

USAWC STRATEGY RESEARCH PROJECT

POST TRAUMATIC STRESS DISORDER: THE FACTS!

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ABSTRACT

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Following the attacks on the Twin Towers of the World Trade Center and the Pentagon on 11 September 2001, the United States began the Global War on Terror (GWOT) on 07 October 2001 in Afghanistan and expanded the war to include Iraq in March of 2003. As a result of GWOT hundreds of thousands of service men and women have been deployed to Iraq and Afghanistan with 3,410 killed and another 24,795 physically wounded as of 22 February 2007. Likewise, thousands of other service men and women of all ranks have been psychologically wounded and subsequently diagnosed with Post Traumatic Stress Disorder (PTSD) or symptoms of PTSD.

With the apparent increased awareness and diagnosis among service members, little is actually known and understood about PTSD among aspiring strategic leaders. This strategic research project will examine and hopefully dispel the myths about PTSD for strategic leaders by answering the following basic questions. What is PTSD, historical understanding of PTSD, how does PTSD develop, what are the symptoms of PTSD, how common is PTSD, who is most likely to develop PTSD, what are the consequences of PTSD, what are scientists learning from the research, and how is PTSD treated?

POST TRAUMATIC STRESS DISORDER: THE FACTS!

He who did well in war, earns the right to begin doing well in peace.

⇒Robert Browning¹

Following the attacks on the Twin Towers of the World Trade Center and the Pentagon on 11 September 2001, the United States began the Global War on Terror (GWOT) on 07 October 2001 in Afghanistan and expanded the war to include Iraq in March of 2003. As a result of GWOT hundreds of thousands of service men and women have been deployed to Iraq and Afghanistan with 3,509 killed and another 24,795 physically wounded as of 22 February 2007.² Likewise, thousands of other service men and women of all ranks have been psychologically wounded and subsequently diagnosed with Post Traumatic Stress Disorder (PTSD) or symptoms of PTSD. As of November 2006, the Department of Veterans Affairs (VA) now predicts that multiple and extended tours of duty in Iraq and Afghanistan will result in an increased rate of PTSD among Soldiers that will likely match or exceed the rate among Vietnam War Veterans.³

With the apparent increased awareness and diagnosis of PTSD among our Soldiers, little is actually known and understood about PTSD among aspiring strategic leaders. This strategic research project will examine and hopefully dispel the myths and state the current facts about PTSD for strategic leaders by answering the following basic fundamental questions. What is PTSD, historical understanding of PTSD, how does PTSD develop, what are the symptoms of PTSD, how common is PTSD, who is most likely to develop PTSD, what are the consequences of PTSD, what are scientists learning from the research, and finally, how is PTSD treated?

At this time it is appropriate to acknowledge assistance I received from the Department of Veterans Affairs (VA), the National Center for Post Traumatic Stress Disorder (NC-PTSD), the Walter Reed Army Medical Center (WRAMC), the Army Physical Fitness Readiness Institute (APFRI), the National Institutes of Mental Health (NIMH) and the American Psychiatric Association (APA) in developing the basic fundamental questions for my strategic research project (SRP).

My Personal Experience and Background with PTSD.

These terribly important professional and strategic questions about PTSD are very near and dear to my heart resulting from my personal experiences in peacetime training and most significantly from recent combat operations in Iraq. The answers to these questions are important to me because in my case, exactly three months after my battalion change of

command and 16 months after my redeployment from Operation Iraqi Freedom I, I was diagnosed with symptoms of PTSD. Yes, as a United States Army tactically focused operations tracked officer, I was shocked, embarrassed, and stunned by this diagnosis. However, deep in my heart of hearts, I can now look back and say I was truly relieved to hear the news. Quite simply, I was relieved because I had not felt right for a very long time, but now I knew and sort of understood why. Fortunately, in my case, with the correct and timely professional help, I am getting better all the time. Furthermore, as I have walked the hallways of Root Hall and sat among my brothers and sisters in Seminar 11 and Bliss Hall over the last nine months, I have quietly wondered to myself about how many of them need to truly start feeling better and feeling right again.

Moreover, and as I just stated, I actually felt relieved to hear the news of my possible diagnosis, but ever since my diagnosis in June of 2005, the more pressing question for me has been “how could this happen to me?” Could it possibly be because I had not trained properly over my twenty year career or was it simply just out of my control and something I could do nothing to prevent? As one doctor told me “you simply have a chemical imbalance in your brain which makes you more susceptible to the disorder.” Regardless, I am still wrestling with how this could happen to me and most importantly how I could prevent it from happening again.

By June of 2005, I had just completed my twentieth year of active duty in the U.S. Army. Likewise, by all accounts over those twenty years, I had voluntarily experienced some of the toughest mentally and physically challenging training the U.S. Army had to offer. For example, I am for the most part, a twelve year light airborne field artillery veteran and master parachutist from the 82nd Airborne Division with 137 tactical parachute jumps, a ranger school graduate, an air assault school graduate from the 101st Airborne Division (Air Assault), a veteran of countless danger-close combined arms live fire exercises, a veteran of too numerous to count high pressure rotations to the National, Joint Readiness, and Combat Maneuver Training Centers, and multiple division level Warfigther exercises with the 2nd Infantry Division, 82nd Airborne Division, and the 101st Airborne Division (Air Assault).

Yet was all this high quality peacetime training not enough to mentally and physically prepare me for my six month deployment to austere Afghanistan in 2002 and then off to Iraq in February 2003 for the invasion and then nation building until March 2004? Without question, I conclude that my training did mentally and physically prepare me! By all accounts from sometimes brutally honest subordinates, peers, superiors, and constant critical self assessments, I aggressively met the difficult and multiple challenges of combat for the first time during my eighteenth through twentieth years of active U.S. military service. Granted, during

these eighteen months of combat duty, twelve of which were as a field artillery battalion commander transformed to fight as light air assault infantry in Iraq, I, along with my Soldiers was exposed to numerous hostile and difficult situations. The following are statistics of my battalion's combat experience as we know it, what we live with today, and what we are proud of.

We served then and live today knowing that we will not and did not bring all of our beloved friends, buddies, and Soldiers home. Eight of our beloved Soldiers did not make it home, but instead died among their brothers in Iraq. Regretfully, another 40 of our Soldiers earned the Purple Heart from wounds sustained by gunshots, improvised explosive devices (IEDs), mortar and rocket propelled grenade (RPG) blasts, anti-vehicle mines, and also by a friendly helicopter collision due to hostile fire. Similarly, six of our vehicles were destroyed beyond repair from hostile enemy contacts. Fondly, we are most proud of our bravery and commitment to duty in our daily missions to improve the quality of life for the Iraqi citizens. We compassionately facilitated the rebuilding of twenty Iraqi schools, patrolled a sector the size of the Borough of Carlisle, detained numerous high value targets, confiscated hundreds of illegal weapons, escorted hundreds of fuel trucks from Turkey to Mosul, and remorselessly killed the enemy when challenged.

With this arguably distinguished and honorable record and performance in combat conducted with no obvious hints or signs of PTSD, I was truly shocked and stunned when diagnosed with PTSD at least 16 months after most of the previously mentioned incidences happened. Honestly, my immediate response to the diagnosis was to retire from the U.S. Army as soon as possible. To make a long story short, I privately saw myself as damaged goods, guilty over the loss of my Soldiers, unfit for duty, and went against the guidance of my wife and supervisor and submitted my retirement paperwork. Fortunately, after a month of initial counseling I realized the Army was a wartime, yet compassionate, institution which had the patience to allow me, a career officer, to seek treatment and begin healing. Most importantly, I realized the Army had the right professionals in place that allowed me to deal with this disorder and with little public or professional exposure.

Quite frankly, at the time, I was not even concerned about public or professional exposure, perceptions, promotions, and professional development because I just wanted to find peace. So, with my background presented and with the reality that I was definitely not alone with this disorder, I shall now write to dispel the myths and erroneous perceptions about PTSD. Unfortunately, my fellow aspiring strategic leader, PTSD can happen to the best of us and our Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen, but rest assured there is now good

news of treatment, understanding, and hope. Likewise, until further stated and for simplicity, the term Soldiers will refer to all military services when mentioned in this SRP.

What is Post Traumatic Stress Disorder?

Obviously, the first critical question of interest for any concerned aspiring strategic leader is: What is the Department of Defense (DOD) definition or more specifically what is the VA definition of PTSD? The VA has a subordinate department, the NC-PTSD, formed in response to a 1989 congressional mandate focusing on PTSD research, education, and consultation. The NC-PTSD states “PTSD is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape.”⁴ For comparison, the APA further expands and broadens the definition and states that “PTSD was once called shell shock and affects hundreds of thousands of people who have survived earthquakes, airplane crashes, terrorist bombings, inner-city violence, domestic abuse, rape, war, genocide, and other disasters, both natural and human made.”⁵ Likewise, the highly respected and often professionally used Webster’s New World Medical Dictionary (WNWMD) which even further broadens the definition of PTSD states “it is a common anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.”⁶ The WNWMD even goes so far as to add that family members of victims also can develop the disorder which is not mentioned or discussed by the APA or the NC-PTSD in any significant detail.

From my experience, I do not dispute the professional medical definitions of PTSD presented by the APA, NC-PTSD, or the WNWMD. I will say, however, that I believe my experience with PTSD was more like that of a “family member of victims” developing it as stated by the WNWMD. For example, late in my counseling treatment in May of 2006, I was told by an absolutely wonderful military medical contracted civilian counselor that my relatively slow developing reactions and feelings relative to these traumatic incidences in Iraq was more common with how a parent would over time grieve the loss of a child or a severely injured child. This explanation made sense in my mind because as a battalion commander in combat, I saw myself as the parent or at least the responsible older brother to my Soldiers. It was my job, my duty to make the right tactical decisions all the time to bring all my Soldiers, my men, home.

I remember very vividly in Iraq, when I got to the physical and mental breaking point about seeing my Soldiers wounded or dead in the streets of Mosul. After 14 months of deployment we were all simply mentally and physically exhausted. I had basically reached a point that I

personally could not stand to see another one of my Soldiers pinned with a Purple Heart. I told my battalion Command Sergeant Major, "I just cannot stand it and seeing it only infuriates me to kill the enemy bastards." Maybe I was or am weak, I do not know, but I do know I spent that last month of the deployment trying, praying, and hoping to prevent it from happening again. Thank God, none of my men earned the award in our last month; I think we deserved not to earn it again.

Moreover, about the definition of PTSD, I have also learned the vast majority of survivors of trauma do successfully return to a normal life given a little time and rest. I believe this is the truth for most of the men from my battalion that I served with in Iraq. However, as stated by the NC-PTSD in great detail, some Soldiers will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may actually develop PTSD and most definitely are the ones in need of immediate professional help.⁷ The NC-PTSD, NIMH, and APA concur that Soldiers who suffer from PTSD often relive the experience through nightmares and flashbacks (as was not my case), have difficulty sleeping (as was my case), and feel detached or estranged (as was my case), and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

PTSD is also marked by clear biological changes (as was my case) with a gradual weight loss and nervousness as well as psychological symptoms (as was not my case). The NC-PTSD further states, and the aspiring strategic leader should beware, that PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health.⁸ The APA concludes that the disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.⁹

In my case, I was struggling with occupational instability and difficulties in parenting. I reached a point of concern professionally in June of 2005 when I significantly lost my motivation at work. Simple tasks well below my pay grade seemed monumental and it was extremely hard for me to concentrate in my new position, now no longer a battalion commander. Thank God I never physically harmed my family; I did however, frequently experience, almost immediately upon redeployment from Iraq, an extremely impatient and irritable behavior towards them or even an unnecessary hot tempered overreaction during our normal interactions.

Historical Understanding of Post Traumatic Stress Disorder.

Now that we have a general idea of what PTSD is, the next most critical question of interest for the aspiring strategic leader is a basic historical understanding of PTSD. Although PTSD might seem like a relatively new disorder, on the contrary, and by all accounts from the APA, NIMH, and NC-PTSD, it is not. What is new about PTSD in January 2007 is the increasing awareness by more and more medical professionals, counselors, and clergy. For obvious reasons both civilian and military medical professionals are more aware of the disorder because of on-going operations in Iraq and Afghanistan. The accuracy and currency of the NC-PTSD research data base has also assisted medical professionals in becoming more familiar with the symptoms. Subsequently, because of these factors, the medical profession is more likely to make a diagnosis of PTSD and recommend the appropriate treatment. Amazingly, the NC-PTSD data base highlights written accounts of similar symptoms that go back to ancient times. There is also clear documentation in the historical medical literature starting with the Civil War when a PTSD-like disorder was known as "Da Costa's Syndrome" and more commonly known as shell shock from World War I (WWI) and World War II (WWII).¹⁰ The NC-PTSD has particularly good descriptions of PTSD in the medical literature on combat veterans of World War II and obviously on Holocaust survivors, as well.¹¹

The NC-PTSD and APA agree that their professional research and documentation of PTSD only began in earnest after the Vietnam War. One can speculate that with continuous advances in medical science, education, and communication technologies post WWII, Korean War, and Vietnam War have tremendously assisted in acknowledging and diagnosing the disorder. For example, the National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in that group was 15.2% at that time and that 30% had experienced the disorder at some point since returning from Vietnam.¹²

The NC-PTSD data base reflects that PTSD has subsequently been observed in all veteran populations, including World War II, Korean conflict, Vietnam, Persian Gulf, and all the smaller scale armed conflict deployments of the mid to late 1980s and 1990s. Likewise, the majority of United Nations peacekeeping forces deployed to other war zones around the world are represented in the research data base.¹³ For comparison, there are similar findings of PTSD in military veterans in other countries. For example, Australian Vietnam Veterans experience many of the same symptoms that American Vietnam Veterans experience. On the contrary and more remarkably, after three years, there are no signs of ill mental health among regular U.K. military personnel who served in the Iraq War, according to a U.K. national defense study published in May 2006 by The Lancet Medical Journal.¹⁴

PTSD is not only a problem for veterans. It can occur in men and women, adults and children, Western and non-Western cultural groups, and all socioeconomic strata.¹⁵ Further details will describe who is most likely to develop PTSD, but for now, a U.S. national study of American civilians conducted in 1995 estimated that the lifetime prevalence of PTSD was 5% in men and 10% in women. A 2005 revision of this study reports that PTSD occurs in about 8% of all Americans.¹⁶

How Does Post Traumatic Stress Disorder Develop?

At this point in my research, the obvious professional answer and consensus among the APA, NIMH, and NC-PTSD is that exposure to a traumatic or stressful event is a prerequisite. The most frequent and documented traumatic and stressful events associated with PTSD for men are combat exposure, childhood neglect, rape, and childhood physical abuse. Similarly, the most stressful and traumatic events for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.¹⁷ The one professional exception to this rule is PTSD developing in a family member of a previously diagnosed patient. The general agreement here is the family member then develops the disorder from a stressful or even traumatic exposure with the diagnosed patient. Here is the old cycle of violence or cycle of abuse at its best.

Likewise, most Soldiers who are exposed to a traumatic or stressful event will actually experience some of the symptoms of PTSD immediately following the event, but now even a year or more following exposure symptoms arise.¹⁸ Similarly, a more recent trend of “cumulative combat or deployment stress” has also caused significant increases in diagnosed cases among the U.S. military. For example, Ms. Joyce Raezer, the Director of Government Relations at the National Military Family Association (NMFA), says “some Soldiers now on their fourth or fifth tour are bringing all the baggage from the last deployment into the next.”¹⁹ The APA and especially the NC-PTSD through the VA concur that the following is generally true for our Soldiers. These organizations believe the course of chronic PTSD usually involves periods of symptom increase followed by remission or decrease, although some Soldiers may experience symptoms that are unremitting and severe.²⁰ Likewise, some older veterans, who report a lifetime of only mild symptoms, experience significant increases in symptoms following retirement, severe medical illness in themselves or their spouses, or reminders of their military service (such as reunions or media broadcasts of the anniversaries of war events).²¹

What are the Symptoms of Post Traumatic Stress Disorder?

In general terms and more importantly, in basic Soldier language, I have tried to simply articulate, not change the medical definition of the required symptoms of PTSD. The VA, NC-PTSD, WNWMD, NIMH, and APA, recommend that the diagnosis of PTSD requires one or more symptoms from each of the following categories be present for at least a month. Furthermore, these organizations require that a symptom or symptoms must seriously interfere with one leading a normal life. The basic symptoms are and I paraphrase:²²

1. Reliving the event through upsetting thoughts, nightmares or flashbacks, or having very strong mental and physical reactions if something reminds the person of the event.
2. Avoiding activities, thoughts, feelings or conversations that remind the person of the event; feeling numb to one's surroundings; or being unable to remember details of the event.
3. Having a loss of interest in important activities, feeling all alone, being unable to have normal emotions or feeling that there is nothing to look forward to in the future.
4. Feeling that one can never relax and must be on guard all the time to protect oneself, trouble sleeping, feeling irritable, overreacting when startled, angry outbursts or trouble concentrating.

How Common is Post Traumatic Stress Disorder?

Now that we have a basic understanding of what it is, a historical perspective of it, how it develops, and what are the symptoms, the next obvious question to answer for the aspiring strategic leader is just how common is this disorder. More specifically, how common is PTSD among our Soldiers returning from Iraq and Afghanistan? The bottom-line is, and supported by current data, PTSD is very common and becoming more prevalent all the time in the U.S. military.

For example, as of November 2006, the VA states about one in six of the more than 184,500 returning veterans who have sought care through the VA have been diagnosed with PTSD.²³ In August 2006, the VA announced that almost 64,000 discharged Soldiers had been diagnosed with a mental disorder and almost 34,500 with PTSD.²⁴ Therefore, the aspiring strategic leader can assume with great confidence that the rate is expected to climb even higher since we already know it can take months and sometimes even years for PTSD to manifest in the victim or family member. In fact, in November 2006, Colonel Charles Engel, a clinician at WRAMC said “up to 29 percent of the Soldiers returning from Iraq and Afghanistan will suffer from PTSD and expects the rate to go much higher.”²⁵ Other medical experts concur and say

the PTSD rate especially among Iraq Veterans could well eclipse the 30 percent lifetime rate found in a 1990 national study of Vietnam Veterans.²⁶

The NC-PTSD concludes that since medical records and data have been kept, generally about 30 percent of the men and women who have spent time in war zones will and have experienced PTSD. Likewise, an additional 20 to 25 percent have had or will have partial PTSD at some point in their lives. In comparison to Iraq and Afghanistan, the NC-PTSD states that more than half of all male Vietnam Veterans and almost half of all female Vietnam Veterans have experienced "clinically serious stress reaction symptoms."²⁷ Similarly, PTSD has also been detected among veterans of the Gulf War, with some estimates running as high as 8 percent, but most experts agree that generally the rate will remain lower based primarily on the relatively short duration of the deployment and war.

Moreover, for a perspective and comparison, the NC-PTSD also states an estimated 7.8 percent of non-military Americans will experience PTSD at some point in their lives, with women at 10.4 percent being twice as likely as men at 5 percent to develop PTSD. Furthermore, about 3.6 percent of U.S. adults aged 18 to 54 or 5.2 million U.S. citizens will have PTSD diagnosis during the course of a given year.²⁸

Who is Most Likely to Develop Post Traumatic Stress Disorder?

The bottom-line conclusion from the APA, NC-PTSD, and especially the NIMH is that Soldiers who have suffered abuse as children or who have had other previous traumatic experiences are more likely to develop the disorder.²⁹ This conclusion would support the recent theory of "cumulative combat stress or trauma" which results from frequent or multiple deployments of our Soldiers to Iraq and Afghanistan. Similarly, the medical professionals used to believe that Soldiers who tend to be emotionally numb after a trauma were showing a healthy response, but now some researchers suspect that Soldiers who experience this emotional distancing may be more prone to PTSD.³⁰

The VA through the NC-PTSD essentially lists four general categories of those in the military most likely to develop PTSD. The study does not break it down by sex, ethnic group, race, or even religion, for example. Regardless of the lack of specificity, here are the general categories from the NC-PTSD.³¹

1. Soldiers that experience greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual victimization, real or perceived responsibility, and betrayal.
2. Soldiers with prior vulnerability factors such as genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events.

3. Soldiers that report greater perceived threat or danger, suffering, upset, terror, and horror or fear.

4. Soldiers with a social environment that produces shame, guilt, stigmatization, or self-hatred.

What are the Consequences of PTSD?

As with any mental or physical disorder, if left untreated the consequences can be significantly harsh and sometimes dangerous for the Soldier or even concerned family members and friends. This fact is especially frightening and a cause for concern if PTSD is left untreated and ignored by the effected Soldier or ignored by the chain of command at any level from strategic to squad. For instance, just as Vietnam Veterans, the Iraq and Afghanistan Veterans with PTSD are found to have profound and difficult problems in their daily lives. These include problems in family, other interpersonal relationships, problems with employment, and involvement with the criminal justice system. Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, and discomfort in other parts of the body are common in Soldiers with PTSD.³²

Another harsh reality and concern for some Soldiers with PTSD is the presence of a preexisting disorder or development of another disorder. Obviously, the presence of a preexisting disorder or new disorder can only exacerbate the problems with PTSD for the Soldier and his family or friends. Our Soldiers with these unfortunate conditions are extremely vulnerable and at great personal risk. For instance, Jesus Bocanegra, a 24 year old former Army sergeant, says “now that I am back home and plagued with anxiety attacks, I tried to close myself off from the world by drinking to the point of passing out, then progressed to marijuana use and then cocaine use.” He goes on to say “the only way to sustain myself day to day is to keep myself drugged up, but it made it worse.”³³ The NC-PTSD states that co-occurring disorders most prevalent for male Soldiers with PTSD were alcohol abuse or dependence (51.9 percent), major depressive episodes (47.9 percent), conduct disorders (43.3 percent), and drug abuse and dependence (34.5 percent). The disorders most frequently co-occurring with PTSD among female Soldiers were major depressive disorders (48.5 percent), simple phobias (29 percent), social phobias (28.4 percent), and alcohol abuse/dependence (27.9 percent).³⁴

What are Scientists Learning from Research?

Annually, the APA, NIMH and the VA sponsor a wide range of basic, clinical, and genetic studies of PTSD which is good news for our Soldiers. Granted the majority of these recent discoveries will “read like Greek” to the aspiring strategic leader, regardless, I have tried to

simplify the discussion as much as possible. The following are significant recent research findings from the NIMH and endorsed by the APA and VA.³⁵

1. NIMH researchers have found that the hippocampus—a part of the brain critical to memory and emotion, appears to be different in cases of PTSD. Changes in the hippocampus are thought to be responsible for flashbacks that occur in Soldiers with this disorder.

2. Soldiers with PTSD tend to have abnormal levels of key hormones involved in response to stress. Some studies have shown that cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal.

3. When Soldiers are in danger, they produce high levels of natural opiates, which can temporarily mask pain. Scientists have found that Soldiers with PTSD continue to produce those higher levels even after the danger has passed; possibly leading to the blunted emotions associated with the condition.

4. PTSD is associated with the increased likelihood of co-occurring psychiatric disorders. In a large-scale NIMH study, 88 percent of men and 79 percent of women with PTSD met criteria for another psychiatric disorder.

How is Post Traumatic Stress Disorder Treated?

As I stated previously in the personal experience and background section of this SRP, my research now confirms there is definitely good news of treatment, understanding, and hope for our Soldiers, unlike other periods in U.S. military history. As a result of the continued U.S. military deployments to Iraq and Afghanistan, more professional military leaders, medical professionals, counselors, and clergy across the nation are better acquainted with the definition, symptoms, consequences, and treatment of PTSD. Today, psychiatrists and other mental health professionals have experienced success in treating the very real and painful effects of PTSD.³⁶ Basically, once PTSD is diagnosed it can be professionally treated by a variety of forms of “talk therapy” (the most preferred) and “drug therapy” (the least preferred). By all accounts, especially from the VA, NC-PTSD, and the WRAMC, both therapies are now available and frequently and successfully used in Iraq, Afghanistan, and home station. Similarly, NIMH now encourages primary care providers to ask patients about experiences with violence, recent losses, and traumatic events, especially if symptoms keep recurring. Likewise, when PTSD is diagnosed, referral to a mental health professional that has had experience treating Soldiers with the disorder is recommended.³⁷

I have summarized in basic Soldier language some of the “talk therapy” techniques recommended by the APA and endorsed by NC-PTSD and NIMH. Techniques in this category listed by the APA are as follows:³⁸

1. Behavior therapy focuses on correcting the painful patterns of behavior and thought by teaching relaxation techniques and examining the mental processes that are causing the pain. A therapist may recommend “exposure therapy” which means having the patient relive the stress or traumatic event.

2. Psychotherapy “talk therapy” focuses on helping the individual examine personal values and how behavior and experience during the traumatic event affected them. As stated, this is generally done one-on-one with a counselor and best done with good results soon after a traumatic event.

3. Family therapy may also be recommended because the behavior of spouse and children may result from and affect the individual with PTSD. This is great for the home station environment.

4. Discussion groups or peer-counseling groups encourage survivors of similar traumatic events to share their experiences and reactions. The bottom-line here is: Soldiers help one another realize that many Soldiers would have done the same thing and felt the same emotions. This technique is arguably the most effective in or out of theater following a traumatic event. Again for emphasis, “talk type therapy” is best used with very successful results soon after a traumatic event.

Moreover, a medical professional is not likely to use “drug therapy” techniques to treat a PTSD patient, nor do most patients want drug therapy. However, the APA concludes it would be premature at this point to conclude that drug therapy is less effective overall since drug trials for PTSD are at a very early stage.³⁹ Simply stated, drug therapy appears to be highly effective for some individuals and is helpful for many more. For example, the symptom relief that medication provides allows most patients to participate more effectively in “talk therapy” when their condition may otherwise prohibit it. Regardless, the most widely used drug treatments for PTSD are the selective serotonin reuptake inhibitors, such as Lexapro, Prozac and Zoloft.⁴⁰

Conclusion

Without question, PTSD is a significant strategic problem and issue facing our Soldiers, the U.S. military as a whole, and all aspiring strategic leaders. The good news is that we as strategic and compassionate U.S. military leaders, and as a military institution at war, are dealing with this issue. We are facing this issue, by most professional medical and patient

accounts, the right way by providing the best possible care and treatment for our Soldiers both in and out of theater. More importantly, we are now providing care and treatment when it is most needed and that is in theater soon after the traumatic event.

Unfortunately, the bad news is and the reality is, we as strategic leaders cannot, in most cases, prevent PTSD from occurring in our Soldiers. Fortunately, what we can prevent is PTSD from becoming a life changing, crippling, or destroying event and issue for our Soldiers. We can, in most cases, prevent PTSD from becoming such a disorder that it makes our Soldiers non-deployable or unable to function appropriately in the unit. Yes, Soldiers with PTSD can function appropriately in our units! However, timely diagnosis, care, and treatment are critical and will prevent the worst from occurring with PTSD. Similarly, education about PTSD, especially the ability of the chain of command, from strategic to squad, to identify the symptoms or early indicators of PTSD, is essential to success.

Remarkably, during my research, I discovered some active duty military officers and even military clergy at the United States Army War College do not recognize PTSD as a significant disorder or for that matter as a disorder at all. These professional military officers acknowledge PTSD more as an easy medical excuse from doing one's military duty. This disturbing point only highlights the need for continued education and awareness among the U.S. military's very best aspiring strategic leaders.

Finally, I leave my fellow aspiring strategic leaders with this very personal advice about PTSD. You did very well in war and have earned the right to begin doing well in peace, so if you need help, then by all means, please take or call for an immediate "Strategic Time Out."

Endnotes

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