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The military's post-traumatic stress dilemma

By Tyler E. Boudreau | March 9, 2009

WITH ARMY and Marine Corps suicide rates climbing dramatically, surpassing even those killed in Iraq and Afghanistan last month, the nation is increasingly disturbed and demanding treatment for veterans. But these suicide reports highlight an important distinction: A significant portion of those returning from war are not yet veterans; they are still active or reserve service members, which means, above all, that they probably will be going back to one of our theaters of operations. And that means that any treatment for post-traumatic stress will be positioned in direct conflict with the mission itself. As a former Marine captain and rifle company commander, I witnessed this conflict firsthand.

In response to the stigma surrounding post-traumatic stress in the military, Admiral Michael Mullen, chairman of the Joint Chiefs of Staff, said in May 2008, "It's time we made everyone in uniform aware that the act of reaching out for help is, in fact, one of the most courageous acts and one of the first big steps to reclaiming your career, your life, and your future." It is heartening to hear the man at the top speaking so forcefully on this issue. And while Mullen is, no doubt, genuinely concerned for these men and women in uniform, I suspect this issue may not be as simply resolved as he makes it sound.

I was in Iraq in 2004. From the day we had arrived home to the day we were scheduled to return to Iraq was exactly nine months. The pressure to prepare ourselves quickly was intense. When the first Marine came to my office and asked to see the psychiatrist about some troubling issues from our time in Iraq, I was sympathetic. I said, "No problem." When another half dozen or so Marines approached me with the same request, I was only somewhat concerned.

But when all of them and several more returned from their appointments with recommendations for discharge, I'll admit I was alarmed. Suddenly I was not as concerned about their mental health as I was about my company's troop strength. Manpower is not an endless spigot. There are always recruitment strains and so there are limits to how many men are available. My company would be allocated only so many Marines for our deployment. Whatever we lost before embarkation, for whatever reasons, we just went without.

As all those Marines in my company began filtering out, some from essential positions, I started to worry about the welfare of those remaining. I worried, quite naturally, that if the exodus continued, we might not have enough to accomplish our mission or to survive on the battlefield. My sympathies for those individuals claiming post-traumatic stress began to wane. A commander cannot serve in earnest both the mission and the psychologically wounded. When the two come in conflict, as they routinely do as a result of repeated deployments, the commander will feel an internal and institutional pressure to maintain the integrity of his unit. I did. And there begins a grassroots, albeit subconscious, resistance to Mullen's plan to destigmatize the people who seek help. Because as much as I cared about my Marines, it was difficult to look upon those who sought to leave without suspicion or even mild contempt.

In the spring of 2008, RAND released its well-known report in which it estimated that one in five service members returning from war will contend with symptoms of post-traumatic stress or depression. In a typical rifle company, those estimates would represent a loss of at least 30 men. I knew I couldn't afford that. Commanders at every level know it. The military knows it, too; it knows it can't afford a 20 percent reduction in forces and it can be counted on to prevent that from ever happening - even Admiral Mullen. One can only imagine the military's dismay if, through its own rigorous efforts to screen and encourage soldiers to report their invisible wounds, commanders were suddenly faced with hundreds of thousands of troops demanding treatment and discharge.

Where psychological and traumatic brain injuries can still, to some extent, be doubted and debated, and when their treatment stands in opposition to troop strength and to mission accomplishment, the needs of those wounded service members will be subordinated.

The result by necessity, which we are already witnessing today, will be dubious treatment protocols within the military aimed at retention, diagnosed soldiers returning to the battlefield, and a slowly diminished emphasis on screening. It will happen. It has begun already. There will be no policy shift. There will be no change in the language we hear from our leaders. But we will know all too well that our soldiers are still not being properly treated by the ever-increasing number of suicides that occur.

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