and symptoms. Unfortunately, this doctrinal reference, like those which preceded it, also fails to provide many specific tactical measures that commanders can implement to mitigate PTSD. The other challenge with the use of Field Manuals as a means of educating and training the force concerns awareness and availability. The Combat Arms PTSD Leader survey taken by former and current battalion commanders indicated that only four of the thirty-seven combat arms officers were even aware that FM 6-22.5 or FM 4-02.51 existed and had consulted either manual during or following deployment.⁷⁷ FM 4- 02.51 could prove a very effective point of reference for a battalion commander, but only if he is aware of its existence and is able to translate the knowledge gained by reading it into a training and educational program within his or her unit.

Fortunately, military leaders recognize that more must be done to augment existing doctrine in order to better train and educate the train soldiers and leaders in the prevention and mitigation of PTSD and its manifestations.⁷⁸ A review of current educational and training

⁷⁷ Combat Arms Tactical PTSD Leader Survey.

⁷⁸ Chiarelli, Email to all senior leaders concerning suicides.

techniques and directives began in earnest in 2003 and continues today as the Army continues to struggle through a period some call “crisis intervention”⁷⁹ In response to the mounting psychiatric casualties and manifestations, the Army subsequently committed billions of dollars to study these disorders, provide resources to soldiers and their families modify educational and training techniques and programs.

A review of Army Directive 2007-02 highlights recent command emphasis placed on preparing soldiers and their families for the rigors of combat. This directive is a consolidated listing of 113 separate tasks that the Army leadership expects all subordinate leaders to implement throughout the 7 deployment cycle support stages which include; train-up/preparation, mobilization, deployment, employment, redeployment, post-deployment, and reconstitution.⁸⁰ This document serves to identify, codify, and assign responsibility for these tasks and delineate during which phase the leadership will conduct them. Though this directive is a fairly comprehensive listing of training and education tasks, careful analysis indicates that most tasks simply reflect day-to-day operational requirements necessary to effectively run a unit and do not specifically address PTSD or its manifestations. In fact, only thirty-seven of the 113 tasks are directly linked to prevention or mitigation of PTSD symptoms or manifestations and of those thirty-seven tasks, nine represent standard briefings. These briefings, as mandated by the Army Directive 2007-2, include; sexual assault prevention and response, substance abuse, safety, personnel policy impact briefs, suicide awareness, medical threats, Military OneSource awareness, Family Advocacy Program for soldiers and families, and a preventive medical

⁷⁹ Grace, January 22, 2009 Interview. Crisis intervention implies reactive vice proactive training and educational programs.

⁸⁰ Department of the Army, “Policy Guidance-Deployment Cycle Support,” 8-18. Subsequent review of two divisional level training directives indicate that many units simply mirror the training requirements, as outlined in the Army directive and fail to mandate additional training for leaders and soldiers.

brief.⁸¹ While few will argue with the necessity of providing information to soldiers, this particular forum is arguably less effective than hands on training. This document does, however, direct that all soldiers conduct the Battlemind pre-deployment, post deployment, and suicide prevention training as part of the deployment cycle process. It also dictates that leaders receive additional training in the form of the Battlemind Leader Training Module prior to deployment.

Battlemind Training is a promising, innovative and scenario based training program first developed in 2003 at Walter Reed Army Hospital in response to a public outcry for assistance with dealing with the stressors associated with combat. This training and education program is based upon the train-the-trainer concept and consists of both video and briefing modules focused on strengthening a soldiers' inner strength to face fear and adversity with courage during combat, instilling the will and perseverance to win on the modern battlefield, and developing mental and emotional resilience.⁸² The Battlemind program also strives to institutionalize Battlemind principles and concepts into the Army training and education system in order to reduce existing behavioral health barriers and facilitate organizational growth.⁸³ What makes this training and education program revolutionary is that it integrates videos, scenarios, and briefings to emphasize the relationship between stressors prevalent on the field of battle and the mental,

⁸¹ Ibid., 8-18. Military OneSource is a 24/7 resource for members of the armed forces and their families and provides information concerning topics such as coping with deployments, budgeting, transition from the service, moving, crisis response, and the wounded warrior program. More information regarding Military OneSource can be found at: <http://www.militaryonesource.com/skins/MOS/home.aspx>. The Family Advocacy Program (FAP) is an Army program which focuses on prevention education programs and procedures for identifying, reporting, investigating, and treatment of child and spouse abuse. This program is designed to strengthen families. More information concerning FAP can be located in Army Regulation 608-18, The Army Family Advocacy Program, at: http://www.army.mil/usapa/epubs/pdf/r608_18.pdf.

⁸² Battlemind, "Army Suicide Prevention Program (2008 Video)," <https://www.battlemind.army.mil/sso/index.cfm?PageTypeName=LifeCycle&videoId=25> (accessed January 31, 2009).

⁸³ Ibid.

emotional and physical effects that result from exposure to them. This approach represents a tremendous effort to bridge the gap between traditional education and training as depicted in current doctrine and that which is necessary to condition soldiers to effectively both during combat and upon return.

The Battlemind training and education program modules are categorized into three areas of emphasis; deployment cycle, life cycle, and soldier support. Within the deployment cycle category, one finds the Battlemind Video which is further subdivided into 6 subsections to facilitate review. Topics of discussion and education within this category range from conditioning or preparing soldiers for the sights, sounds, and smells of combat, to identifying and coping with emotional trauma, mild traumatic brain injury (mTBI) and PTSD during preparation for deployment. This video helps soldiers to not only understand what environmental, physical and emotional stressors exist on the battlefield, but also understand the relationship between these stressors and the physiological and mental actions and reactions they cause. This program emphasizes to the soldier that which he can expect to experience on the battlefield, explains what he or she can expect immediately upon deployment and entry into a hostile environment, and outlines what they can do to remain mentally tough and capable. Success, according to the video, requires each soldier to “steel their mind”, be a battle buddy, listen to non-commissioned and commissioned officers, trust in their training, and maintain contact with friends and family.⁸⁴

Another sub-section within the deployment cycle educational module concerns mTBI and PTSD. These videos define PTSD and mTBI and outline the symptoms for the soldiers and leaders. Implementation of role playing scenarios coupled with a formatted briefing provide

⁸⁴ Battlemind, “Steeling Your Battlemind (2008 Video),” <https://www.battlemind.army.mil/sso/index.cfm?PageTypeName=DeploymentCycle&videoId=19> (accessed January 31, 2009).

information which helps soldiers identify with these challenges and demonstrates how one might respond to help those afflicted with either injury. The prevalent theme throughout both videos, however, is that everyone experiences and reacts to the stresses of combat differently and although most never require treatment, these afflictions are treatable.

The second area of emphasis, life cycle, focuses on PTSD as described above (same video) but also discusses suicide prevention at length. The video describes the risk factors, operational stress factors, and symptoms associated with suicide. The strength of this video in comparison to traditional educational and training briefs and current doctrinal references is that following each point of discussion, the soldier sees a short role-playing video clip reinforcing the key points of the discussion topic. This reinforces that lesson which the target audience is to learn from the training experience. The suicide prevention video not only addresses those points pertinent to a soldier, but also addresses leader responsibilities as well. This video series emphasizes that the Army Suicide Prevention Program (SASP) is a commander's program and as such, facilitates an understanding of his or her responsibilities and actions necessary to identify and find help for a Soldier who may be considering suicide due to relationship, financial, or administrative problems.⁸⁵

The third and final area of emphasis within Battlemind is called the soldier support cycle. The target audience of the educational experience within this cycle does not concentrate on active duty soldiers but instead includes; National Guard and Reserve Component, network providers and military families. The fourteen videos contained within the Battlemind support cycle training and education modules address a myriad of topics and provide tools for young

⁸⁵ Battlemind, "Army Suicide Prevention Program (2008 Video)."

children and families to use to facilitate their efforts to process and cope with separation anxiety in a healthy way.

The Battlemind website also provides numerous resources to soldiers and leaders for implementation and augmentation with the video series. These resources include; numerous training materials and brochures, unit behavioral health needs assessment survey, unit needs assessment survey manual, in-brief formats, and training modules for families and soldiers during pre-deployment, redeployment, and post deployment. Of specific interest, however, is the Pre-Deployment Battlemind for Leaders Training Module.

This 73-slide presentation is a more comprehensive explanation of those topics discussed in the “Steel Your Mind” video and integrates lessons learned from studies dating back to 1952. A study conducted by the Operations Research Office entitled, “A Study of Combat Stress –Korea 1952”, concluded that morale, cohesion, and leadership had the biggest impact on combat stress prevention.⁸⁶ Fortunately, these lessons are not lost in the Pre-Deployment Battlemind for Leaders Training Module. In fact, this training module effectively demonstrates how morale, cohesion, and leadership can address both the symptoms and the stressors associated with PTSD. So how then does this training module differ from traditional briefings using current doctrine? Most doctrinal references regarding combat stress since 1952 stressed the importance of morale, cohesion, and leadership as it relates to combat stress, but most focused more on defining the symptoms as opposed to providing specific techniques for addressing the stressors. Since 2001, however, the Army has attempted to shift its training base from one which historically reacted to symptoms, to one which fosters a command climate characterized by high morale, sterling

⁸⁶ Stanley Davis et al., *A Study of Combat Stress –Korea 1952*, (Baltimore: Operations Research Office, John Hopkins University, 1952), 131-133, 156.

leadership and unit cohesion. This more proactive stance which aggressively addresses combat stressors before they become symptoms represents a new paradigm.

The Pre-Deployment Battlemind for Leaders Training Module defines, describes, and exposes the leader to the cruel nature of combat. This leader module places emphasis on describing the chaos of combat, the profile of the enemy, the nature of war, and provides worst day scenarios for leaders to contemplate.⁸⁷ Embedded throughout is a description of what the leaders may see, hear, smell, think, and feel. The training model then expounds on the human element of friction with what is called the ten 10 “facts of combat” which include: fear is common, soldiers may die or be wounded, combat creates communication and information break downs, warriors frequently perceive failures in leadership, combat impacts every warrior mentally and emotionally, the physical and mental health effects of combat are frequently misunderstood, warriors are reluctant to admit they have mental health problems, deployments are hard on families, the combat environment is harsh and demanding, and combat stress poses moral and ethical challenges.⁸⁸ The identification and description of these “Facts of Combat” is important, but this training module goes one step further by providing findings regarding each of the 10 “Facts of Combat” followed by actions that the leader can take to address associated stressors and symptoms. This module, in conjunction with the other Battlemind modules, provides leaders with a mental picture of what they can expect on the battlefield and follows training principles also used by police and other first responders best described by Dave Grossman as “stress inoculation” in his book *On Combat*.⁸⁹

⁸⁷ Battlemind, “Pre-Deployment Battlemind for Leaders Training Brief-2008,” slides 1-70.
<https://www.battlemind.army.mil/sso/index.cfm?PageTypeName=DeploymentCycle> (accessed January 31, 2009).

⁸⁸ Ibid., slides 29-70.

⁸⁹ Grossman, *On Combat: Psychology and Physiology of Deadly Conflict in War and Peace*, 132-138.

Clearly the Army views the Battlemind approach to training and educating its soldiers a success and as such, decided to transition Battlemind training from a deployment cycle requirement to standard training Army-wide.⁹⁰ In fact, soldiers, non-commissioned officers, and officers receive this training in its entirety or as prescribed by the chain of command while attending training institutions to include but not limited to: basic training, officer candidate school, and the officer basic and career courses.⁹¹ But is the integration of Battlemind in and of itself enough to turn the tide in the fight against PTSD? Is the Army providing battalion commanders with the tools necessary to address both the stressors and symptoms of PTSD on the modern battlefield?

In light of the rising number of soldiers returning from combat with PTSD or its manifestations, the answer to this question is arguably no; the Army needs to do more to help commanders fight the “unseen” enemy called combat operational stress or PTSD. Based upon research, one can argue that the Army has always been reactive as opposed to proactive in this regard. Although the Army leadership has placed command emphasis on the issue of PTSD in recent years and dedicated vast resources to facilitate research and develop programs to address it, the Army must continue to change the culture of the Army to proactively address the realities of combat and institutionalize this culture change in the following areas; formal education, doctrine, knowledge management, training, and treatment and diagnosis.

The formal Army educational system which incorporates basic training, the non-commissioned officer education system (NCOES), and officer education system currently

⁹⁰ James Williams III, “Army Expands Battlemind Training,” Army News Service, May 30, 2008, <http://www.army.mil/-news/2008/05/30/9548> (accessed February 1, 2009).

⁹¹ Grace, January 22, 2009 Interview.

addresses the issue of combat operational stress and PTSD using Battlemind as the basis for education.⁹² Interestingly, however, Battlemind training is not mandated for battalion-brigade level commanders during the pre-command course. The Office of the Surgeon General provides a briefing on mTBI and PTSD to all command selectees during the Pre-Command Course at Fort Leavenworth, but it is merely an information briefing and does not follow the education model outlined in Battlemind. Further, those officers selected to command tactical battalions and brigades currently do not receive any additional training while attending the two-week Tactical Commanders Development Course (TCDP) or Brigade Commanders Tactical Development Course (BCTCDP).⁹³ One might wonder why the Army dedicates tremendous time and resources to training and educating soldiers and junior-level officers but does not mandate additional formal training for those commanders who are responsible for their soldiers' health, morale, welfare, and training. The Combat Arms Tactical Commander PTSD survey indicated that although no officer received Battlemind training or any formal PTSD training during TCDP, 85% felt that it would be beneficial.⁹⁴ As such, the Army should mandate Battlemind training into TCDP to ensure that all tactical battalion and brigade commanders are better prepared to develop training and policies that proactively address the stressors associated with PTSD as opposed to reacting to the symptoms of this affliction while in the close fight.

Few will argue that Battlemind is a step in the right direction as the Army continues to look for ways to educate its soldiers and leaders. However, if the Army intends to implement it

⁹²Ibid.

⁹³ The author served as an instructor at the CGSC Tactical Commander Development Program/Pre-Command Course prior to attending AOASF. Discussion with the Mr. Kim Summers, Director, PCC on January 22, 2009 verified that Battlemind is not integrated in TCDP and that students only get a brief from the Office of the Surgeon General, while attending PCC.

⁹⁴ Combat Arms Tactical Commanders PTSD Survey, February 2009.

into the formal educational system as the basis for combat stress training and education, then it needs to address shortfalls in this program if it is to remain effective and relevant. Review of this program indicates that this training and educational experience provides training modules for soldiers and leaders which focus on pre-deployment and post deployment activities but fails to provide a deployment module for use in theater.⁹⁵ Currently, the only resource provided by this program for tactical leaders during deployment is a Battlemind Psychological Debriefing Module. Although the Battlemind Psychological Debriefing Module is useful, 75% of the commanders that took the Combat Arms Tactical Commander PTSD Survey indicated that an off-the-shelf-training experience focusing on tactics, techniques, and procedures (TTPs) while deployed would prove useful.⁹⁶

Another aspect of Battlemind that needs review is the Battlemind Leader Development Module. The Battlemind Leader Development Module does not integrate videos into the training experience like it does with all other training modules, nor does it specifically address leaders at the battalion and brigade command level. Instead, it focuses on all leaders and uses a 73-slide briefing packet as the basis by which leaders are educated and trained. This author believes that the integration of videos and scenarios like those included in the other modules, will enhance the training and educational experience and more effectively reinforce important aspects of the training.

The Leader Development Module does address the ten Facts of Combat and provides some insight as to what actions a tactical leader can take to address the stressors and symptoms

⁹⁵ Battlemind, "Deployment Cycle," <https://www.battlemind.army.mil/index.cfm> (accessed January 29, 2009).

⁹⁶ Combat Arms Tactical Commanders PTSD Survey.

associated with combat stress and its manifestations. However, over eighty percent of those who took the Combat Arms Tactical Commander PTSD Survey indicated that more insight into TTPs and a doctrinal update to address stressors of combat would prove beneficial.⁹⁷ Clearly, addressing the issue of integrating PTSD training into the formal education system of Army leaders using programs such as Battlemind is a step in the right direction, but program effectiveness depends upon a clear linkage between education, doctrine and command emphasis at all levels.

Current Army doctrine, specifically FM 4-02.51, *Combat and Operational Stress Control*, highlights that combat operational stress “*control*” is a commander’s responsibility, provides a comprehensive list of protection factors and highlights stress behaviors which are worthy of study.⁹⁸ This document thoroughly addresses the stressors and symptoms associated with combat stress, such as those depicted in Battlemind, but like Battlemind, also fails to provide many specific tactical examples that a battalion commander can implement prior to or during deployment to mitigate stressors on the battlefield. Although one may also question whether a commander can “*control*” combat operational stress as FM 4-02.5 suggests, provides more insight and options for dealing with the stressors and symptoms of combat stress than previous doctrine and thus, promotes proactive leaders within the ranks. Unfortunately, this manual is only useful if leaders apply the information contained in it and if the areas of emphasis are reflected in other key doctrinal manuals. Interestingly, nearly thirty-five percent of those who took the Combat Arms Tactical PTSD Survey were unaware of the specifics of Battlemind

⁹⁷ Ibid.

⁹⁸ Headquarters, Department of the Army, *FM 4-02.51: Combat and Operational Stress Control* (United States: United States Government, September 29, 1994), 1-1 to 1-6.

or the existence of FM 4-02.51.⁹⁹ Further, if one subscribes to the belief that unit cohesion, leadership, and training all serve to prevent PTSD as indicated in both Battlemind Training and FM 4-02.51, then why is PTSD not discussed in depth in either FM 6-22, (Army Leadership-October 2006), or FM 7-0, (Training for Full Spectrum Operations-December 2008)? One might also wonder why, if command emphasis on PTSD prevention and mitigation continues to increase within the Army, has FM 22-51 (Leader's Manual for Combat Stress Control) not been updated since 1994 to reflect the change in training and education and the vast lessons the Army has learned? Lastly, why is the term "combat operational stress" used in lieu of PTSD in FM 4-02.51 and avoided in the operational force? Arguably, the military must acknowledge the existence of PTSD within its formations if it is to combat the affliction. Clearly, more must be done to ensure doctrine remains relevant and synchronized using the Battlemind model as the bases for education and training.

Updating doctrine alone, however, is not enough. The Army must find a better way of making resources available to the leader to facilitate knowledge management. If one does a search of PTSD military resources on the internet, he will get in excess of 3,550,000 hits.¹⁰⁰ How can one effectively and efficiently extrapolate that which he needs from so many sources and so much information? The Government currently has many sources and data bases available on the internet which one can access to include, Army Knowledge Online, Army Onesource, National Center for Posttraumatic Stress Disorder, Department of Veterans Affairs, and

⁹⁹ Combat Arms Tactical Commanders PTSD Survey

¹⁰⁰ Author typed in PTSD military resources on yahoo search on 2 February.

Battlemind to name just a few.¹⁰¹ Perhaps the Army needs to consolidate current doctrine, policies, lessons learned, assessment tools, and training methodologies in one location to facilitate ease of access such as Command.Net, AKO, or CALL to facilitate easy access to pertinent information?

Finally, the Army needs to mandate that all battalion and brigade commanders provide a PTSD After Action Review (AAR) which focuses on tactical mitigation procedures to one organization, such as the Center For Army Lessons Learned (CALL), within 30 days of redeployment from combat. A search of the CALL data base in October of 2008, and subsequent discussion with Nancy Quintero, a LTC in the United States Army Reserves and medical professional who serves as a military analyst for CALL, highlighted the fact that the center does not have any tactical references on PTSD available to commanders.¹⁰² The Combat Arms PTSD survey indicated that commanders implemented several tactical measures to address PTSD stressors prior to and during deployment to include: development of battalion-level combat stress working groups, ensuring the unit chaplain conducted battlefield circulation with the commander, and mandating an entire unit visits the combat stress teams after a traumatic experience to reduce stigma and ensure everyone (to include leaders) gets help.¹⁰³ Commanders also indicated that they attempted to mitigate the stressors that cause PTSD by providing information and training to all soldiers during the deployment to enhance confidence, and mitigate fear. Examples provided by commanders in the PTSD survey include: mandating

¹⁰¹ Army Knowledge Online (AKO) is located at www.us.army.mil; Army Onesource is located at www.armyonesource.com; the National Center for Posttraumatic Stress Disorder is located at ncptsd.va.gov; www.va.gov; Battlemind is located at www.battlemind.army.mil.

¹⁰² Nancy Quintero is a LTC, USAR and Military Analyst for the Center For Army Lessons Learned.

¹⁰³ Combat Arms Tactical Commanders PTSD Survey.

operations and intelligence briefs (O&I) for all individual replacements and for those returning from leave prior to deployment to the battlefield, and mandating periodic O&I briefs for units in their entirety.¹⁰⁴ Commanders emphasized the importance of individual training while deployed to address PTSD and as such, mandated a period of acclimation and confidence training for replacements prior to sending them to a unit on the battlefield, mandated unit-level periodic combat stress briefs and training, and mandated verification that replacements' families were integrated into the family readiness group prior to sending them to a unit in the field.¹⁰⁵ These are just a few techniques offered by commanders but where are they consolidated so that commanders can refer to these tactics, techniques and procedures prior to and during deployment? Perhaps a battalion commander PTSD tactics, techniques, and procedures handbook would serve as a tool to help battalion commanders implement policies and develop training to combat PTSD.

Another area in which the Army must institutionalize a culture change is the manner in which it trains the force. Emphasis on the principles of stress inoculation, which focuses on exposing military to conditions in training that closely resemble that which they will likely experience in combat, has proven successful among first responders such as members of police special weapons and techniques (SWAT) teams and appears to be the basis of Battlemind.¹⁰⁶ “There is an old Army adage that says, “You don’t have to practice being miserable.” “There is some truth in these words, but sometimes they are used as an excuse to avoid hard, rigorous

¹⁰⁴ Combat Arms Tactical Commanders PTSD Survey.

¹⁰⁵ Ibid.

¹⁰⁶ Grossman, *On Killing*, 132-158

training. Sometimes there is value in practicing to be miserable.”¹⁰⁷ If one subscribes to this philosophy, then it is clear that commanders must be creative in planning and resourcing training to ensure that all soldiers experience as much as possible, including the sights, sounds, smells, and emotions of battle. Physical training that focuses on team building, and mandates the execution of tasks that might prove necessary in combat like buddy carries, is critical. Another example of adding realism to training involves using dummies as opposed to e-type silhouette targets during marksmanship training or integrating paint ball training or computer simulations in lieu of blanks during close combat training.¹⁰⁸ There are hundreds of techniques available but they are only effective if a commander integrates them into training.

The final area where the Army must institutionalize a culture change concerns diagnosis and assessment. Army Directive 2007-2 mandates the use of the PDHA and PDHA-R prior to and following deployment but does not mandate the use of any assessment tool *during* deployment.¹⁰⁹ As such, there are no means by which a care provider or leader can determine the extent each soldier is affected by the stressors on the battlefield over time. In light of the fact that soldiers receive help for mental or stress related afflictions while deployed based upon a leader’s referral or a soldier’s self-referral, does it make sense to depend upon a leader who may suffer from combat operational stress to identify the affliction in someone else? Further, does it make sense to have a soldier who is suffering from this affliction recognize the symptoms in himself and initiate a referral based upon existing stigmas? Clearly, placing the leader or soldier in such a position, does not lend itself to early and accurate detection of stress disorders in the

¹⁰⁷ Ibid., 132

¹⁰⁸ Ibid., 77-89.

¹⁰⁹ Department of the Army, “Policy Guidance-Deployment Cycle Support,” 1-18.

force. As such, the Army should mandate implementation of an assessment tool that helps to identify potential emotional afflictions in leaders and soldiers during deployment where treatment is more effective as opposed to waiting until the soldier returns from combat when treatment is more difficult and symptoms are possibly more traumatic.

Clearly, more must be done to support tactical commanders as they attempt to mitigate and manage stressors which foster conditions whereby PTSD is likely to develop and reduce the tactical, strategic, and fiscal impact on this nation. As of 2006 nearly 39,000 of the approximately 690,000 veterans of OIF and OEF who had separated from military service and were eligible for health care provided by the Veteran's Affairs were diagnosed with PTSD or other mental disorders.¹¹⁰ When one considers that this figure only accounts for those active duty soldiers who had separated from service as late as 2006, and does not consider those who remained on active duty, were in the National Guard and Reserves, Department of Defense and civilian contractors, or those who sought treatment outside the VA during this time period, it becomes clear that it is impossible to determine the exact number of veterans/soldiers currently suffering from PTSD or definitively project the number of veterans who will acquire the affliction later. Likewise, it is impossible to accurately determine current costs or project future costs associated with treatment and diagnosis of PTSD. One can deduce, however, that the current estimates of those suffering and subsequent cost is likely conservative. One study conducted by RAND, however, estimates that on a per-case basis over a two-year period, PTSD costs are estimated between \$5,904 and \$10,298; major depression costs are estimated between \$15,461 and \$25,757, while costs associated with co-morbid PTSD and major depression are

¹¹⁰ Matthew S. Goldbert, "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," Congressional Budget Office Testimony (October 17, 2007): 1-10.

approximately \$12,427 to \$16,884¹¹¹. In light of the fact that PTSD-related and major depression-related costs could range from \$4.0 to \$6.2 billion over a two-year period with an additional \$591 million to \$910 million dollars dedicated to diagnosing and treating mTBI within the first year after its diagnosis, one can see that the fiscal implications associated with these afflictions on the U.S. economy and DOD budget is staggering.¹¹² The Congressional Budget Office estimates that over the next ten years, VA costs alone for medical care will range from \$7.0 to \$9.0 billion dollars while costs for disability compensation will range between \$2.2 billion to \$3.0 billion dollars.¹¹³ This fiscal and economic impact, however, pales in comparison to the humanitarian and strategic implications that derive from PTSD.

Unless treated, PTSD, major depression, and mTBI have a wide-ranging and negative implications for those who are afflicted and a wide array of consequences that include: lower work productivity, family issues, poor social relationships, increased likelihood of substance abuse, divorce, homelessness, unhealthy behaviors (overeating, smoking, unsafe sex), and increased likelihood of suicide among those afflicted.¹¹⁴ Can the United States ignore the livelihood of those who have served or continue to serve? Most agree that this is simply not an option. Can the Army, which is charged with maintaining a combat effective force, continue to effectively engage in conflict around the globe with soldiers suffering from an affliction which is manifest throughout the ranks? Most would agree that effectiveness will waiver and diminish if more is not done to understand the affliction and determine more effective forms of diagnosis

¹¹¹ The RAND Corporation, *Invisible Wounds of War*, -Psychological and Cognitive Injuries, XXII.

¹¹² *Ibid.*, XXIII.

¹¹³ Matthew S. Goldbert, "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," 1-10.

¹¹⁴ The RAND Corporation, *Invisible Wounds of War*, -Psychological and Cognitive Injuries, XXIII.

and treatment, train and certify more health care professionals to meet the increased demand, close the gap between what facilities and resources are available vice necessary, change the culture to reduce stigmas and promote diagnosis and treatment, and train and educate commanders in an effort to mitigate and manage tactical stressors on the battlefield. Failure in this regard, may lead to a “hollow” force, reduce this nation’s readiness, and leave society with a problem for which it is destined to cope with for decades to come. The problem does not end merely when the war is over and the soldiers come home as exemplified by the fact that of the 300,000 disabled WWI veterans, nearly 50,000 remained hospitalized twenty years later for psychiatric illnesses.¹¹⁵ These casualties, combined with those of WWII, accounted for 102,000 hospital beds in the United States well into the late 1940s.¹¹⁶ Is this the legacy the military wants to leave generations to come? Most would likely shudder at this looming prospect. The United States, in what is arguably the most volatile time in world history, must be prepared and capable of responding to a variety of threats and can ill afford to continue the reactive response to combat stress which has demonstrated from a historical perspective since the Revolutionary War.

¹¹⁵ Coleman, *Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War*, 46.

¹¹⁶ *Ibid.*, 54.

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