Strategy Research Project

EMERGING GENERATION OF POST-TRAUMATIC STRESS DISORDER VICTIMS

BY

LIEUTENANT COLONEL JOE E. ARNOLD
United States Army

USAWC CLASS OF 2011

U.S. Army War College, Carlisle Barracks, PA 17013-5050

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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE *(DD-MM-YYYY)*	**2. REPORT TYPE**	**3. DATES COVERED** *(From - To)*
02-02-2011	Strategy Research Project	

4. TITLE AND SUBTITLE
Emerging Generation of Post-Traumatic Stress Disorder Victims

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)
Lieutenant Colonel Joe E. Arnold

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Dr. Sara Morgan
Department of Command, Leadership, & Management

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army War College
122 Forbes Avenue
Carlisle, PA 17013

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT
Distribution A: Unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT
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15. SUBJECT TERMS
PTSD, Social Support, Professional Military Education

16. SECURITY CLASSIFICATION OF:			**17. LIMITATION OF ABSTRACT**	**18. NUMBER OF PAGES**	**19a. NAME OF RESPONSIBLE PERSON**
a. REPORT	**b. ABSTRACT**	**c. THIS PAGE**			**19b. TELEPHONE NUMBER** *(include area code)*
UNCLASSIFED	UNCLASSIFED	UNCLASSIFED	UNLIMITED	26	

USAWC STRATEGY RESEARCH PROJECT

EMERGING GENERATION OF POST-TRAUMATIC STRESS DISORDER VICTIMS

by

Lieutenant Colonel Joe E. Arnold
United States Army

Dr. Sara Morgan
Project Adviser

This SRP is submitted in partial fulfillment of the requirements of the Master of Strategic Studies Degree. The U.S. Army War College is accredited by the Commission on Higher Education of the Middle States Association of Colleges and Schools, 3624 Market Street, Philadelphia, PA 19104, (215) 662-5606. The Commission on Higher Education is an institutional accrediting agency recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation.

U.S. Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

ABSTRACT

AUTHOR: Lieutenant Colonel Joe E. Arnold

TITLE: Emerging Generation of Post-Traumatic Stress Disorder Victims

FORMAT: Strategy Research Project

DATE: 2 February 2011 WORD COUNT: 5,172 PAGES: 26

KEY TERMS: PTSD, Social Support, Professional Military Education

CLASSIFICATION: Unclassified

The U.S. Army has been at war for more than nine years. Despite our successes on the battlefield, our forces remain engaged with enemies that pose unseen mental challenges. Today's leaders and Soldiers serve in operational tempos that challenge the moral fiber of our great Army. The stressors of repeated deployments are approaching a breaking point. These stressors are manifested as latent pre-deployment period as they begin the first phase the Army's three-phase readiness cycle (Train, Ready, and Reset), designated the Army Force Generation model. Once deployed, our Soldiers are committed to arduous 18- hour days that last for months on end. They are constantly exposed to the grim reality of blood-laden warfare as they receive the weary words of a strained family stateside. As a result, stressors become more acute. This Strategic Research Project (SRP) explores the challenges of contemporary combat. It discusses the impact of Post-Traumatic Stress Disorder (PTSD) on the Vietnam Veteran, our Soldiers and Families. Multiple deployments, stressed Soldiers and troubled Families are taking a toll on our force. This SRP concludes with recommendations for our current strategy in regards to diagnosed and undiagnosed PTSD victims in order to maintain the strength of our great Army.

EMERGING GENERATION OF POST-TRAUMATIC STRESS DISORDER VICTIMS

> Let us strive on to finish the work we are in, to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan.[1]
>
> —Abraham Lincoln

To echo the words of President Lincoln, we should make every attempt to care for Soldiers and their families who have made great sacrifices to defend our great nation. The U.S. Army has been at war for more than nine years. Despite their successes on the battlefield, our Soldiers remain engaged with enemies that pose unseen challenges. Today's leaders and Soldiers serve in operational tempos that challenge the moral fiber of our great Army. The stressors of repeated deployments are approaching a breaking point. As our Soldiers endure the stressors of multiple deployments, they are mentally and physically challenged to perform their duties. These stressors are manifested as latent pre-deployment period as they begin the first phase the Army's three-phase readiness cycle (Train, Ready, and Reset), designated the Army Force Generation (AFORGEN) model. ARFORGEN is designed to identify, build, train and synchronize the movement of deployable forces in support of the Combatant Commanders' requirements.

Once a unit or individual is identified for deployment according to AFORGEN requirements, they immediately shift focus to deployment tasks. After the deployment commences, Soldiers often endure arduous 18-hour days that last for months on end. Soldiers are constantly exposed to the grim reality of blood-laden warfare as they receive the weary words of a strained family stateside. Stressors then become more acute. Soldiers of the U.S. Army (both officer and enlisted) will endure many challenges

associated with the stressors of our current campaign efforts in the Middle East. Adequate preparation for such stressors, and cycles of change that inherently accompany multiple deployments is imperative for our success, as we continue to transform our Army while at the same time execute two protracted campaigns. This preparation must begin with the Soldier, the Soldier's family, and the Soldier's Unit. The source of such preparation comes in the way of guidance and knowledge in order to take the appropriate course of action for our Soldiers and families.

In the meantime, while the Army's efforts to sustain a well-prepared and ready force, our Soldiers, and their families face multiple challenges that eventually lead to stressful ordeals as Soldiers prepare to deploy. Many factors contribute to this stressful undertaking. For starters, today's Soldiers and families are expected to perform heroically in a society reliant on social media and video interaction via the internet. These media consist of a diverse mix of born-again religious believers and new agers who garner their values from the latest action movie and daily talk shows.[2] However, a large percentage of our Soldiers will endure multiple deployments to areas of violent conflict that will challenge their moral character, because we live in an era of continual conflict. A Soldiers' mental agility and adaptability have become overriding operational factors in the aftermath of the 9/11 attacks.

Since the 9/11 attacks, our nation has asked a great deal of our Soldiers, who have responded in a remarkable manner. However, the mental resilience required to perform is not immune to stress. These stressors begin to intensify as the Soldier prepares for successive deployments. Multiple deployments have now become a predictable cycle or way of life for many within the U.S Army. There are four cycles most

deploying Soldiers with undiagnosed Post-Traumatic Stress Disorder (PTSD) will experience which may occur before, during or after deployment. The initial cycle begins in a subtle dormant pre-deployment state when our Soldiers, despite their military training, are mentally oriented to the larger society's values (focused on mundane events and not focused on deployment). Pressures mount, stressors are compounded. But our Soldiers are only in Cycle One.

Cycle Two begins when they return home to a warm reception of a grateful nation and huge yellow ribbons that drape the threshold of the family residence. But in the quiet of night, they are visited by haunting mental reenactments of the operating tempo (OPTEMPTO) and combat missions. Instead of the warmth of a family's love, they are perplexed by the troubling images that play out in their minds.[3] The family and society tries to understand how to help integrate the weary Soldiers back into the norms of family life and ordinary citizenship. Unfortunately, most returning Soldiers attempt to conceal their confusion and stress. Based upon my experience as a commander, too often their mental ordeal manifests itself in domestic violence, crime, insomnia, alcohol, and drug dependency. They are no longer returning heroes. Rather they are tormented Veterans. Despite their ordeals, many successfully proceed through this cycle.

Cycle Three begins with the issuance of the fragmentary order (FRAGO) directing preparation for another deployment. The Soldiers enter Cycle One which in essence is the beginning of the recurring events and stressors. It typically repeats the ordeal that characterized the first deployment. However, it can be safely said that the Soldier is mentally and morally challenged to deploy.[4] So, when the stressors set in during the second train-up, the Soldiers are simply counseled to hang in there. The

Soldier endures and performs the numerous tasks associated with the next deployment, which also entails making sure family matters are in order. Anticipation of the challenges of the deployment and concerns about their families' begin to weigh heavy on the minds of our Soldiers. The Soldier is now approaching the breaking point.

Cycle Four concludes with post-deployment activities. However, one could argue that the levels of emphasis on such activities are not enforced as in previous Cycles. Now, having endured the stress of deployment for the second time, many entertain the thoughts of exiting the military. Often times, the decision to pursue life outside of the military outweigh the reality of repeating the painful stressors again. The resultant, retention levels fluctuate as younger officers and enlisted Soldiers transition into the civilian population. Their mental health problems are not left behind.[5] But they have served in an Army where mission accomplishment is emphasized more than interpersonal relationships.[6] They have contributed to the mission, but at what price? As newly released Army Veterans, they bring their stresses and mental disorders from repeated deployments back to the larger society whose values are inconsistent with Army values. So, after a trip to the therapist and hospital psychiatric ward, the Soldier, soon to be a veteran has been diagnosed with PTSD, a new generation of PTSD victims have arrived.

The increasing number of Soldiers who suffer with diagnosed and undiagnosed PTSD is one of many challenges the U.S. Army faces as a result of our current campaigns. This anxiety disorder affects not only the Soldiers, but the Family as well. PTSD garners much public attention on behalf of our Soldiers. However, much work

remains to be done, especially how it affects family members. The seriousness of PTSD is conveyed in the following definitions.

Definition of PTSD

PTSD has been acknowledged in the medical world as a legitimate disorder by the Diagnostic and Statistical Manual, (DSM) of Mental Disorders.[7]

> The DSM describes PTSD as a psychological disorder in which "a person may experience, after witnessing, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self (i.e. combat, friendly fire, being mortared or rocketed, wounded, captured, driving a truck on a mined road, flying in a helicopter that was shot at, jumping out of a helicopter into a hot LZ) or others (if you had a buddy who was wounded or lost squad members, family member, or seeing anyone who has recently been killed or injured such as being a medic or nurse on a trauma ward, body bagging, seeing someone you didn't know killed, seeing kids, women or other Americans or civilians who had been killed, or wounded, etc.).[8]

The National Center for Post-Traumatic Stress Disorder (NC-PTSD), a subordinate organization within the Veterans Administration (VA),[9] states that "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."[10] It further explains that PTSD 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.

Web MD, an online site, expands and broadens the definition and explains that

> PTSD, once called shell shock or battle fatigue syndrome, is a serious condition that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened. PTSD is a lasting consequence of traumatic ordeals that cause intense fear, helplessness, or horror, such as a sexual or physical assault, the unexpected death of a loved one, an accident, war, or natural

> disaster. Families of victims can also develop post-traumatic stress disorder, as can emergency personnel and rescue workers.[11]

Similarly, the American Medical Association, defines “PTSD as a debilitating condition that can follow a terrifying event such as a rape-that involves intense fear, helplessness, and horror.”[12] It also reports that PTSD is known to affect more women than men due to childhood sexual abuse.[13] Moreover, it states that PTSD can occur at any age, including in children and adolescents. The forgoing perspective on the causes of PTSD provides a greater appreciation for the challenges many Soldiers and family members may encounter. Certainly many Vietnam Veterans have endured PTSD for many years.

PTSD and its Effect on Vietnam Veteran

The aftermath of the Vietnam conflict has been cited as the beginning of our understanding of the psychological effects of trauma.[14] In particular, it exposed society to the effects of PTSD- a new epidemic of disturbed, violent, and neglected military personnel.[15] In a war such as Vietnam that lasted for more than 10 years (1961-1975), in which ultimately the only thing that mattered was living or dying, many Veterans were exposed to dreadful events and images that were heartbreaking and monstrous.[16] War theorist Clausewitz used the term “friction to describe the physical, mental, and emotional stressors of dreadful events associated with combat”.[17] Images retained from war experiences not only cause lifelong disabling psychiatric symptoms, they can also ruin good character.[18]

From the Vietnam War, these images include, a child having been exposed to napalm seeking help as the jelled gasoline continues to burn the skin from her body.[19] They include eye witness accounts of a Viet Cong being shot at point blank range in the

head as his body falls to the ground and blood sprays into the air[20] or of a family crying in agony by the grave of a relative who was just shot or burned to death. These unsettling images continue to torment many Vietnam Veterans as they struggle to reintegrate into a society that holds them responsible for such atrocities. Many Vietnam Veterans continue to seek treatment in order to alleviate their unseen torment. They suffer from the epidemic now known as PTSD, perhaps triggered by the death, destruction and graphic images which are now embedded within their minds.

As a result of Veterans diagnosed with PTSD significant effort has been made to treat their illness. Leading the effort is the National Vietnam Veterans Readjustment Study Group (NVVRS). The NVVRS was formed after a Congressional mandate in 1983 to better understand the psychological effects of combat in the Vietnam War.[21] The NVVRS contained detailed comparisons of the psychosocial status of the Vietnam Theater Veterans, Vietnam-era Veterans, and a comparable civilian population.

The researchers reported that 30.9% of all men who served in the Vietnam conflict developed PTSD while only about 15% had been assigned to combat units.[22] Among Vietnam Veterans, approximately 15% of men and 9% of women were found to have PTSD at the time of the study. Approximately 30% of men and 27% of women had PTSD at some point in their life following Vietnam (note Table 1). These rates were much higher than those found among non-Vietnam Veterans and civilians. The rates are alarming since they indicate that at the time of the study, there were more than 830,000 cases of PTSD as a result of the Vietnam War.[23]

PTSD	
Current	Lifetime
Males	
15.2	30.9
Females	
8.5	26.9

Table 1: Rates of PTSD for Vietnam Theater Veterans

In addition to the previous analysis, the NVVRS conducted another study to determine other factors contributing to the Vietnam Veterans' psychological disorders. As a result of the study, it was discovered that depression, anxiety, and alcohol abuse were also prevalent problems among Vietnam Veterans other than PTSD.[24]

Nearly all of these disorders were common among Vietnam Theater Veterans. However, initial investigation revealed few differences between Vietnam Theater Veterans and Vietnam era Veterans.[25] (note Table 2).

Current disorders	Lifetime disorders
Males	
Alcohol abuse/ dependence	Alcohol abuse/ dependence
Generalized anxiety disorder	Generalized anxiety disorder
	Antisocial Personality Disorder
Females	
Depression	Generalized Anxiety Disorder
Generalized Anxiety Disorder	Alcohol abuse/ dependence

Table 2: Most-Prevalent Disorders among Vietnam Theater Veterans

Strategy for Vietnam Veterans Suffering from PTSD

Despite the efforts of the NVVRS, which conducted the most comprehensive study of Vietnam Veterans, many Veterans continue to suffer in silence. They do not trust the systems, or they fear that asking for help will bring dishonor to them and their families. Available evidence remains critically important in understanding the effects of war on Veterans.[26] To counter this stigma, the Veterans Affairs organization has and

continues to establish programs to better understand the importance of developing and applying mental health treatments to those who continue to suffer from PTSD or other psychological and readjustment problems.

The NVVRS research confirms that preparation for pre-deployment, deployment, and post-deployment activities can provide indicators on who develops PTSD, and those who are likely to maintain PTSD.[27] An important message for Veterans and Soldiers already exposed to combat stress is that early detection and social support plays a critical role in reducing PTSD symptoms and enabling Veterans to lead normal lives.

PTSD and its Impact on Today's Soldier

Our current Wars in Iraq and Afghanistan present a similar challenge to that in the aftermath of the Vietnam War. Although closely related in terms of the amount of time we've been engaged in conflict within the Middle East, this war presents new challenges, especially in the frequency of a Soldiers' exposure to the images that continue to play out in his or her mind due to repeated deployments. Most Soldiers, who entered the Army since 2001 and were assigned to operational commands, have no idea of what garrison life in the Army has to offer. They have repeatedly trained for deployment, deployed, returned to be immediately train up for the next deployment. According to a RAND study conducted earlier this year, many within our ranks are now approaching their third and some their forth deployments.[28] But today's Soldiers serve in a volunteer force, unlike our Vietnam Veterans many of whom were drafted.

Volunteers or draftees, once deployed to the theater of operation, the stressors of deployment continue to strain, damage, and destroy relationships (social interaction) that are important to deterring the onset of PTSD. The current operational environment

and living conditions have a propensity to foster individual isolation. Drawn to electronic media and game devices, individuals fail to build or maintain relationships. The recruiting slogan “Army of One” has become a reality. Soldiers retreat to personal games, or they spend countless hours agonizing over e-mails received from home and online chat via Face book or Twitter. They have not developed the skills needed to interact, in order to solve relationship problems, or to overcome the stressors caused by the repeated challenges of deployments.

To further complicate matters, Soldiers and their family support systems, are to some degree, forced to function apart. Little to no effort is directed at developing healthy support systems prior, during and following deployments.[29] The Army emphasizes unit readiness and mission accomplishment. Although this is paramount in the Soldiers line of duty, the individual’s support system is just as important, if not more important, for sustaining our Soldiers and keeping them fit for successive deployments.

However, the isolation and separation from the Soldiers’ support system forces the deceptive mask that convinced the Soldier that they were ready to deploy to reveal itself very quickly. Soldiers face significant stressors in combat, they are witnesses to Improvised Explosive Devices, roadside bombs and human body dismemberment which subsequently force distress, anxiety and the signs & symptoms of PTSD to emerge as the Soldiers are exposed to these horrors daily. Reality is the hard and sometimes cold heart that houses the moral man or woman comes to the surface.[30] When given an option to make the right decision or act with compassion or empathy, the Soldier’s mind fails to engage. At this point, the stressors are too big to control and have gone astray.

However, the Soldier manages to make it through their ordeal on the prospect of knowing it will soon be over.

One of several positive thoughts that plague their mind is redeployment and reuniting with their family and friends. After their return home, the families and society have no idea of the images or experiences resident in their Soldiers' minds, gathered during the past 12-15 months of deployment. But, if the Soldier fails to seek treatment, eventually their turmoil is exposed. In some cases, they reveal themselves in a horrible manner. Statistics do not lie: More than 1.6 million U.S. service members have deployed to the current theater of operation (49% active duty and 51% National Guard and Reserves).[31] Of that, more than 300,000 have already sought treatment for PTSD. Alarmingly, the Veterans Administration estimates that in the next several years the numbers are expected to reach 700,000 as more Soldiers transition from active duty.[32] Even more alarming is the fact that most Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans seeking treatment range in ages from 18-24. These young Veterans have a greater probability of seeking mental health treatment as a result of PTSD than those OEF/OIF Veterans who are age 40 or older. An emerging generation of PTSD victims continues to grow.

Family Impact

> Missing someone gets easier everyday because even though you are one day further from the last time you saw them, you are one day closer to the next time you will.[33]

Our Family members continue to stand shoulder to shoulder with our Soldiers through the stressors of repeated deployments. And the deployments have begun to take a toll on the family as well as the Soldier. In terms of its traditional definition, the family is a fundamental social group in society typically consisting of one or two parents

and their children; this may also simply include a union between man and woman. However, the responsibilities imposed upon the Soldier's left-behind parent or spouse include managing the household budget, getting the children off to school, to doctors' appointments, and to extracurricular activities. The task of serving as both the mother and father (or vice versa) to the children of deployed Soldiers is a challenge. Left behind for 12 to 15 months, the family (and parent) is forced to take on multiple roles with very little support, which can be significantly taxing. In doing so, the stressors on the Soldiers begin to mount, increasing throughout the deployment.

However, the stressors start much sooner than the deployment phase. The stressors begin to surface during the pre-deployment training process and requirements leading up to deployment which escalates the tension levied on the family. During the Soldier Readiness Process (SRP) which is one of the many pre-deployment requirements, includes legal briefings, mental health briefings, medical briefings, and such procedures as immunizations, and test of vision and hearing.[34] However, during this busy activity, Soldiers have little time to attend to family matters. Little or no relationship training (caused by the separation of deployment) is provided during SRP, which occupies most of the Soldiers' time immediately prior to deployment.

Nonetheless, the family musters up the courage to be supportive and conceal their stressful ordeals so no additional stress is added to their already stressed Soldier. After the deployment occurs, they begin to build a family without their Soldier. Each member assumes a greater role in order to remain functional and to compensate for their absent warrior. But that compensation does not fill the void as major milestones

such as a child's first step, graduations, or anniversaries occur. These absences could essentially lead to lasting effects on the entire family.

Stressors that Soldiers endure during deployment have a significant impact on the Family after they return home. Some of the issues affecting families that occurs secondary to long-multiple deployments are marital conflicts. Parental roles and responsibilities become problematic over time ideally when one parent has held the responsibility for 12-15 months. Subsequently, when the other parent returns from deployment and he or she is not mentally or physically ready to re-assume some of the roles previously held prior to deployment; Family issues around adjustment, transition, re-integration back into the family creates dissonance or discord among other Family problems that occur secondary to 12 to 15 month deployments.[35] Family disruptions emerge regarding daily routines that were established by the spouse left-behind during the 12 to 15 month deployment. Spouses are challenged, questioned, and sometimes completely disregarded by the returning Soldier. Undiagnosed PTSD, adjustment disorders, or any other mental health disorders may further complicate many of the readjustment issues noted above.[36]

Furthermore, the impact of deployments upon family members diagnosed or undiagnosed with PTSD is an unresolved issue primarily because family members do not readily seek treatment and when doing so, the treatment is not monitored, followed or tracked by MEDCOM or Behavioral Health. Family members are often referred out of the network with little to no oversight, to include clinical follow-ups and continuous treatment. The impact of military deployments upon the family affects the very fabric that holds the Army together, namely the spouses and children left behind on the home

front.[37] Yet to date there is little information regarding the extent to which families have been affected, or how deployments may influence child and adolescent behavior or mental health.

Lastly, there is very little knowledge about how caregivers (siblings, grandparents, aunts, and uncles) cope with the stressors associated with repeated deployments. We lack adequate knowledge and insight on how Soldiers recognize the impact of the deployment on their family members, or whether experiences differ for families of active component vs. reserve component personnel. Understanding how family members deal with the stressors during and after a Soldiers' deployment is critical in determining the need for particular programs.

The stressors of multiple deployments on the family will continue as long as we are an Army at war. Programs to strengthen the social interaction and treatment for our families may alleviate the stressors of deployment. As Senior Leaders, there must be increased support of military families with programs that are effective across the board. To date, the Army Covenant Program serves as the corner stone for such activities:

> In the words of our Secretary and Chief of Staff of the Army, "Never before in the history of our Army have we asked so much of our Families. They are serving side-by-side with our Soldiers, enduring their hardships and providing the unconditional love and support that truly make our Army strong. The Army Family Covenant pledges our commitment to support Soldiers and their Families and resource programs to provide them a quality of life commensurate with their service."
>
> On 8 October 2007, the Army unveiled the Army Family Covenant, which institutionalizes the Army's commitment to provide Soldiers and Families — Active, Guard, and Reserve — a quality of life commensurate with their level of service and sacrifice to the Nation. It commits the Army to improve Family readiness by: Standardizing Family programs and services, increasing accessibility to health care, improving Soldier and Family housing, ensuring excellence in child, youth and school services, and expanding education and employment opportunities for Family members.[38]

Remaining committed to such a program as the Army Covenant is a step in the right direction. However, it must be embraced at each level and available to every family member before, during, and after a stressful deployment ordeal. Such a readily accessible program would greatly assist in deterring the number of PTSD cases that may come as a result of deployment experiences.

What Have We Done?

The Department of Defense has implemented military education and support which comes from a variety of civilian sources. Military One Source, Military Family Life Consultants, and the Yellow Ribbon are only some of the organizations that provide ancillary support. These organizations are largely staffed by civilians. Civilians primarily function in the roles previously noted and are extremely valuable in most situations.

However, a significant part of successful reintegration and successful growth and development comes from interacting with someone who explicitly understands the challenge. Communication, respect, and integration are fundamental at every level to enable the family to progressively transform from a negative impact to a more positive family impact. Senior leaders must listen carefully, execute and support subordinates from start to finish regarding these issues.

Lack of Ability to Detect the Manifestation of PTSD

The Army has done and continues to do a remarkable job of ensuring our Soldiers receive adequate training prior to any deployment. This also ensures that Soldiers are taken care of regarding ancillary services and medical treatment pre-deployment and post-deployment. Also, upon return our Soldiers are inundated with a myriad of services and service providers. Many of these are valuable, high quality

services, but due to the nature of deployments and losses associated with deployments, many Soldiers lack the trust required to seek the assistance of these services.

It is evident that we as Army Leaders lack the basic requirements that would assist in detection of PTSD. Most Army leaders do not possess the clinical acumen and professional training to understand, detect, and recognize, and treat PTSD unlike Behavioral Health Personnel. The personnel that comprise of the Army's Behavioral Health Division consist of the following specialties: Psychiatry, Social Work, Psychology, and Counseling to include Army Substance Abuse Program.[39]

All Army Behavioral Health personnel are professionally trained and licensed to understand, detect, recognize, and treat the warning signs and symptoms of PTSD.[40] So why aren't they attached or assigned to units as they begin their deployment train up or deployed to the theater of operations as a part of a unit? Talking with someone that understands and speaks the same language is critically important to healing and growth process. Without this process, traumatic experiences can become intimidating and overwhelming.

Establishing contact with someone that has been there, walked among the Soldiers', and truly understands, has always assisted in the healing and growth process. This is the essence of interpersonal relationships, and the ability to connect with a fellow Soldier. Again I question why isn't this a part of the entire deployment process? Soldiers are required to seek the treatment on their own terms. The responsibility is put squarely upon the shoulders of the Soldier to initiate the process of seeking help or treatment. But Soldiers have little knowledge or understanding about the process of seeking help with mental health or problems associated with themselves or their family members.

Initiating treatment can be daunting. Negative past experiences jeopardize success of PTSD treatment. Our Soldiers are being harmed unintentionally because we lack training, experience, and expertise to understand, detect, recognize, and subsequently treat the warning signs and symptoms of PTSD.

Until the Army begins to aggressively integrate behavioral health assets as a part of the deployment phases, inadvertent delays to treatment will continue to obstruct the healing process, especially for Soldiers who suffer with PTSD.

Conclusion /Recommendation

A significant problem associated with diagnosed and undiagnosed PTSD due to the stressors associated with repeated deployments is the lack of adequate and functional support systems and education for our Soldiers. This support system should include the Soldier's family, friends, and chain of command; it should specifically include their battle buddy, squad leader, platoon sergeant, first sergeant, company commander, battalion commander, and brigade commanders.

The Soldiers' support system must be embraced, reinforced, and supported by Senior Leaders. This supportive framework provides the Soldier with multiple avenues of approach to address a myriad of issues, in a manner that alleviates the stigma associated with seeking mental health treatment. Soldiers often consider their peers weak, soft, and less than a warrior if they seek treatment for PTSD or any other mental health issue. However, the Soldiers' Chain of Command can eliminate this stigmatization through a mandate of professional military education. It should certainly be a prerequisite for all Army leaders prior to assuming any leadership position. To ensure it extends across the ranks, it should be mandated as an annual training requirement outlined in AR 350-1. It should not be limited to reintegration training,

however, reunification training, and strengthening redeployment training, which will include the family.

Second, Army leaders should take a more proactive approach toward understanding, detecting and referring our Soldiers to Behavioral Health personnel, rather than taking a reactive approach towards PTSD. This approach would allow us to treat the symptoms of diagnosed or undiagnosed PTSD rather than the problem, or its outcome, such as suicide, addictions, and abuse. Embedding Behavioral Health personnel into the deployment processes would foster trust, understanding and possibly a short turn-around regarding restoration, relaxation, and replenishment of our Soldiers.

Third, we should place the same level of emphasis on post deployment training as with pre-deployment training. This training set should allow for normal emotions to surface. Viewing pain as a sign of weakness has prevented, delayed, and prolonged the care required to get our Soldiers on the appropriate path to recovery from loses that create trauma, anxiety and distress. As noted throughout this paper, deployments are notorious for the losses they incur, such as separation, daily interaction, normal support, and losses associated with trauma. The inability to recognize and allow normal responses or emotions continues to be problematic upon the return home.

Lastly, the Army may consider endorsing a spiritual approach to the healing process. Lacking spiritual guidance, the soldier may be denied a range of skills and beliefs to address loss, and other stressors. Self-centered, demanding behavior replaces the valuable act of giving and receiving. Activities involving the Chaplain or spiritual-based activities may be emphasized. It is imperative for our Soldiers to be able

to openly express, practice and engage in dialogue with fellow Soldiers and Senior Leaders to strengthen their spiritual connections.

As previously stated, while the Army continues to transform and evolve in the twenty-first century simultaneously supporting two protracted campaigns, the amount of time invested in the health, welfare, and readiness of our Soldiers and family members must remain our top priority.[41] As Senior Leaders, a commitment to strengthening our force by supporting and providing our Soldiers with education, treatment, and rehabilitation, may counter the stressors that cause PTSD. To achieve the victory we've become accustomed to, we must remain vigilant and never forget the most important resource we have is our Soldiers. As Senior Leaders, we not only want to win the Battle, we want to win the War. In doing so, allows the US Army to remain the most powerful Army in the world.

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