

Hidden Toll of the War in Iraq

MENTAL HEALTH AND THE MILITARY

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INTRODUCTION

The alarming number of suicides earlier this year among U.S. troops serving in Iraq has raised a red flag about the mental strain on our service men and women as they face grueling battles and a conflict with no clear end in sight. These suicides are only the most visible manifestation of the rising mental health toll from the Iraq war and other U.S. combat operations abroad. Studies indicate that troops who served in Iraq are suffering from post traumatic stress disorder and other problems brought on by their experiences on a scale not seen since Vietnam.

These figures have mental health professionals and veterans groups worried, and with good reason. At a time when our troops are working hard to answer the nation's call, their own needs remain unmet. Barriers to mental health care persist both in the field and at home, leaving mental health problems to fester.

The personal burden on troops affected by mental trauma and on their families is enormous, and these mental health problems have consequences for communities and the nation as well. The full extent of this hidden cost of war will not be apparent for some years to come, but experts believe it may involve tens of thousands of service members. Preparing for the challenge at hand and extending the appropriate care and respect to our troops must be a top priority.

This paper explores some of the figures and contributing factors of the mental health cost to our troops. It discusses some of the challenges related to service members' mental health before, during and after deployment, and examines the consequences of unmet needs. Finally, it makes

recommendations for our military and political leaders.

UNDERSTANDING THE NUMBERS

Significant numbers of U.S. troops may need mental health services as a result of their combat in Iraq, and many have already been affected. As these figures are related to the nature of the combat operations themselves, an examination of both the numbers and the contributing factors is important for a full understanding of the problem.

Evacuations, Diagnosis and Data

According to the U.S. Army, there have been over 13,263 medical evacuations from Iraq since the beginning of combat operations in March 2003, and 6 percent of those were for psychiatric reasons.ⁱ These statistics only reflect Army evacuations and do not include the other services fighting on the battlefield. Since psychiatric ailments are largely treated in the field and only the most severe cases are evacuated, this figure is significant, and the number of individuals experiencing mental health problems in the field is undoubtedly larger.

Indeed, a study published in the New England Journal of Medicine (NEJM) in July 2004 revealed that 15.6 percent of Marines and 17.1 percent of soldiers surveyed after duty in Iraq "met the screening criteria for major depression, generalized anxiety, or [Post Traumatic Stress Disorder (PTSD)]."ⁱⁱ The authors noted that the numbers may understate the prevalence of mental disorders because they do not reflect those returning troops in the units examined who were unable to participate due to injury or removal.ⁱⁱⁱ The figures indicate that roughly one in six

troops returning from the war in Iraq will be in need of psychological care and counseling as a result of their wartime service.

These troubling findings have been echoed elsewhere. A subsequent survey of paratroopers who had served in Iraq found that 17.4 percent also showed symptoms of PTSD, a debilitating condition brought on by traumatic or life threatening situations.^{iv} In comparison, 1991 Persian Gulf War veterans showed rates of PTSD of 9 percent.^v

The rise in psychological trauma associated with the war in Iraq should not surprise experts. The extent of wartime trauma is directly proportional to the type of warfare fought and the experiences encountered. Studies of Vietnam veterans show that between 26 and 31 percent have experienced PTSD.^{vi} This rate is understandable given that the Vietnam War's combat environment included both guerilla and conventional warfare. It is arguable that the war in Iraq compares to the Vietnam War, as there is no safe place, no enemy lines, and threats surround the soldier on all sides.

Situations that can contribute to the development of PTSD – including armed conflict, the unexpected and sudden death of unit members, capture, terrorism and accidents – are present in the current Iraq war on a larger scale than in the 1991 Gulf War.^{vii} In the first Gulf War, most combat engagements were long-range tank battles in combination with massive Iraqi surrender, and troops did not enter Baghdad to engage in urban combat. Operation Iraqi Freedom is dramatically different. Urban combat mixed with an unidentifiable enemy and prolonged deployment of combat forces have combined to create a deleterious effect on the service member. While Operation

Desert Storm lasted slightly over one month, Operation Iraqi Freedom has dragged on for more than 17 months, and many troops have been deployed for periods ranging from at least six months to more than a year away from home. As a result, exposure to the stresses of war has been much greater this time around.

Stress Factors in the Iraq War

U.S. troops in Iraq are experiencing both external and internal stressors. Among the most common wartime external stressors are adverse physical conditions. These include extreme temperatures, both hot and cold. In Iraq, the average temperature can reach 110 degrees Fahrenheit in the summer, and this extreme of temperatures and humidity, coupled with the scarcity of water, can have a devastating effect on men and equipment.^{viii} Soldiers reported that multiple injuries occurred in Iraq due to poor hydration and lack of logistical re-supply of water.^{ix} Several soldiers died during the hottest months of 2003 due to the devastating effects of heat and combat operations.^x

Other external stressors can include lack of proper equipment to conduct the mission. In 2003, an estimated 12 percent of Operation Iraqi Freedom soldiers were equipped with body armor.^{xi} Additionally, logistical difficulties hampered the delivery of food, ammunition and other critical supplies.^{xii} The extension of combat operations itself can induce stress.^{xiii} Soldiers who thought they had completed their tours in Iraq were placed on "Stop Loss," which creates an involuntary extension of the individual's duty beyond the term of his or her formal contract.^{xiv} Eighteen-hour days lasting from weeks to months have taken their toll and prevented troops from receiving proper rest and recuperation.

This kind of strain can exacerbate internal stressors including fear of death and injury, inability to identify enemies from non-combatants, long-distance relationship problems due to deployment, multiple losses of unit members to war, and persistent financial worries or pay problems while deployed. This last stressor can be particularly troubling for National Guard and Reserve troops, who may worry about civilian jobs at home.^{xv}

A possible new stressor from this war may be survival of a traumatic event with debilitating circumstances due to improved body armor. Improved body armor has created a situation where troops are surviving what normally would be life-ending attacks. However, these troops are often left with multiple amputations, losing arms and legs or sustaining brain injury. While early on in their recovery, many express regret that they didn't die rather than survive with missing limbs, this effect usually wears off as the individual begins rehabilitation.

The mental strain on troops in the field can be compounded by the pace of operations in Iraq. Acute stress is a reaction to an immediate threat, commonly known as the fight or flight response. Common acute stressors include noise, crowding, isolation, hunger, high technology (e.g., complicated military equipment), and perceived danger. Under most circumstances, once the acute threat has passed, levels of stress hormones return to normal. In Iraq, however, troops are frequently placed in continuous stressful situations where stress can become chronic.

BREAKS IN THE SYSTEM

Aside from their perceived need, service members' desire and ability to receive appropriate mental health care is also affected by military practices, procedures and attitudes. While the military is attempting to meet personnel needs, troops have found barriers to adequate care before, during and after deployment.

Pre- and Post-Deployment Exams

An extensive pre-deployment medical examination and the associated supporting documentation are necessary to establish a service member's baseline health. Changes in physical and mental health can then be properly detected in thorough post-deployment examinations. When these measures are not conducted or are conducted inadequately, individuals with existing mental health problems can be sent into the field, raising the level of risk to themselves and their colleagues. Moreover, service members lacking pre-deployment screening paperwork to attest to their state of health can be improperly diagnosed with pre-existing mental conditions upon their return from service. Such individuals can lose out not only on appropriate care, but also on compensation available from the Department of Defense (DOD) for troops medically retired or discharged due to service-disabling war time injury.

Members of Congress, the media and veterans' advocacy groups have raised concerns that troops are not being adequately screened for health problems before combat and that they are not receiving adequate care after combat. These concerns were reflected in a March 2003 congressional hearing conducted five days after President Bush signaled the start of the

war in Iraq. Members of Congress and experts who testified raised doubts that DOD was following a 1997 law (PL 105-85) that specifically requires pre- and post-deployment medical exams, including mental health assessments. The controversy surrounded whether the paper questionnaires used by DOD fulfilled those requirements sufficiently.^{xvi}

The Government Accountability Office (GAO) investigated compliance with the law at the request of several members of Congress, and issued a report in September 2003.^{xvii} The GAO reviewed the medical records of 1,071 Army and Air Force service members and found that 38 to 98 percent were missing one or both of their paper-driven health questionnaires.^{xviii} The GAO concluded that the Army and Air Force did not comply with DOD policies for force health protection and surveillance and that continued noncompliance with these policies could result in service members deploying with health problems or experiencing delays in obtaining care when they return.^{xix}

The Army did indeed deploy medically unfit troops to Iraq, as was revealed in March 2004, when a number of National Guard and Reserve members came forward to attest to the problem.^{xx} The issue was also discussed in an October 2003 internal Army report obtained by United Press International. The report disclosed that "[v]ariability in pre-deployment screening guidelines for mental health issues may have resulted in some soldiers with mental health diagnoses being inappropriately deployed."^{xxi}

Several members of Congress have introduced legislation to address flaws in DOD's health evaluation system. Senators Hillary Clinton and Jim Talent sponsored the Armed Forces Personnel Medical

Readiness and Tracking Act of 2004, which aims to correct loopholes used by the Department of Defense under current law. The legislation was accepted as an amendment to the Defense Authorization bill (S2400) in June 2004.^{xxii}

A forthcoming report from the GAO on force health protection and surveillance policies for Operation Iraqi Freedom will provide a report card on current practices and their impact on troops.

Fear of Stigmatization

Given a military culture where having to ask for help is often looked upon as a weakness, fear of being stigmatized by their comrades or leaders is an often-cited barrier to care among members of the armed forces. Troops are also concerned about patient confidentiality, embarrassment, and perceptions about their continued ability to lead.^{xxiii} According to the New England Journal of Medicine study, fear of stigmatization was "disproportionately greatest among those most in need of help from mental health services."^{xxiv}

Troops who experience wartime psychological trauma are thus hit doubly-hard. Rather than focusing on their medical needs, they must weigh the risk of self reporting mental health concerns and the possible career stigma attached to it. The military is aware of service members' fears of career stigma, but to date has not broken down this crucial barrier to care. Despite the efforts of the NEJM study and a December 2003 Army Mental Health Advisory Team report to shed light on the issue, stigmatization will remain a problem until the military changes its culture.

The issue of stigmatization was brought into stark relief in October 2003, when Staff Sgt. Georg-Andreas Pogany was charged with cowardice after he attempted to seek help for a combat stress reaction he experienced while serving in Iraq. Pogany found himself the first soldier since the Vietnam era to be charged with such an offence, which bears a maximum punishment of death.^{xxv} Though all formal charges against him have since been dropped, the treatment of Pogany sent shock waves through the military, confirming in service members' minds that there are significant risks in seeking mental health care during war. Additionally, since the Pogany case, it does not appear that the military has assured troops in the field that it is both understandable and desirable for them to seek help. The incident illustrates the type of problem that can occur as a result of insensitivity or ignorance of mental health issues in the field.

Problems with Care in the Field

The military sent combat-stress teams into Iraq with the deployed force to try to alleviate generalized anxiety resulting from wartime operations. The goal of combat-stress teams is to treat troops on the battlefield within a short-term period and send them back to their units. The hope is that immediate limited care will reduce PTSD.^{xxvi}

The problem for many service members who go through this process is that they receive anti-anxiety drugs to address depression, sleeping pills to address restlessness, and powerful psychotropic drugs to address psychological problems, but find there is little time for talk therapy about the issues that confront them.^{xxvii} It is true that a warm meal and a comfortable bed go a long way to help an exhausted service member

recover and return to fight, but more study is needed to determine how the drugs administered affect military functioning in the highly stressful combat environment to which these troops are returned.

The military is quick to evacuate combat-wounded troops, but opts to treat psychological trauma in the theater of operation. While there is data to suggest that keeping units together can in some cases speed recovery for troops who are simply overworked, more study is needed to ensure that purposely re-introducing troops into the environment in which their psychological trauma occurred does not cause further harm. Such measures would not be prescribed for trauma victims in the civilian world, and although our troops are at war, they are no less human or in need of proper care than others.

The Mental Health Advisory Team (MHAT) sent by the Army to assess mental health issues related to Operation Iraqi Freedom discussed several other problems with care in the field in its December 2003 report. Among its findings, the MHAT cited a lack of knowledge about services among soldiers surveyed – just over half “reported knowing how to obtain behavioral health care in theater.”^{xxviii} The MHAT also found problems with access to mental health services, including difficulty traveling to service locations. In addition, the MHAT noted that 50 percent of the providers interviewed “reported they had not received adequate training in combat stress prior to deployment.”^{xxix}

Based on its findings, the MHAT made detailed recommendations for improving mental health care at the theater and unit level. While the report and recommendations are an important attempt

to improve the conditions for soldiers, it is unclear to what extent the Army has implemented the recommendations and moved to make real improvements.

Barriers to Care at Home

As troops begin to rotate out of Iraq and Afghanistan, they are being met by communities that often have no concept of how to help reintegrate them into society. Moreover, readjustment information for families can be sporadic or in some cases nonexistent. For active duty troops, general barriers to care may include a lack of trained clinicians, long delays for receipt of mental health services, and inability to get time off from work for care.^{xxx} Many National Guard and Reserve troops may face additional problems due to the distances separating them from access to military counselors.^{xxxii}

DOD has established several programs to help soldiers cope with mental health needs and other problems, including “Military One Source,” a program available via phone or Internet to help troops deal with a wide variety of life issues.^{xxxiii} The program provides consultants who can lend assistance 24-hours-a-day, year-round. A service member may speak to a consultant or go online for information such as articles, worksheets, and educational materials. Another program, “Courage to Care,” is designed as an information clearing house to help troops and families readjust. Courage to Care uses fact sheets written for physicians as well as for service members. The idea is to provide a paper roadmap to recovery after war.^{xxxiii}

There are also several relatively new programs under development, including a DOD clinical trial called Project DE-STRESS (Delivery of Self Training and

Education for Stressful Situations), which attempts to improve care for traumatic stress via computer-assisted approaches.^{xxxiv}

While they have been insufficient in some cases, these programs and others can be helpful for service members who seek them out.^{xxxv} However, it appears that there is no centralized DOD effort to provide proactive patient to clinician care. Rather than conducting aggressive outreach, DOD waits for service members to report problems themselves, which many soldiers experiencing PTSD and other mental health problems are reluctant to do, as discussed above.

Active duty, National Guard, and Reserve troops leaving combat operations will either remain in the military or be discharged due to service-ending medical injuries. Responsibility for care of discharged service members passes from DOD to the Department of Veterans Affairs (VA). The VA has also experienced problems with outreach to veterans, but appears to be attempting to improve its capabilities.

Veterans Affairs Secretary Anthony Principi is reviewing a plan to conduct a complete overhaul of the mental health care services delivery platform within the VA nationwide. In a forthcoming report entitled “Availability and Access to Mental Health and Substance Abuse Services for Veterans,” the Serious Mental Illnesses Committee (SMI) appointed by Principi to address mental health care in the VA identifies four major gaps that prevent veterans from receiving VA mental health services and translates them into goals for action. These goals include:

- Restoring the VA’s ability to deliver state-of-the-art care for veterans with substance abuse disorders consistently;

- Establishing case management programs for homeless veterans with mental illness or substance abuse problems; and
- Developing support services for veterans in collaboration with community partners.^{xxxvi}

The SMI committee has provided a roadmap for success in taking care of mentally ill veterans, but funding and implementation are still necessary.

CONSEQUENCES OF INADEQUATE ACTION

The aftermath of the Vietnam War demonstrated the consequences of failing to provide our warriors with immediate treatment, care, and readjustment services to help them recover from traumatic wartime exposures. The human cost on the affected troops can be devastating and the financial cost to the nation can be life-long. This time around, we must be prepared to act immediately to mitigate some of the long-term costs and save service members from years of suffering.

The Toll on Soldiers and Their Families

War produces mental health injuries that are just as debilitating as wounds from bullets and bombs. For some service members, the act of defending one's country is a powerful and defining moment. For others, the act of war is a devastating event where lives are taken or forever changed. Troops with mental health problems from the wars in Iraq and Afghanistan often feel traumatized in ways they themselves can't express.

PTSD and other mental conditions can take a tremendous toll on the individual service member and his or her family. Many service members with PTSD have involuntary flashbacks, obsessive memories, nightmares,

or frightening thoughts, especially when exposed to events or objects that remind them of the trauma they experienced (something as simple as a loud sound, for example). The manifestations of PTSD include:

- Re-experiencing a disturbing event through vivid memories or flashbacks;
- Feeling "emotionally numb;"
- Feeling overwhelmed by everyday situations and demonstrating diminished interest in normal tasks or usual interests;
- Crying uncontrollably;
- Withdrawing or isolating oneself from family and friends, and avoiding social situations;
- Relying increasingly on alcohol or drugs to get through the day;
- Feeling extremely moody, irritable, angry, suspicious, or frightened;
- Having difficulty falling or staying asleep, sleeping too much, and having nightmares;
- Feeling guilty about surviving the event or being unable to solve the problem, change the event, or prevent the disaster; and
- Feeling fear and a sense of doom about the future.^{xxxvii}

Some individuals suffering from wartime mental trauma express both suicidal and homicidal thoughts. "Sometimes I want to kill people," stated one soldier interviewed for this paper.^{xxxviii} Others can have violent outbursts with family members and friends. One soldier interviewed had a verbal outburst upon spotting a car full of Muslim men and women on vacation. This comment was immediately followed by a soft whispered apology, "I don't know why I said that, maybe they're not bad people." The soldier placed his hands on his head and

got up to take some pills. He swallowed his medicine, sat back down while taking deep labored breaths, and then leaned back and closed his eyes.^{xxxix}

If left untreated, PTSD and other psychological traumas, because of their debilitating nature, can inhibit individuals from functioning to various degrees. Moreover, rather than disappearing on their own over time, the problems can persist in the long term. Professor Joshua S. Goldstein of the Watson Institute for International Studies at Brown University has written at length about the longer-term effects of wartime trauma, citing historical data showing that many soldiers suffer serious and long-lasting psychological damage as a result of combat experience.^{xi}

The Toll on Communities and the Country

The diagnosis and treatment of mental disorders is thus critical not only for our troops, veterans, and their families, but also for their broader communities. This is particularly true in the case of returning National Guard and Reserve soldiers. They must reintegrate into their community and return to work without the support mechanisms and resources afforded to active duty soldiers at their military installations.

Moreover, the cost to the nation of caring for troops returning from Iraq with disabling mental health conditions may be significant. If a 24-year-old married male soldier with one child were to develop PTSD to the degree of unemployability, that soldier could receive compensation payments from the VA of over \$2,400 per month for the remainder of his life.^{xii} Over an average male lifespan, such costs could amount to more than \$1.3 million, not counting inflation.^{xiii} As there is evidence that treating

PTSD can help in reducing some of its symptoms, treatment is not only important to the individual's health, but may also help to reduce the burden of lifetime disability payments.^{xliii}

GUIDELINES FOR ACTION

There are a number of concrete steps that the Department of Defense, the administration and Congress can take to address current shortfalls and meet coming challenges in mental health care for our soldiers and veterans.

These steps are based on three principles:

- It is an operational imperative to understand how the battlefield of the 21st century affects our troops and to make sure that the military properly trains and prepares soldiers, sailors, airmen and Marines for the stresses that modern warfare creates. This is a matter of military readiness and should be important to commanders and leaders at all levels without stigma.
- The military must make the up-front investment in its medical surveillance capability, including mental health care, so that it can effectively monitor medical and mental health trends before, during and after a combat deployment.
- The country owes every military member sent to fight and potentially die in combat access to proper care while deployed, upon his or her return to the United States and after leaving active military service.

The Department of Defense should work to improve mental health care in the field of combat. Combat, particularly ground combat, produces a high-stress environment that can be corrosive to troops' mental health. DOD should take steps to implement

fully the recommendations made by the Army Mental Health Advisory Team for improving mental health care in the field. In addition, similar follow-up studies in current and future military operations should become standard, so that troops' needs can be addressed and methods of care assessed and improved regularly.

The Department of Defense must ensure that all troops are given pre- and post-deployment medical examinations. Medical examinations – including mental health assessments – to identify troops who should not be deployed or who need help after returning home are critical. They should be completed for all active duty and Guard and Reserve troops. Pre-deployment examinations should take place at an individual's home station before departure to the mobilization site. Troops with pre-existing conditions that prevent deployment should be rehabilitated, reclassified or seen before a medical evaluation board. Post-deployment examinations should be required within a specified period after the units return to the United States. Questionnaires are not sufficient to establish physical and mental fitness.

The Department of Defense and the Department of Veterans Affairs should provide aggressive mental health counseling and outreach programs for returning troops and their families. Studies have shown that troops who need mental health services do not always seek or receive them because of stigma and other barriers to care. In order to address this challenge and prevent mental health problems from developing into severely debilitating conditions, the DOD and the VA

should work with local civilian agencies, chaplains and family centers to reach out to active duty and Guard and Reserve troops, veterans and families proactively and systematically.

The Department of Defense and the Department of Veterans Affairs must work as a team to provide proper and seamless care for our soldiers and veterans. No combat veteran leaving military service should fall through the bureaucratic cracks. The DOD and the VA should improve the system for handing over responsibility from the DOD to the VA for on-going medical care of those leaving the service. The hand-off should include a detailed history of care provided, including mental health, and an assessment of what each patient may require in the future.

The Department of Defense should launch a service-wide anti-stigma campaign. The stigma associated with seeking help for mental health problems will not decrease without a service-wide campaign to change perceptions and attitudes among troops and leadership. Training and education programs for military members and their families should be initiated. In addition, commercial ads similar to those currently targeting depression among civilians could be run in military newspapers and magazines as well as on Armed Forces Radio. The ads could present symptoms and descriptions of common combat-related and other mental health problems, publicize resources, encourage troops to come forward, and guarantee that seeking treatment will not be held against an individual's career.

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- ⁱ Army Medical Department, News and Media, Army Medical Evacuation Statistics for OIF & OEF, August 19, 2004, <http://www.armymedicine.army.mil/default2.htm>.
- ⁱⁱ Charles W. Hoge, MD, Carl A. Castro, Ph.D, Stephen C. Messer, Ph.D, Dennis McGurk, Ph.D, Dave I. Cotting, Ph.D, and Robert L. Koffman, MD, M.P.H., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, Vol. 351, No. 1 (July 1, 2004).
- ⁱⁱⁱ Ibid.
- ^{iv} M.L. Lyke, "The Unseen Cost of War: American Minds," *Seattle Post-Intelligencer*, August 27, 2004. And "Survey: Soldiers Suffer Stress Disorder," *Associated Press*, August 10, 2004. The survey was of 1300 Fort Bragg paratroopers from the 2nd Brigade of the 82nd Airborne Division 2nd Brigade.
- ^v National Center for PTSD, Executive Summary, Returning Persian Gulf Troops: First years findings, April, 1992, <http://www.ncptsd.org/publications/cq/v3/n2/rosenhec.html>.
- ^{vi} "The estimated lifetime prevalence of PTSD among American Vietnam theater veterans is 30.9% for men and 26.9% for women." See the National Center for PTSD, Epidemiological Facts about PTSD, National Vietnam Veterans Readjustment Survey, http://www.ncptsd.org/facts/general/fs_epidemiological.html
- ^{vii} For PTSD see the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*, 1994.
- ^{viii} WeatherBase, Baghdad, Iraq, <http://www.weatherbase.com/weather/weather.php3?s=005604&refer=>
- ^{ix} Author interview with Operation Iraqi Freedom Veterans, 17 July 2004.
- ^x Edmund Sanders, "Heat of Battle Takes Toll on U.S. Forces," *Los Angeles Times*, August 11, 2004. For an interesting discussion of the effects of heat, see Borden Institute, Walter Reed Army Medical Center, report, "Medical Aspects of Harsh Environments," <http://www.bordeninstitute.army.mil/medasopofharshenvrnmnts/>. The report describes the intricacies of heat related injuries reaching back to historical times. This current war will also validate lessons learned and expose systemic failures. Hopefully, the understanding gained will lead to the next generation of improvements for the next generation of soldiers. Regardless of improvements, however, heat and cold will always be significant stressors in any war.
- ^{xi} Army Posture Statement, Protecting Army Forces, <http://www.army.mil/aps/04/index.html>.
- ^{xii} David Zucchini, "Army Takes Its War Effort to Task; Report says U.S. forces prevailed in Iraq despite deep supply shortages and bad intelligence," *Los Angeles Times*, July 3, 2004.
- ^{xiii} T. Trent Gegax, "Wartime Stress: Poor morale and high suicide rates point to big problems for troops in Iraq," *Newsweek*, April 2, 2004, <http://msnbc.msn.com/id/4632956/site/newsweek/>.
- ^{xiv} Tom Squitieri, "Nation, Army expanding 'stop loss' order to keep soldiers from leaving," *USA Today*, January 5, 2004, http://www.usatoday.com/news/nation/2004-01-05-army-troops_x.htm.
- ^{xv} Larry Margasak, "Increasing number of Guard, Reserve troops say they've lost jobs, benefits," *Associated Press*, August 15, 2004.
- ^{xvi} Hearing of the Subcommittee on National Security, Emerging Threats and International Relations of the House Committee on Government Reform, "Protecting the Health of Deployed Forces: Lessons Learned From the Persian Gulf War," March 25, 2003.
- ^{xvii} Government Accountability Office, Report number GAO-03-1041, "Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance," September 19, 2003, August 25, 2004, <http://www.gao.gov/atext/d031041.txt>.
- ^{xviii} Ibid.
- ^{xix} Ibid.
- ^{xx} David Goldstein, "US Sent Medically Unfit Soldiers to Iraq, Pentagon Acknowledges," *Knight Ridder*, March 25, 2004.
- ^{xxi} Mark Benjamin, "Army sent mentally ill troops to Iraq," *United Press International*, March 12, 2004, <http://www.upi.com/view.cfm?StoryID=20040312-042634-9733r>.
- ^{xxii} "U.S. Senate Passes Clinton-Talent Military Health Readiness Legislation," Office of Senator Hillary Rodham Clinton, June 18, 2004. <http://clinton.senate.gov/~clinton/news/2004/2004618846.html>. However, the amendment language still does not require mandatory pre- and post-deployment physical and mental examinations, leaving room for troops to fall through the cracks.
- ^{xxiii} Julie Sell, "Are we ready to welcome our troops?," *Chicago Tribune*, March 7, 2004; and Charles W. Hoge, MD, Carl A. Castro, Ph.D, Stephen C. Messer, Ph.D, Dennis McGurk, Ph.D, Dave I. Cotting, Ph.D, and Robert L. Koffman, MD, M.P.H., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, Vol. 351, No. 1 (July 1, 2004).

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- ^{xxiv} Charles W. Hoge, MD, Carl A. Castro, Ph.D, Stephen C. Messer, Ph.D, Dennis McGurk, Ph.D, Dave I. Cotting, Ph.D, and Robert L. Koffman, MD, M.P.H., “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *New England Journal of Medicine*, Vol. 351, No. 1 (July 1, 2004).
- ^{xxv} Mark Glassman, “When Grace Flees Under Fire,” *New York Times*, July 25, 2004; and Maria Fleet, “Case dropped against U.S. soldier initially accused of cowardice,” *CNN*, July 15, 2004
<http://www.cnn.com/2004/US/07/15/army.dropped.charges/>.
- ^{xxvi} Mark Benjamin, “10% at Army hospital had mental problems,” *United Press International*, February 18, 2004; and Edward Colimore, “Combat’s mental wounds; In Iraq, the military struggles to heal war’s often-disabling effects, while at home, suspicions of false claims have grown,” *The Philadelphia Enquirer*, May 10, 2004.
- ^{xxvii} Author interview with Operation Iraqi Freedom veterans, 17 July 2004.
- ^{xxviii} Operation Iraqi Freedom Mental Health Advisory Team Report, December 16, 2003.
- ^{xxix} *Ibid.*
- ^{xxx} Author interview with Operation Iraqi Freedom veterans, 17 July 2004; for more examples, see House Armed Services Committee Subcommittee on Total Force hearing, “Reserve Component Healthcare; Current and Future Deployments,” January 21, 2004.
- ^{xxxi} Julie Sell, “Are we ready to welcome our troops?,” *Chicago Tribune*, March 7, 2004.
- ^{xxxii} Military One Source, <https://www.militaryonesource.com>.
- ^{xxxiii} Courage to Care, <http://www.usuhs.mil/psy/courage.html>.
- ^{xxxiv} Project DE-STRESS, http://deploymentlink.osd.mil/news/may04/news_051104_003.shtml.
- ^{xxxv} One Source proved inadequate in the case of Sgt. Jeffrey Sloss, who committed suicide in 2004 after attempting to get help from the service. His Wife, Pam Sloss, sent letters to Congress to express her anger and try to affect change for others stating:
I am very dismayed that he was not properly counseled prior to being released to come home. The services did not seem readily available.... Upon searching the Internet, I found a number for Army OneSource. My husband called on March 27, 2004. He was referred to a counseling service in Spartanburg, SC, who would not be able to see him until June 2, 2004. Needless to say, we never made it. My husband had an urgent need, and it was unmet.
See Letter to Senator Lindsey O. Graham, Republican from South Carolina, Attention to Military Mental Health Issues, Pam Sloss, August 7, 2004, http://congress.org/congressorg/bio/userletter/?id=531&letter_id=104460391.
- ^{xxxvi} Meeting of the Committee on Care for Serious Mental Illnesses, 28 July, 2004.
- ^{xxxvii} Center for PTSD, War-Zone-Related Stress Reactions, http://www.ncptsd.org/war/war_veteran.html
- ^{xxxviii} Author interview with “Matt,” Operation Iraqi Freedom Veteran, 17 July, 2004.
- ^{xxxix} Author interview with Operation Iraqi Freedom Veterans, July 17 2004.
- ^{xl} Joshua S. Goldstein, *War and Gender: How Gender Shapes the War System and Vice Versa*, PTSD, Chapter 5, Cambridge University Press, September 2001, August 25, 2004, <http://www.warandgender.com/wgptsd.htm>.
- ^{xli} Department of Veterans Affairs, Compensation Rate Table, <http://www.vba.va.gov/bln/21/Rates/comp01.htm>; for information on how the VA evaluates levels of disability, see *Vietnam Veterans of America Guide on PTSD, General Rating Formula for Mental Disorders*, <http://www.vva.org/Benefits/ptsd.htm#Evaluates>.
- ^{xlii} A 72 year male lifespan was used in this calculation.
- ^{xliii} See Center for PTSD, “Treatment of PTSD: a National Center for PTSD Fact sheet,” http://www.ncptsd.org/facts/treatment/fs_treatment.html; and Dudley D. Blake, Ph.D., “Treatment Outcome Research on Post-traumatic Stress Disorder,” *NCP Clinical Newsletter* 3(2): Spring 1993, <http://www.ncptsd.org/publications/cq/v3/n2/blake.html>.