



## POST-TRAUMATIC STRESS DISORDER FIGHTING THE BATTLE WITHIN

*Carla Sizer*  
*Claude Toland*

*There is no instance of a nation benefitting from prolonged warfare.*

—Sun Tzu  
*The Art of War*

On a night in July 2007, in Sparta, Minnesota, Noah Pierce raised a gun to his head and pulled the trigger. Noah was a 23-year-old Army veteran who spent two tours in Iraq. Noah had been diagnosed with post-traumatic stress disorder (PTSD) as a result of his multiple tours in Iraq. While there, Noah was directly involved in the killing of several enemy combatants in house-to-house raids. Regrettably, Noah also ran over a child by accident as she dashed into the road in front of his Bradley. He witnessed the deaths of friends killed in combat as well as roadside bomb attacks. On a morning in July 2007, Noah's friend found him slumped over his steering wheel with a suicide note indicating the horrors with which Noah lived.<sup>1</sup> Unfortunately, Noah's story is neither unique nor uncommon in 2010. The suicide rate at the time of publication had surpassed the record high for the US Army set in 2008, and it continues to rise. There is little disagreement that many, if not most, who chose to take their own lives suffered from PTSD. The evidence suggests that the time has come to formally address PTSD from a comprehensive policy perspective.

### **Background**

The United States military has troops deployed in nearly 130 countries around the world performing a vast range of missions. Some US deployments are a result Cold War-era commitments that have existed for more than 50 years, while others are the direct result of US involvement in Iraq and Afghanistan. Sources suggest more than 1.7 million military personnel have been deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) since 2001—of which 500,000 have been deployed more than once and 330,000 have sustained severe combat injuries. The result: hundreds of thousands of service members are at risk for PTSD, depression, and traumatic brain injury (TBI).<sup>2</sup> According to the Department of Veterans Af-

fairs, approximately 1,800 US troops have been maimed by penetrating head wounds, and hundreds of thousands more may have suffered a mild TBI as a result of improvised explosive device (IED) blast waves.<sup>3</sup> No one questions the impact physical wounds such as amputations, brain injuries, burns, and shrapnel can have on a service member. However, what has been less understood until now is how enduring long-term pain can disable individuals who suffer from the invisible wounds of war—and there is none more profound facing the military today than PTSD.

## What Is PTSD?

PTSD is an emotional trauma that can have debilitating long-term negative effects, which are not always visible. PTSD typically develops after exposure to a traumatic event in the face of grave physical harm or threats manifesting in severe depression or generalized anxiety. This combat-related affliction is not new to the military. In fact, the psychological experiences of war have likely been a problem of earlier wars for as long as warfare itself has existed.

Although PTSD has existed for centuries, it has been often overlooked and misunderstood. During the 1800s, soldiers were regularly diagnosed with “exhaustion” following battle. War-weary soldiers were commonly sent to the rear for a short time only to be returned to the front lines a short time later. In 1876, the common diagnosis for Civil War soldiers was “soldier’s heart.” Symptoms included startle responses, hyper-vigilance, and heart arrhythmias. During World War I, mental fatigue became known as the “effort syndrome” or “shell shock,” and later, during World War II, as “combat fatigue.” All of these terms describe military veterans who were exhibiting symptoms of stress and anxiety as the result of combat trauma. Despite the changing terminology, the effects were the same. In 1980, PTSD became a formalized diagnosis after experts determined anxiety disorders were commonly triggered by exposure to traumatic events.<sup>4</sup>

## A Tale of Two Pattons

Consistent with the attitudes documented in the 1800s, the controversial World War II American general, George S. Patton Jr., embraced a “get over it” type of attitude and was known to have slapped soldiers for what he believed was malingering in US field hospitals. Ironically, the current director of manpower and personnel on the Joint Staff at the Pentagon is US Army Brig Gen Gary S. Patton (no relationship to the World War II hero). He spoke out publicly in 2009 admitting that he suffered from PTSD as a result of his combat experience in Iraq and has since sought counseling for emotional trauma. Although the names of these two generals are the same, their perspectives on what we now know to be PTSD could not be more different. The latter General Patton has emerged as an exemplar for those suffering from PTSD by talking publicly about his own battles with stress and how counseling has

helped him deal with PTSD. By removing some of the stigma associated with seeking professional help, he hopes to influence contemporary perceptions of PTSD as a battle fought within long after the cessation of combat hostilities. Given the traditional stigma associated with military personnel seeking mental health assistance, service members tend to be very reluctant in pursuing treatment. A 2005 study by the National Center for PTSD reported approximately 40 percent of service members experiencing PTSD indicated an interest in receiving treatment.<sup>5</sup> Nevertheless, many believe coming forward could put their careers at risk. Among the proportion who do seek treatment, many do so at their own expense to maintain privacy. However, the greatest concern are for those who forego treatment altogether.

### **A Modern Perspective of PTSD**

The large number of injuries produced as a result of the current conflicts has brought PTSD to the forefront of the debate by military experts. A study by the RAND Corporation found that a huge gap exists between understanding mental health needs of deployed veterans and the need to focus on PTSD as a major issue.<sup>6</sup> Nevertheless, the full extent to which mental health problems are being detected and appropriately treated remains unclear. More detailed and increased mental health screening is required for all battlefield-injured veterans.<sup>7</sup> Unfortunately, PTSD is emerging as the signature injury for many US military service members deployed to Iraq and Afghanistan since 2001. Preliminary findings suggest that PTSD will be present in at least 18 percent of those serving in Iraq and 11 percent of those serving in Afghanistan. The notable increase in suicide among military personnel can be directly linked to a stressed, strained, and exhausted military. The unprecedented numbers of redeployments to Iraq and Afghanistan only exacerbate the stress placed on soldiers. The killing of five fellow soldiers by one of their own in May 2009 serves to illustrate the mental toll that the current wars are taking on our troops.<sup>8</sup> Research indicates an estimated 550 to 650 veterans committing suicide each month as a direct result of PTSD. Sadly, their names aren't considered part of the more than 5, 100 military war deaths, which rise with each passing month.<sup>9</sup> Nor will the psychological disorders caused by the wars in Iraq and Afghanistan be included as part of the 50,000 severe combat wounds inflicted thus far.<sup>10</sup>

Recently, the Department of Defense (DOD) and the Veterans Administration (VA) have come under Congressional and public scrutiny regarding their capacity to address PTSD. Under current policy, veterans must prove a service connection where they "engaged in combat with the enemy" to get the VA to cover care related to PTSD and provide benefits. VA rules generally require a combat action decoration, unit records, or other documentation to prove a veteran engaged in combat with the enemy. On a claim for PTSD, veterans must show credible third-party evidence that they suffered combat-related stress, such as eyewitness verification. Unfortunately, the VA's standard of proof for what constitutes "engaging in combat with the enemy" is often too high for

many veterans suffering from PTSD to prove their case since this standard, devised in 1993, fails to recognize what we now know about this debilitating illness and the nature of today's counterinsurgencies.

## **The Current Situation**

While all soldiers deployed to a war zone will feel some degree of stress, Pentagon surveys suggest that most will manage to readjust to normal. However, as many as 30 percent of troops with three or more deployments are likely to suffer from serious mental-health problems.<sup>11</sup> The current 12 months between deployments seems inadequate for soldiers to recover from the stress of a combat deployment before heading back to war. Thus, the number of soldiers requiring long-term mental-health services will continue to increase with both the increased frequency and duration of combat deployments. Service members and their families need the immediate attention of the nation to ensure successful reintegration, transition, and recovery pre- and post-deployment.

## **Conclusions**

From the words of retired Gen Colin Powell, former chairman of the Joint Chiefs of Staff:

This country has a profound obligation to honor its commitments to our veterans—including the lifetime medical care they were promised. Moreover, healthcare is an important incentive in attracting quality recruits to today's all-volunteer armed forces, on which our very national security depends.<sup>12</sup>

Since the 1930s, the VA has provided primary care, specialized care, and related medical and social support services for veterans of the United States military. Our military service members earned the best care this country can afford. Unfortunately, there is a shortfall in our knowledge and understanding about the mental health needs of our combat veterans, as well as gaps in the access and quality of care that must be addressed. With PTSD symptoms on the rise, it is up to the DOD and the VA to improve their ability to assist our veterans. The cost of mental health care is not and should never be an excuse to ignore the needs of these service members.

## **Recommendations**

### **Ensure DOD and VA Commitment**

The first step in the journey to resolving issues surrounding PTSD is to make everyone aware that PTSD is real. Second, the DOD and VA must make a comprehensive commitment to provide mental health services for our combat veterans. Service members must be aggressively encouraged to seek care without being concerned with the stigma often associated with it.

## **Understand Veteran Needs**

While there is wide policy interest and concern by the VA and the DOD, there are still significant gaps in understanding the needs of our veterans. The DOD and VA need to find ways to work effectively with civilian and military practitioners in an effort to discover the best treatments for combat-related PTSD and to improve both the efficiency and transparency of the system. Otherwise, we risk facing another generation of combat veterans similar to that of Vietnam. Military leaders and mental health physicians should consider screening combat veterans for PTSD immediately upon their return to the United States. Preemptive treatments should also be considered, including PTSD recognition for family members, service members, and battle buddies.

## **Reduce Stigma**

Online tools should be developed to assist service members who wish to find out privately if they are experiencing symptoms of PTSD and guide them to appropriate resources to get help. Although most service members will initially be treated in military treatment facilities, the mental health clinics can then contact the service member privately so that they may receive a referral for off-base counseling. Perhaps if service members had access to confidential treatment, there might be an increase in veterans seeking out the help they need. To help eliminate the stigma associated with seeking psychological health treatment, it is imperative to change military culture and encourage service members to seek treatment. Furthermore, it is equally important to provide commanders, families, and friends the information they need to effectively guide those suffering with PTSD.

Along with physical, mental, and social screening, there should also be mandatory screening that includes brain scans for traumatic brain injury. These screenings should be as common as receiving anthrax vaccinations before deployments. Long-term assessments should also be made, not just with the service member, but with the immediate family as well. If there are underserved areas, then civilian mental health centers should be incentivized to care for these combat vets.

## **Improve Access to Care**

The VA faces challenges in providing access to care for OEF/OIF veterans, many of whom have difficulty securing appointments, particularly in facilities that have been resourced primarily to meet the demands of older vets. This new group of veterans needs special attention and a high priority. The DOD and the VA need to consider that there is a substantial unmet need for treatment of PTSD and major depression among military service members following deployment. With more than 300,000 new cases of mental health conditions among OEF/OIF veterans, a commensurate increase in treatment capacity and

qualified providers is desperately needed. Incentivizing qualified professionals is one way to attract and retain well-trained mental health professionals.

The bottom line is that veterans should follow Brig Gen Gary S. Patton's example and be empowered to seek appropriate care. Likewise, commanders, supervisors, and family members must encourage individuals to seek health care before problems become critical. A comprehensive system to monitor the follow-up care of PTSD victims also needs to be established. It is important to keep in mind that it is not just the traumatic experience of war, but it is also the constant reminders and meaning of those events that actually create the trauma our service members experience. Unfortunately, the prevalence of traumatic mental injuries among veterans is high and is destined to continue growing in the future.

### Notes

(All notes appear in shortened form. For full details, see the appropriate entry in the bibliography.)

1. Gilbertson, "The Life and Lonely Death."
2. Ibid. See also Murdough, "Pain, Depression, PTSD."
3. Glasser, "A Shock Wave of Brain Injuries"; Hoge et al., "Association of Posttraumatic Stress Disorder," 150-53; Hoge et al., "Mild Traumatic Brain Injury," 453-63; Tanielian et al., *Invisible Wounds of War*.
4. MacGregor et al., "Psychological Correlates of Battle and Nonbattle Injury," 224.
5. National Center for PTSD, *Returning from the War Zone*.
6. Shen, Arkes, and Pilgrim, "The Effects of Deployment Intensity," 217.
7. MacGregor et al., "Psychological Correlates of Battle and Nonbattle Injury."
8. Ibid.
9. Murdough, "Pain, Depression, PTSD."
10. Gilbertson, "The Life and Lonely Death."
11. Polusny et al., "Impact of Prior Operation Enduring Freedom/Operation Iraqi Freedom Combat Duty," 35.
12. National Association for Uniformed Services, [http://www.naus.org/news/news\\_veterans.html](http://www.naus.org/news/news_veterans.html).

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### About the Authors

**Dr. Carla Sizer** is recently retired from the United States Air Force after 21 years of honorable service. Her last military duty station was as an assistant professor at the United States Air Force Academy. She currently works as a program manager for the Department of Defense at Peterson Air Force Base, where she manages space control sensor programs. Dr. Sizer's interests include researching post-traumatic stress, mentoring others, and public speaking. Dr. Sizer's eldest son was killed in action during Operation Iraqi Freedom on 5 September 2007. After her son's death she founded the Pikes Peak Gold Star Mother's Support Group, which is for mothers who have lost their sons or daughters in war. She also founded the Specialist Dane R. Balcon Junior Reserve Officer Training Corps (JROTC) Scholarship Fund, dedicated for JROTC cadets in high school who plan to pursue higher education. Dr. Sizer completed her undergraduate work at Southern Illinois University at Carbondale and her graduate work at Georgia College and State University in public administration. She earned her doctorate from the University of Phoenix.

**Dr. Claude Toland** is the president of DeVry University—Houston Metro. He joined DeVry University in June 2007 as the dean of academic affairs, where he provided leadership in developing and growing DeVry's academic programs. Prior to joining DeVry University, Dr. Toland served as campus director for the University of Phoenix. Dr. Toland earned a bachelor's degree from Colorado Christian University in addition to two master's degrees and a doctorate from the University of Phoenix.