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The Officer

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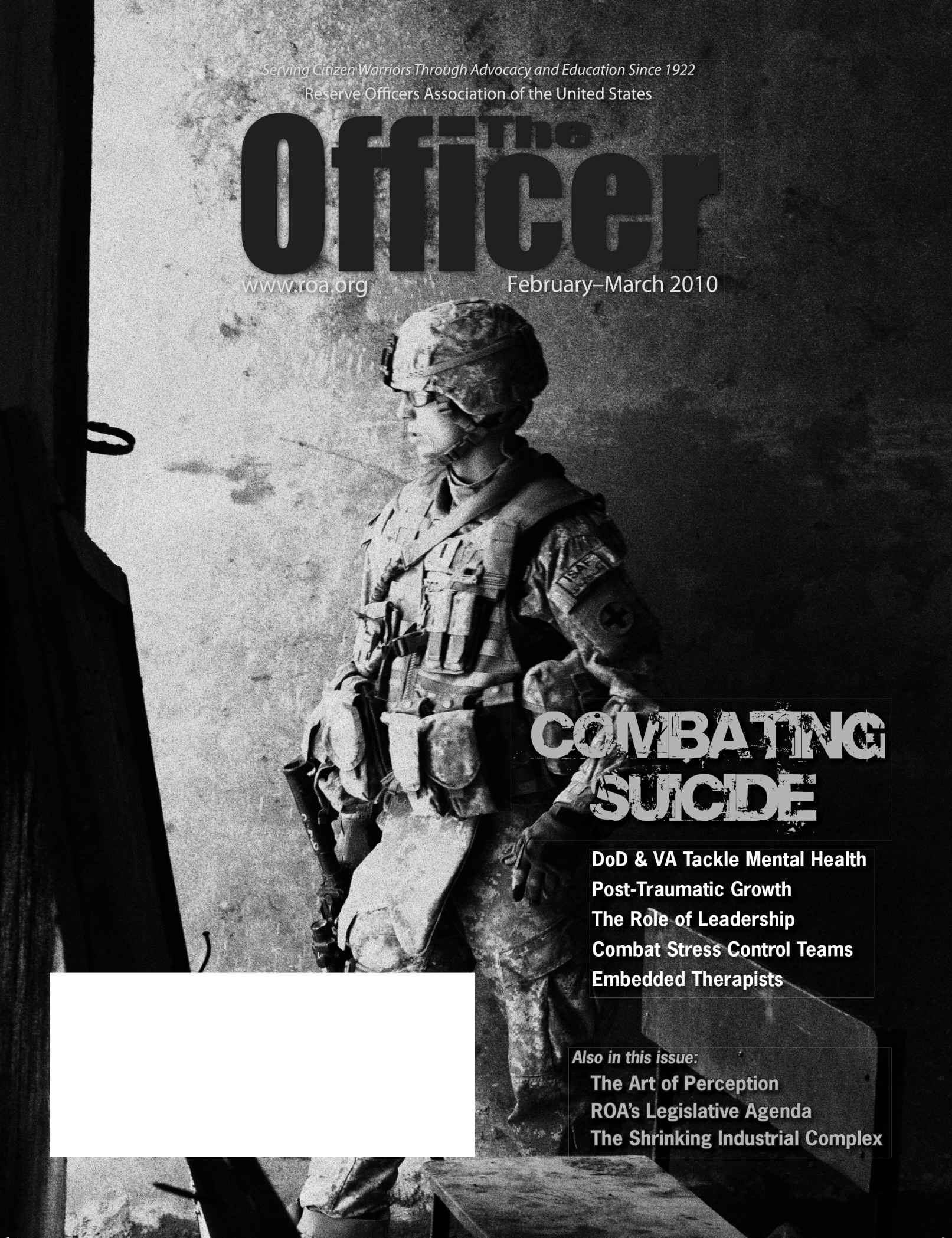

COMBATING SUICIDE

DoD & VA Tackle Mental Health
Post-Traumatic Growth
The Role of Leadership
Combat Stress Control Teams
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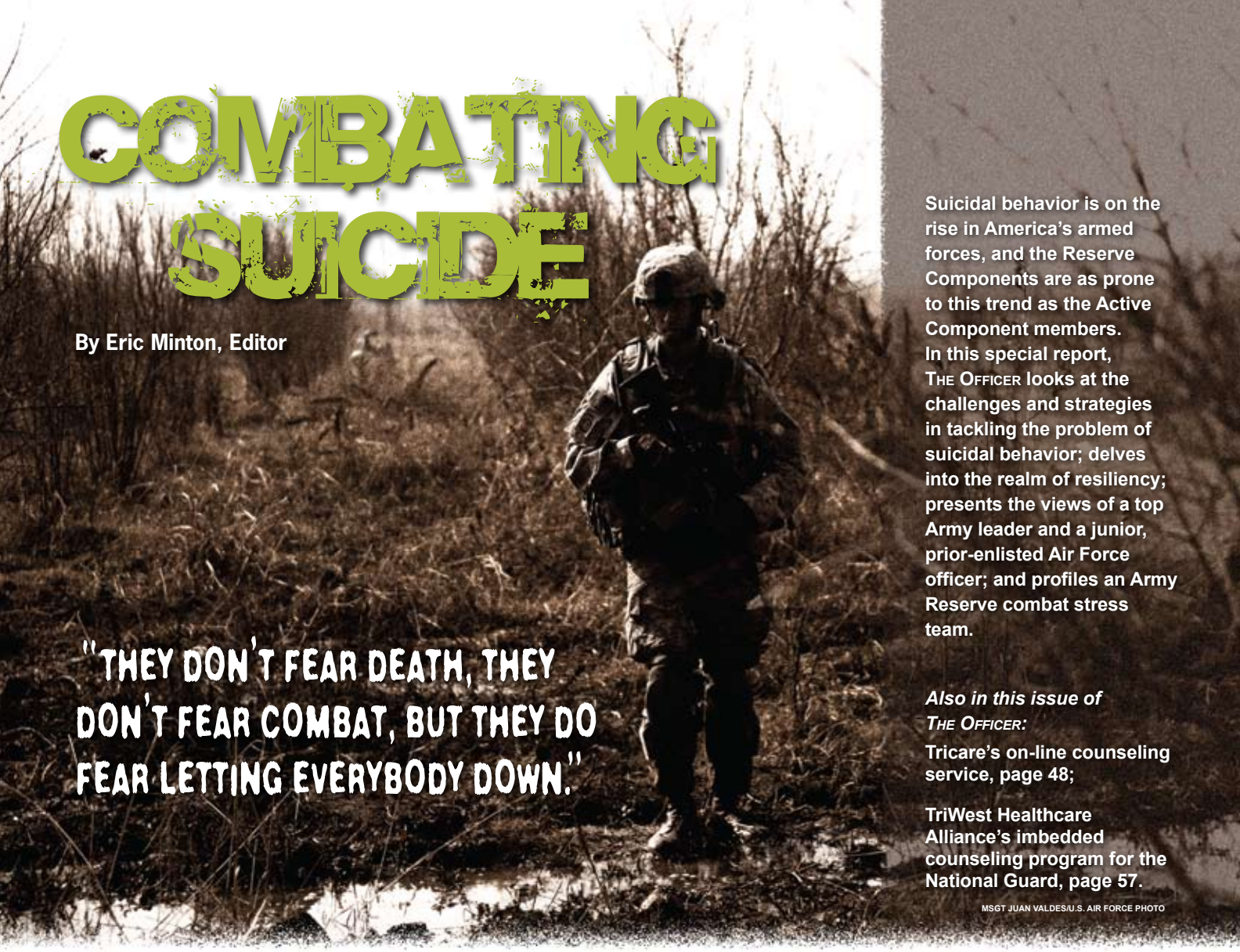
COMBATING SUICIDE

By Eric Minton, Editor



MSGT JUAN VALDES/U.S. AIR FORCE PHOTO

Suicidal behavior is on the rise in America's armed forces, and the Reserve Components are as prone to this trend as the Active Component members. In this special report, THE OFFICER looks at the challenges and strategies in tackling the problem of suicidal behavior; delves into the realm of resiliency; presents the views of a top Army leader and a junior, prior-enlisted Air Force officer; and profiles an Army Reserve combat stress team.

Also in this issue of THE OFFICER:

Tricare's on-line counseling service, page 48;

TriWest Healthcare Alliance's imbedded counseling program for the National Guard, page 57.

On the phone with his wife on the other side of the continent, U.S. Marine Corps Maj John Ruocco promised that he would not kill himself, that he would get help. Three hours later, the Cobra gunship pilot, an Iraq War vet who flew 75 combat missions, took his own life, hanging himself in a hotel room near Camp Pendleton, Calif. That was in 2005. Today, his widow, Kim, and their two sons, now 13 and 15, along with Maj Ruocco's parents, siblings, friends, and fellow Marines are enduring his final act.

That same year, another Marine, James Taulbee, came home after a nine-month deployment to Iraq as part of a small craft company with Headquarters Battalion, 2nd Marine Division. His 90-person detachment had one member killed in action while in Iraq, but lost more to substance abuse and auto accidents after coming home. "A lot of them haven't been doing so well," said SSG Taulbee, now a recruiter for the Army Reserve in York, Pa. He wasn't doing too well himself, he said. "It took years for me to realize I needed help." Along the way, his marriage ended, as did a subsequent engagement, and he blames his "mental health issues" in part for those dissolutions. Finally, after one "strenuous day of work," he headed to the Veterans Affairs Medical Center in Lebanon, Pa., found the mental health clinic, walked in, and asked for help. "I'm feeling as well as can be expected," SSG Taulbee told THE OFFICER in December. "I'm still alive."

SSG Taulbee is not another military suicide statistic; while it would be instructive to have a statistic for suicides prevented, keeping someone alive is not a quantifiable measure. It's hard enough to get an accurate count of suicides because many deaths labeled as accidental can be spurred by a death wish or mental-health-induced recklessness with drugs or alcohol, a vehicle, the home or work environment, or criminal behavior including fighting. Rather than using the term *suicide*, perhaps we should lump it all under the label *suicidal behavior*.

After all, the high rate of suicides and suicidal behavior in the services needs to be seen in the larger context of mental health throughout the entire force. The challenge for the nation's armed forces is to address the whole mental health landscape, both in-theater and at home, and not just exclusively with post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). That's a challenge

further exacerbated for the Reserve Component because of its geographic disbursement, seams in health care delivery, and its members' dual-role lives as warriors and civilian employees.

It's a challenge that both the Department of Defense (DoD) and the Department of Veterans Affairs (VA) are tackling from many directions. Meanwhile, a primary source for suicide prevention and mental health assistance is the individual: the individual servicemember with a problem, and that individual's individual buddies, leaders, and family members who need to be willing—and know how—to intervene.

Disturbing Trends

The Army reported 102 confirmed suicides and 45 suspected suicides among its active forces from January through November 2009. Another 71 suicides were reported among Reserve Component Soldiers not on active duty, 41 of those confirmed and 30 still under investigation. This is a sharp rise from the same period in 2008, which saw 127 suicides among the active forces and 50 in the Reserve Component. *CQ Today*, in a Nov. 25 article citing DoD statistics, reported 47 suicides in the Navy, 34 in the Air Force, and 42 in the Marine Corps.

For the Army, the trend in suicide rates is upward. In Fiscal Year (FY) 2008, the Army reported a total of 133 suicides across all components, up from 109 in FY 07 and 93 in FY 06. The trend is slightly upward for the Marine Corps, too, which saw 41 suicides in the calendar year of 2008, plus 146 attempted suicides.

More troubling is comparing this trend with that of the civilian population in the United States, where suicide is the fourth leading cause of death among people ages 25 to 44, according to the National Institute of Mental Health (NIMH), but is the third leading cause of death among Marines. Historically, the suicide rate has been lower in the military than among civilians, but in 2008 the suicide rate in the Army, 20.2 per 100,000, exceeded the age-adjusted rate of 19.2 per 100,000 in the civilian population, the NIMH reports.

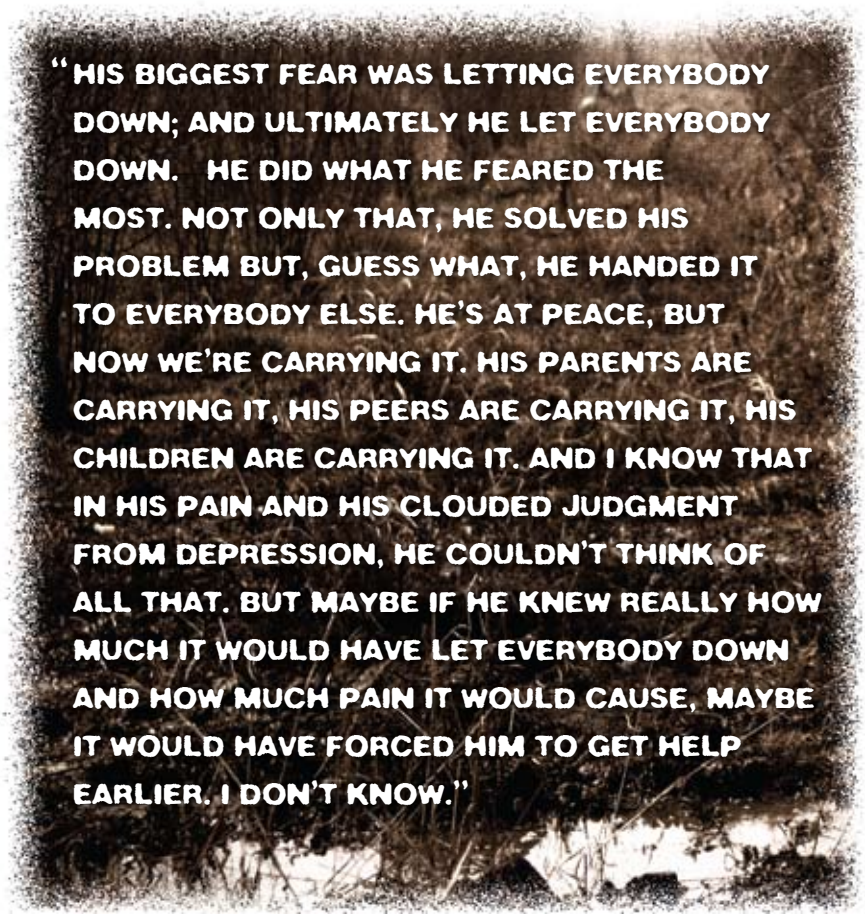
The question is *why*. Overstressed force? Multiple deployments? The particular demands of 21st century culture? Statistical anomaly? All of these theories, and more, may be worth exploring, but DoD isn't leaving the question up to theorizing.

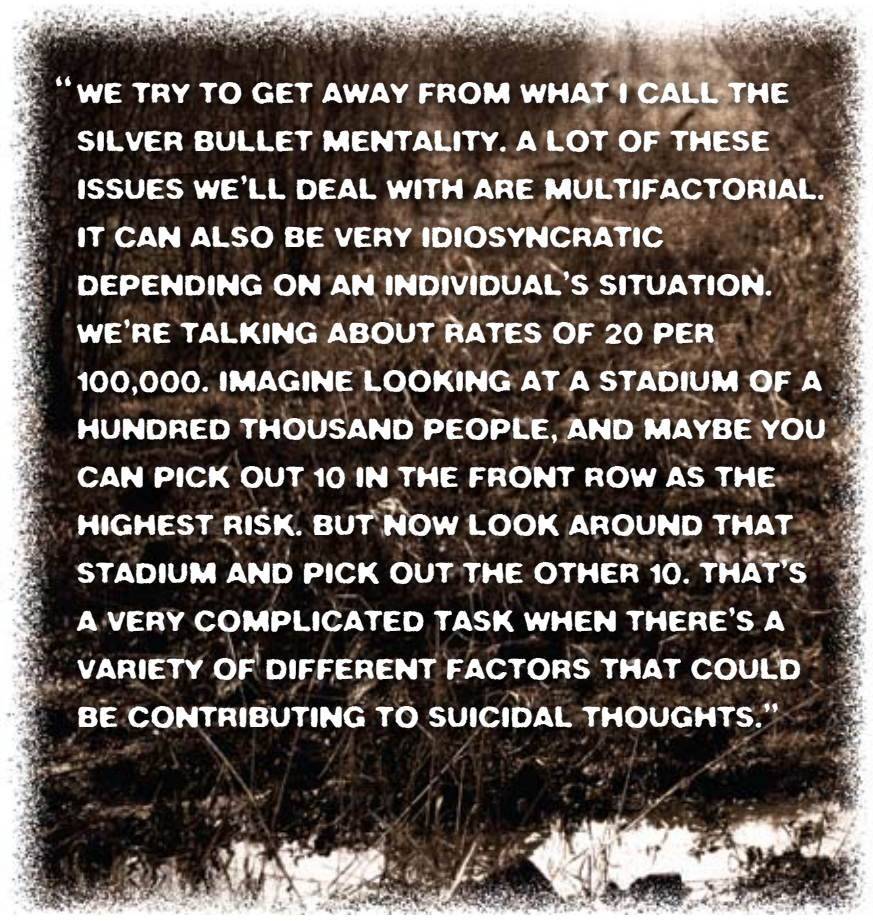
In October 2008, the Army signed a memorandum of understanding with NIMH to conduct a study into suicide patterns and causes, using the Army as a sample population. The $50 million study— involving the Uniformed Services University of Health Sciences at Bethesda, Md., the University of Michigan in Ann Arbor, Harvard Medical School in Cambridge, Mass., and Columbia University in New York City—is the largest of its kind ever conducted and will use a variety of surveys and medical evidence to discern any psychological and physiological patterns leading to suicides.

"When somebody commits suicide, it's done," said MG Robert J. Kasulke, USAR, commanding general of the Army Reserve Medical Command and ROA's national surgeon. "We're desperately trying to find out what would be a warning signal for somebody to develop suicidal ideations. If we look at it like somebody developing a heart problem, if we can figure out what those symptoms are five years before, we can deal with it early and turn off that risk factor so they don't go into mental health problems or try to commit suicide."

This study is similar to—and could be as groundbreaking as—the Framingham Heart Study. Launched in 1948 by the National Heart, Lung, and Blood Institute, that study followed three generations of Framingham, Mass., residents with surveys measuring their diet, exercise, habits, blood pressure, cholesterol levels, and other medical and genetic factors. Through it, researchers were able to determine the major risk factors we all know today for heart disease.

DoD, through the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), is already tracking factors in known suicides among active servicemembers with a program called the DoD Suicide Event Report (DoDSER). All four of the services agreed on 250 data points to be gathered with each suicide, and with this database the DCoE's Suicide Prevention and





Risk Reduction Committee (SPARRC) has identified some primary risk factors. The first report, in draft form and not officially released as of this writing, found that relationship issues was the number-one risk factor, identified in more than 50 percent of suicides. Facing charges under the Uniformed Code of Military Justice was the second highest risk factor, and substance abuse was third. DoDSER is making a concerted effort to include Reserve Component suicides, said CDR Janet Hawkins, PHS, chief of the Prevention Division in DCoE's Resilience and Prevention Directorate and chairwoman of the SPARRC, but it's been hard: civilian medical examiners classify deaths differently from the military, she said.

These risk factors are just that: factors, plural. "We try to get away from what I call the silver bullet mentality," said Dr. Mark Bates, interim director of DCoE's Resilience and Prevention Directorate, in a phone interview with The Officer. "A lot of these issues we deal with are multifactorial. It can also be very idiosyncratic depending on an individual's situation. We're talking about rates of 20 per 100,000. Imagine looking at a stadium of a hundred thousand people, and maybe you can pick out 10 in the front row as the highest risk. But now look around that stadium and pick out the other 10. That's a very complicated task when there's a variety of different factors that could be contributing to suicidal thoughts."

The Perfect Storm

Ms. Ruocco's experience with mental health issues predated her husband's suicide. She has been a social worker for almost 20 years, providing mental health services in both the military and civilian communities. Today, she is the director of suicide education and support with the Tragedy Assistance Program for Survivors (TAPS), a national veterans service organization providing peer-based support and resources for families affected by the death of a servicemember, and she tours military installations speaking on suicide prevention. She also is a member of the DoD Task Force on the Prevention of Suicide in the Armed Forces. The Officer interviewed her in her TAPS office in Washington, D.C.

Though the individual's path to suicidal behavior is singular and seldom understood by anyone else, Ms. Ruocco said most are a "perfect storm" of events that lead to the individual's final act. "It's easier in the military to get to that point because you have so many more risk factors for suicide than you do in civilian life," she said. She listed some examples:

- The difficulty in getting help because of the stigma and because it may derail a career through interfering with deployments or assigned duties;
- Sleep deprivation due to duty;
- Frequent separations from support systems;
- Losing the sense of belongingness, an essential part of the military culture;
- Losing the sense of purpose, which is integral to bonding with the peer group;
- A desensitization to the idea of death and pain;
- Knowing "how to die very easily" along with easy access to weapons; and,
- "They are also usually black-and-white thinkers and doers," Ms. Ruocco said. If they see themselves as the problem, they will remove that problem themselves.

She juxtaposes these risk factors with the absence of the protective factors typical in the civilian sector: staying in one place, being able to rest, unhampered access to therapy and treatments, being able to talk to peers, and maintaining a sense of belongingness despite mental illness or depression. "Those things are more difficult to obtain in the military," she said.

Military sloganeering, such as "You're only as strong as your weakest link" and "Death before dishonor," exacerbates this perfect storm, she said. "For a Marine or Soldier, when you're no longer valuable or you're dragging your unit down, that's a dishonorable thing. They don't fear death, they don't fear combat, but they do fear letting somebody down, especially their family or their peers."

Maj Ruocco was so loved by his family, his in-laws, and his friends that he was a godparent to eight children. He willingly took on the burdens of others. But

that personality was also the kind that didn't want to be a burden to others. Ms. Ruocco feels that in the three hours between his promise not to kill himself—"I would never do that to you and the boys," she heard him say—and the time he did the deed, he sat in that hotel room alone, spiraling into a thought process in which he saw his ongoing depression as a burden to his family and fellow Marines.

"His biggest fear was letting everybody down; and ultimately he let everybody down," she said. "He did what he feared the most. Not only that, he solved his problem but, guess what, he handed it to everybody else. Everybody. He handed his pain to everybody else. He's at peace, but now we're carrying it. His parents are carrying it, his peers are carrying it, his children are carrying it. And I know that in his pain and his clouded judgment from depression, he couldn't think of all that. But maybe if he knew really how much it would have let everybody down and how much pain it would cause, maybe it would have forced him to get help earlier. I don't know."

Out of the Blue

Suicides so often shock friends and colleagues. Maj Ruocco's peers were angry at him, Ms. Ruocco said. "What they said to me was 'We would have helped him; why didn't he say anything to us?'" The answer, frankly, is obvious to many servicemembers who know they need help but are afraid to ask, and is moot for others engaging in suicidal behavior without wholly understanding why.

Ms. Ruocco at least sensed her husband's predisposition to suicide. Even after he told her on the phone he would get help, she cut short her trip and flew straight home from Massachusetts the next morning, worried about what he might do, arriving at the scene soon after Marines from his unit found his body. There was a lifetime of factors she could add up. When he was 17 years old, he had been in a head-on collision in which a friend died. "He never grieved that, never had counseling or dealt with it, and joined the Marine Corps with that as a big secret just waiting to be poked at," Ms. Ruocco said. Ten years before his death, Maj Ruocco had a severe bout with depression that his wife realized was impairing his ability to fly. The couple went into the squadron together and talked to a senior officer they could trust who told them, "This happens to everybody. Take a break, pull yourself together, and come back." Maj Ruocco did just that, taking a few weeks to "will himself out of it," Ms. Ruocco said. "I think you see that in many suicides; there's loss upon loss upon loss, or untreated depression on top of untreated depression that evolves to the point where there's suicide. And often it seems to come out of the blue because there's so much resistance to seeking help but also so much energy goes into hiding the fact that they're depressed."

> "WE'RE DESPERATELY TRYING TO FIND OUT WHAT WOULD BE A WARNING SIGNAL FOR SOMEBODY TO DEVELOP SUICIDAL IDEATIONS. IF WE LOOK AT IT LIKE SOMEBODY DEVELOPING A HEART PROBLEM, IF WE CAN FIGURE OUT WHAT THOSE SYMPTOMS ARE FIVE YEARS BEFORE, WE CAN DEAL WITH IT EARLY AND TURN OFF THAT RISK FACTOR SO THEY DON'T GO INTO MENTAL HEALTH PROBLEMS OR TRY TO COMMIT SUICIDE."

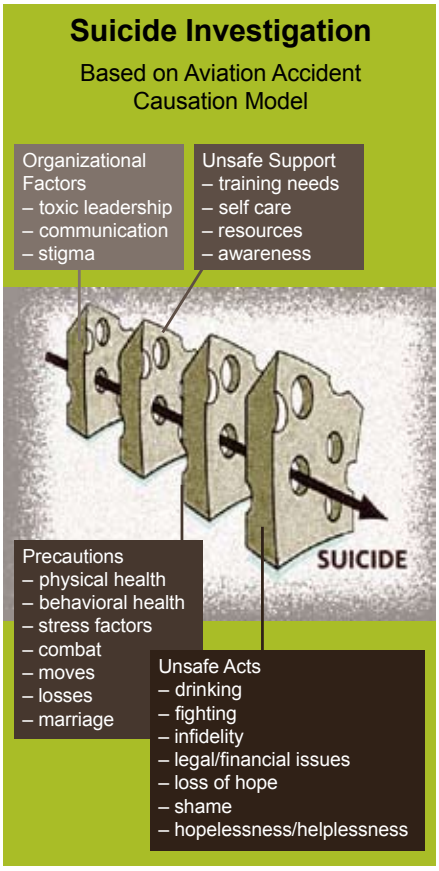
It's counterproductive, therefore, to focus too much on that final straw. For example, while the DoDSER identifies relationship issues as a factor in more than 50 percent of suicides, that may include the guy who kills himself just after breaking up with his girlfriend, but he also might also be suffering from PTSD, getting guff from his supervisor for poor job performance, and falling behind in his rent. Journalists in the mainstream media like to peg the rising suicide rates to a force stressed out by the operations tempo and frequent deployments to Iraq and Afghanistan, but suicide statistics show no significant variance between those who have deployed and those who have not. Besides, one key stressor emerging among U.S. troops in Iraq today is boredom.

Ms. Ruocco found instructive a briefing on aviation accident investigations presented to the DoD Task Force on the Pre-

'The Black Tunnel'

The original draft of this story referred in places to a person's "choice" of suicide and "decision" to take his or her own life. After Kim Ruocco reviewed the draft, she replied that "most professionals feel that suicide is not a 'decision.'" Her e-mail continued:

"A person who 'dies by suicide' (that seems to be the preferred way of saying it among survivors) is in so much psychological pain that he is in an altered state in which he lacks judgment and cannot foresee or consider the consequences of his actions. I personally have spoken to many survivors of suicide attempts who have reinforced this. They consistently tell me that they enter a black tunnel where they can no longer think of anything that is important to them, and they can only think of ending the pain. They claim that they do not want to die, they just want to end the pain. They tell me that there is not a thought process, only reaction. This is part of the reason why survivors and many professionals do not use the term 'commit suicide' because it implies an ability to choose the action."



vention of Suicide in the Armed Forces, a panel that is going way outside the box in looking for ways to stem the suicide tide. In the case of aircraft accidents, investigators piece together physical evidence and the long sequence of events leading up to the incident as a way to prevent more such crashes in the future. Usually, aircraft accidents are the result of events, conditions, and choices among those involved that have fatal repercussions only because they all happened to create a perfectly aligned sequence, like holes lined up in four slices of Swiss cheese that the aircraft passes through.

"Suicide is very similar," Ms. Ruocco said (see graph, left). "There's these layers of safeguards that someone has to go through. And if we can fill the holes in some of those slices of Swiss cheese, I think we'll be able to catch them." She looks back in the case of her husband and, in retrospect, sees how he passed through one stage after another. "There are all kinds of points way before it was a crisis that we could have had an intervention and therefore prevented suicide."

The Stigma of Therapy

Intervention requires the cooperation, at least, if not the initiation of the individual needing the intervention. And to just about everybody involved with halting the rise in military suicides, the largest challenge has been overcoming an entrenched military culture that regards seeking therapy as a career killer and stigmatizes those needing therapy as weak.

That obstacle is being overcome thanks to DoD's top leaders getting on board and ordering mandatory training at all levels. DoD also is broadcasting an effective message using peer-to-peer persuasion.

"At every leadership level, there needs to be an emphasis down the chain, encouraging help-seeking behavior for Soldiers who are struggling, until it reaches the first-line leader level, where true intervention most often occurs," writes GEN Peter W. Chiarelli, vice chief of staff for the Army, in an article he penned for this issue of The Officer (see page 36).

Says Marine Corps Commandant

RESILIENCY AND POST-TRAUMATIC GROWTH

BG Rhonda Cornum

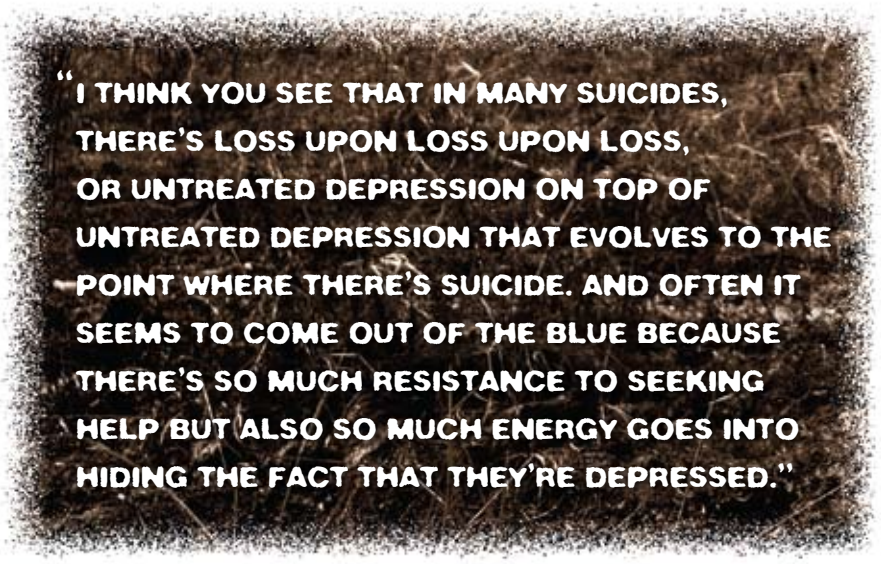
On her knees, Army MAJ Rhonda Cornum, Ph.D., M.D., could feel the pistol pressed against the back of her head. She was a flight surgeon on a rescue mission during the Gulf War when her helicopter was shot down. Five members of the crew were dead. She and two others survived—she suffered two broken arms, a broken hand, and an injured knee—but were now in the hands of the enemy.

With death a trigger twitch away, MAJ Cornum's training went into effect—not her physical training as a Soldier but her psychological training. She began processing worst-case and best-case scenarios, settled on the most probable outcome—that she would be shot—and focused on a positive result: "I thought, well, at least it won't hurt." This might seem like taking the old adage "make lemonade out of lemons" to extreme, but it worked. Not only did MAJ Cornum survive her capture—"The gun went click, but no bullet came, and here I am today"—she is now a brigadier general and director of the Army's Comprehensive Soldier Fitness Program.

The Comprehensive Soldier Fitness Program puts into practice on an institutional level the tools BG Cornum relied on to survive the psychological as well as the physical stress of the battlefield. She calls it "catastrophic thinking." "It gives you better psychological tools to face whatever the challenge is—not just negative challenges," she said. "I don't look at skydiving and running as negative challenges, but they are challenges. You've got to look at whatever's happening and find some way to turn it into a positive experience. Sometimes that's very hard, like when you're kneeling in front of soldiers and a pistol is in the back of your head. You need to practice, have it become second nature, before a challenge like that."

Launched in October 2008 under BG Cornum, the Comprehensive Soldier Fitness Program is a cradle-to-grave psychological fitness regimen and awareness, not unlike a physical fitness program. "It is certainly possible to do CPR to try to stop death by heart attack," BG Cornum said. "But a better thing to do is to train people when young about the importance of body fat and lipid profiles and aerobic exercises. Same thing with psychological fitness. It is important to treat people who have psychological stress and disease, but better to give people coping skills," and keep that psychological acuity trim and fit over time. This is PT with "P" standing for psychological rather than physical.

Aside from her own experience and self-training, BG Cornum comes at this topic from an academic perspective: she has



Gen James T. Jones in a video message introducing an online suicide prevention course: "Marines are known for taking care of each other. A full-fledged study should not be necessary. ... This is about leadership. ... Marines, it's OK to ask for help. NCOs, you have the power to make a difference in the lives of your Marines."

Secretary of Defense Robert Gates chiseled away at the stigma in the spring of 2008 when he announced a new policy stating that mental health counseling will not factor into servicemembers' and civilian defense employees' getting security clearances, unless the counseling is court-ordered or involves violence. Question 21 on the security clearance application—asking whether the applicant has consulted a mental health professional in the previous seven years—now allows a "no" answer if the counseling was for strictly marital, family, or grief counseling, or if the counseling was strictly related to adjustments from service in a military combat environment.

These strong words from the top reverberate in even stronger words from the likes of MG David Blackledge, USA; MAJ Jeff Hall, USA; Sgt Josh Hopper, USMC; and SSG Megan Krause, USA, warriors who tell their stories in riveting videos at www.realwarriors.net. Pulling from the playbook of the NIMH's "Real Men Have Depression" campaign, this website is an ambitious multimedia campaign to urge servicemembers and family members to seek help through the testimonials of servicemembers and family members who themselves needed help. "We've got a lot of anecdotal evidence with people calling in saying, 'Seeing this video gave me permission to seek help,'" Dr. Bates said.

"I think we've tackled this code of silence, especially with people who had

her doctorate in nutrition and biochemistry and later became a surgeon and went into aviation medicine in the Army. In starting up the Comprehensive Soldier Fitness Program, she turned to the University of Pennsylvania, which had developed a resilience training program for teachers of middle school, high school, and college students. Research followed the students into college, and data suggest it was not only effective in improving performance, but decreasing depression, too, she said. "We greened it up, made it Armyfied." Other academic experts from around the country provide specific content to the program.

Upon accession, each Soldier uses a Global Assessment Tool (GAT) to assess his or her own psychological fitness, and then retakes the GAT every year to measure emotional, spiritual, social, and family fitness. And to clarify: "Spiritual fitness" is not religious in nature but "human spirit," whatever set of beliefs, principles, or values that sustain a person beyond institutional and social supports. Soldiers also will begin receiving mental training taught by master resilience trainers (MRT) who teach about preparation, sustainment, and enhancement of resilience skills, a course based on established performance and sports psychology research. MRTs also will be available for family members and Department of Army civilians.

The Comprehensive Soldier Fitness Program was designed with the Reserve Component in mind, BG Cornum said. The GAT will be available on Army Knowledge Online accounts. The MRT sessions are on the Web and can also be conducted when reservists are in other training sessions. Furthermore, MRT slots are available for Reserve Component members. Through November, the Army had trained 199 active MRTs, 11 in the Army Reserve and 12 in the National Guard; the bulk of the active MRTs in this initial phase are drill sergeants who will be training Soldiers in all three components.

Getting past her own trauma also revealed to BG Cornum a largely ignored aspect of psychotraumatology: the phenomenon known as post-traumatic growth, discussed in a 1995 paper by two University of North Carolina–Charlotte professors, Richard G. Tedeschi and Lawrence Calhoun. "I felt I was a better doctor, better family member, better officer, better leader," after her experiences in the Gulf War, including the crash and capture, BG Cornum said.

Part of the resiliency strategy is to help individuals turn down the path of post-traumatic growth rather than post-traumatic stress. Ironically, the two paths have a remarkably similar obstacle: stigma. "There's a bombardment of media and well-intended people telling you that you are going to be 'damaged' by the experience you're going to go through," BG Cornum said. She thought she was odd for coming out of her experiences so positively, and found comfort in finding others who shared her reaction to stress.

"Let me be clear, there is no question, no matter how much training and education people get, there will be some people who don't do well," she said. "These folks deserve and need all the professional help we can provide, period. Even Olympic marathoners sometimes get hurt while competing. But no doubt, training for that marathon leads to a lower rate of injuries than if you try to run it without training."—*EM*

these issues themselves who were very afraid to open up about it," said MG Kasulke. "I'm not saying it's universal, but we're way ahead of where it was two or three years ago. The leadership did a great thing not only to make mandatory education, but actually constructing something of value in laymen's terms."

Ms. Ruocco noted that her husband did the suicide prevention training a year before he died; she described it as a slide show that "everybody joked about." Today, she's seeing much more effective training programs and much less stigma across the ranks in both the Army and Marines, and she has especially noticed that more and more personnel engaged in self-destructive and self-injurious behavior are getting help thanks to the intervention of their peers.

SSG Taulbee, the former Marine and current Army Reserve recruiter, shared his story at an ROA Defense Education Forum on mental health last March. "The biggest thing is to not be afraid to admit there may be a problem," he told The Officer. "If you find you are angry about things you would have shrugged off before you were in combat, you need help. If you're drinking too much, you need help. If you are more reckless in your behavior and doing things you would not have fathomed doing before you deployed, you need help. And there's no shame in it."

Hurdles to Help

Nevertheless, obstacles remain: bureaucratic, geographic, and lingering concerns about impact on careers. Soldiers, Sailors, Airmen, and Marines at all ranks fear that counseling sessions will end up in their military records, and in certain occupations, mental health problems or their treatment are legitimate grounds for suspension from duty. True, the suspension may be temporary, and that time spent getting help and healing could lead to an even longer and more successful career, but that's a high psychological hurdle for somebody already saddled with depression, anxiety, and self-esteem issues.

Ms. Ruocco has seen another disturbing trend. Over the past two years, when she speaks at installations, dozens of Soldiers and Marines will approach after her briefings to talk with her individually. In the early days, they were confiding with her that they needed help but just couldn't work up the courage to say anything. Today, Soldiers and Marines "in tears" are telling her they did seek help, but things are worse. "I think the stigma is decreasing, but I'm not sure the care they are getting is adequate or appropriate," she said.

She feels there's a tendency for health care providers to rely too much on medicine over other types of therapy, and the medication—especially for people with PTSD—is causing drowsiness and interfering with job performance. She's seeing Soldiers in crisis having to wait weeks to get appointments, or clinics available only from 8 a.m. to 3 p.m., Monday through Friday, even though depression keeps time to a clock of its own making.

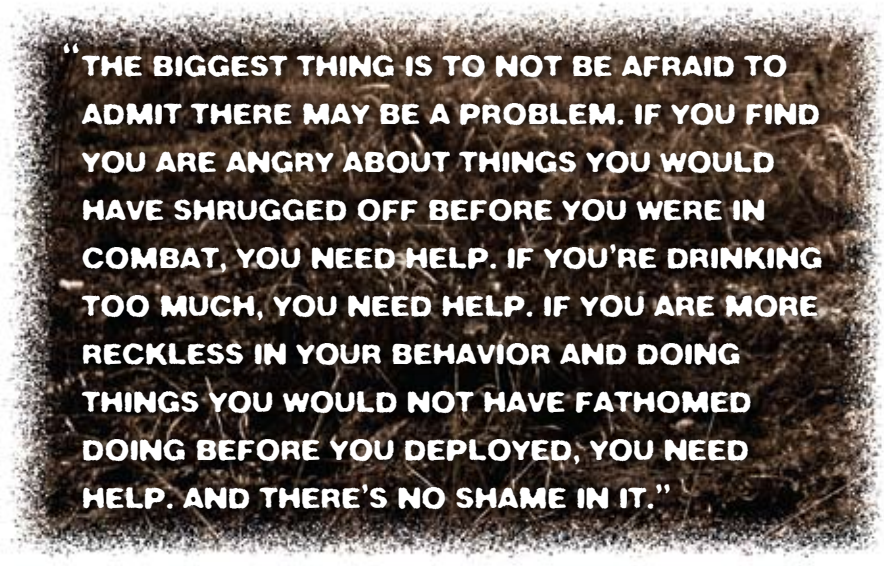
"That's another issue: finding out what treatments work best," MG Kasulke said. "It can't be all the same treatment. For some people, counseling is enough; for some people, group therapy is good. Some people need medication. Some people need all of it. It all has to be tailored to the individual who has the condition. You can't just brand somebody with PTSD based on such-and-such symptoms, and say, 'Here's what you need.'"

Reserve Component members can also fall through the seams in the health care system when they move from active status back to their communities. They are covered for 180 days under the Transition Assistance Management Program, but symptoms of PTSD and even TBI, let alone persistent bouts of depression, sometimes don't manifest for several months after separation.

MG Kasulke is also worried about gaps in treatment of another sort for Reserve Component warriors and families: geographical gaps. Many Guard members and reservists live in small communities not only far from a military installation but far from the nearest mental health care provider. "That's a chronic issue," he said, "and we've actually tackled that in force over the past two or three years, and I think we're starting to turn the corner."

DoD is venturing into new territory to provide care on all levels and in all places. One of the latest initiatives, begun in August, is an on-line counseling service through Tricare providers (see story on page 48). Another initiative is the website www.afterdeployment.org, with resources for a wide range of deployment-related issues ranging from sleep problems to financial matters to relationship problems. It includes a self-assessment tool to indicate if you need help, and coaching modules, as well.

Dr. Bates points out that the web address is a dot-org, not a dot-mil. "That was intentional, because part of the goal is to give an anonymous, non-military resource to servicemembers and family members in case they are worried about stigma." Similarly, the Real Warriors website is a dot-net, and the Tricare program is intended to give service families



a route to help outside the chain of command. The Internet is also a comfortable medium for the highest-risk age group of 17- to 24-year-olds.

The Silent Partners

While the military has noticeably boosted its suicide awareness efforts among the ranks, one military population is still largely left out of the loop: family members—not just the spouse, but parents and siblings, too. As with the individual servicemember's leaders and military colleagues, family members need training in spotting symptoms of PTSD, TBI, depression, or other mental health issues and in seeking help.

Stigma still rules in this realm, Ms. Ruocco said. She notes that parents and siblings adhering to a keep-it-in-the-family principle often are afraid to talk to anyone outside the family about a servicemember who is struggling. Military spouses, meanwhile, generally abide by an unwritten rule that reporting their husband's or wife's problems would be considered a betrayal. Ms. Ruocco related a story of how a spouse's intervention can lead to the right outcome. A friend who, knowledgeable of the Ruoccos' tragedy, intervened with her own husband's commander, and the husband was put on anti-depressants and taken off flying duty while undergoing counseling. He was eventually weaned off the medication and returned to duty and flying status. This is the kind of good-ending story everybody wants to read, but what adjective does Ms. Ruocco use for that wife? "Brave."

Resources are out there for families, but getting that information to family members ahead of time is the challenge, Ms. Ruocco said. "Oftentimes, spouses get busy, they don't want to be called into the squadron or the company for a whole-day training." Parents, especially living some distance away, have even a harder time getting that information. "Let's not wait until they are in a crisis situation to have them scrambling for how to get help."

"That's something we briefed with ADM [Mike] Mullen, [chairman of the Joint Chiefs of Staff]," said SPARRC Chairwoman CDR Hawkins. "We really need to look at families and how we are engaging them with this issue."

John Brown, director of the Veterans Health Administration's Outreach Office for Returning Servicemembers of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF), advocates education for family members throughout the deployment cycle and at the 30-day, 60-day, 90-day Yellow Ribbon events, trying to reach a "teachable moment" when the family members will absorb the importance of the message. His personal belief—one shaped by a 26-year career in the Army Medical Service Corps and his VA career since 2002—is that the prime moment to reach families begins at the 30-day post-deployment event. "If anything is going to happen, it may begin happening during this time. The honeymoon will be over at that point, and the real demeanor of the servicemember in war will surface, whether it's anxiety or depression or PTSD. That's where family members need to know where to call and get the loved one help."

Aggressive Action

When CDR Hawkins talks about SPARRC's activities—such as DoDSER, a Rand study under way looking at DoD's health affairs programs, and creating subcommittees to look at various aspects of suicide prevention messages—she frames it as ways to improve DCoE's services. The longitudinal studies will glean valuable insights into ways to "turn off the suicide switch" in individuals, as MG Kasulke puts it, but military leaders aren't waiting for that information before taking whatever steps they can to turn the trend around.

"We know of some of the major risk factors for suicide, so we want to move upstream to reduce or eliminate those that we can. We have a lot of prevention programs targeting suicide prevention multiple different ways," DCoE's Dr. Bates said, pointing to mandatory training for all individuals and aggressive alcohol and substance abuse programs as examples.

The DoD Task Force on the Prevention of Suicide in the Armed Forces is an ongoing effort to glean insights, spot trends, and seek best practices to provide a holistic approach to suicide prevention and mental health intervention. "The task force is amazing" said Ms. Ruocco. "They have a good mix of clinicians, doctors, specialists, and researchers who really care about the issue and are look-

Mental Health and Suicide Prevention Resources

Defense Center of Excellence Outreach (DCoE) Center—24/7 service for psychological health-related questions, toll-free and confidential: www.dcoe.health.mil/24-7help.aspx, 866-966-1020.

VA Mental Health Resources—www.va.gov, 800-827-1000.

VA Suicide Prevention Lifeline—800-273-TALK.

Military OneSource—Services for all active duty, National Guard, and reserve members at no personal cost: www.militaryonesource.com, 800-342-9647.

Post-Deployment Assistance—A behavioral health Web portal focused on post-deployment problems: www.afterdeployment.org, 800-796-9699.

Real Warriors—A Web portal with peer-to-peer resources on stress, resiliency, and suicide: www.realwarriors.net.

Military Mental Health Online Screening—Anonymous, on-line screening for depression, anxiety, PTSD, and substance abuse: www.mentalhealthscreening.org/, 877-877-3647, military@mentalhealthscreening.org

TAPS—Tragedy Assistance Program for Survivors operates a national toll-free help and information hotline, 24/7: 800-959-8277, www.taps.org.

Deployment Health Clinical Center—www.pdhealth.mil, 800-769-9699.

Deploymed ResearchLINK—www.fhp.osd.mil/deploymed.

Force Health Protection & Readiness—www.fhp.osd.mil, 800-497-6261.

Building Bridges—New program from DCoE for warriors, families, and health professionals: www.dcoe.health.mil/forfamilies.aspx

ing at every little angle and every little point and really trying to find an answer." She also notes the many units trying various intervention programs, and after her talks individual commanders want feedback from her on the success—or not—of their efforts.

"If you compare DoD with just about any other organization in the world, I think it would be hard to find another organization that proactively, comprehensively tries to prevent suicide as much as DoD," said Dr. Bates. MG Kasulke agrees. "We're way ahead of the power curve in aggressively approaching this issue," he said in comparing DoD with the civilian sector.

The VA also has stepped up its efforts to assist warriors who have served in OEF and OIF—and it's not waiting for servicemembers to come to them, either. As of November, 48.5 percent of the 1,094,000 personnel who have served in OEF and OIF have utilized VA's health care services, Mr. Brown said. "That represents a good number. But for me, it's not enough because of the hidden wounds of war and those experiencing delayed symptoms." Among his initiatives is to be at all 61 demobilization sites nationwide for all the services, including the Coast Guard. VA touches all returning servicemembers at least seven times during the first six months of returning home, Mr. Brown said. VA staff also meets those who attend the Individual Ready Reserve musters scheduled throughout the year. At all these sessions, everyone in the audience is enrolled in the VA health care system and linked to their medical center of choice in their community.

The VA also established a call center in May 2008 with the task of phoning every single OIF and OEF veteran. The caller asks if the veteran needs any assistance with health care appointments or other benefits, if he or she is satisfied with the care manager, and if he or she has any employment issues. Health concerns are linked to a program manager at each of the 153 VA medical centers, which must contact the veteran in 48 hours. The call center staff follows up with the veteran within 14 days.

"We have spoken with 25 percent of all these veterans we've called," Mr. Brown said. The rest of the calls were messages left with a loved one or friend, or on an answering machine—but that's not good enough for Mr. Brown. "I want to talk to all of them. I want to hear their voices. Then I will know if they need assistance or not."

Any OEF or OIF veteran can go to one of the 153 VA medical centers; each has an OEF/OIF program manager. That veteran can set up an appointment on the spot or obtain one with a primary care provider within 30 days, Mr. Brown said. The primary care provider will screen the veteran for such things as PTSD, TBI, substance abuse, depression, and military sexual trauma, and then a care plan is developed. Veterans and family members in crisis, meanwhile, can call the VA's suicide 24/7 hotline, 1-800-273-TALK.

SSG Taulbee said he got an ongoing source of help and support the moment he walked into the Lebanon VA Medical Center. "Ever since that time, the VA has been good," he said. He gets reminder notices twice a month

TIME FOR A CULTURE CHANGE

By GEN Peter W. Chiarelli, Vice Chief of Staff of the Army

PO1 MOLLY A. BURGESS/U.S. NAVY PHOTO

GEN Peter W. Chiarelli

GEN Maxwell Thurman, vice chief of staff of the Army in 1985, said: "It is easy enough to provide Soldiers with their basic needs—food and shelter, for example—but it takes skillful, imaginative, and dedicated leaders to create an atmosphere where Soldiers and their family members share a sense of purpose and belonging."

Today's operational tempo makes leadership even more important in caring for the health and welfare of our Soldiers and their families. Increasingly, we have Soldiers who feel isolated within our ranks; they feel they have nowhere to turn and no other option but suicide. Preventing suicide and preserving the overall mental health and well-being of the force is, without a doubt, one of the most difficult challenges of my 37-year career.

As I look across our all-volunteer force of 1.1 million after eight-plus years at war, I am continuously amazed by the resiliency of our officers, noncommissioned officers, and enlisted Soldiers—some with one, two, three, four, or even five deployments to Iraq and Afghanistan. They answered our nation's call in time of war, fully recognizing the hardship and sacrifices that would be asked of them and of their families. Their courage and sense of duty is truly remarkable.

We have all heard stories and seen tremendous examples of leadership at various levels on the battlefield. We must ensure the same focused, caring leadership at home in garrison, committed to fighting a different, yet equally important battle.

Today, NCOs and Soldiers at the unit level bear tremendous responsibility compared to their counterparts in previous generations. The changing nature and rapid pace of warfare has put an immense strain on them, while providing them with few opportunities to rest and recover. The prolonged wear and tear on them and on their families is having a significant impact. And it is manifesting itself in the increased number of individuals suffering from depression, anxiety, and other behavioral and mental health issues. In particular, an increased number of Soldiers are suffering from what I consider to be the "signature wounds" of this war: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI).

We must continue to be diligent in finding ways to diagnose and treat these conditions. I am absolutely amazed at the progress that's been made in recent years, but there is still much work to be done. One area in particular where we haven't made enough progress, in my opinion, is in figuring

out how to convince people that these conditions are real. These injuries are incredibly complex, and it is important to understand the physiological changes that occur in the body as the result of these injuries.

In cases of PTSD and TBI, numerous factors can influence an individual's chances of full recovery. In particular, it is extremely important to treat PTSD and TBI as soon after the traumatic event as possible. Unfortunately, the warrior culture in our Army and the stigma long associated with seeking and receiving help is causing many of our Soldiers to ignore or hide their symptoms.

For example, following an explosively formed penetrator blast that tosses a mine-resistant ambush-protected vehicle 30 feet in the air, many Soldiers and Marines will get out, "high-five" one another, dust themselves off, and declare they're "Good to go!" But, the reality is, that may not be the case—concussive effects are very real, and the most significant damage can occur after the fact.

It is critically important that individuals suffering injuries to the brain be allowed time to heal. Research clearly shows that the brain needs to rest in order to heal after a concussive event. If the concussed brain is allowed to fully recover, there appears to be no danger exposing the patient to high brain activity, associated with returning to duty or combat. However, if the brain is subjected to another concussive event before fully recovering from the first, the damage appears to be compounded and more severe.

Initial response also plays a role in PTSD. Research has shown that the response following a threat or traumatic event can factor significantly into whether an individual develops PTSD. If the Soldiers return to a blaming, shaming, guilt-induced environment, that can contribute to their developing PTSD. Command climate is huge, especially at the first-line leader level!

Soldiers cannot control the very real physical change that occurs in their brains in response to traumatic events. In response to a threat, the brain's limbic system secretes large doses of chemicals in order to get the body ready to respond. If responding normally, the brain's frontal cortex will kick in quickly after these chemicals are released, interpret the threat, and decide what response is required.

However, a malfunctioning frontal cortex does not send those executive orders to cease and desist; and, it can take hours for the body to uptake those hormones and chemicals that were released. Meanwhile, because the frontal cortex didn't "turn off" the threat, the body is thinking, "I can't find the threat, but I'm going to keep looking, because there must be one."

A person suffering from PTSD cannot simply be told to "calm down, relax, and shake it off." The condition requires treatment either to stop the release of chemicals or to help the frontal cortex begin sending the appropriate suppression or "all-clear" response.

Unfortunately, there is a deeply rooted stigma—not only within our military, but across society as a whole—regarding seeking and receiving help for mental and behavioral health issues.

Many Soldiers would rather suffer than be seen by members of their chain of command or their buddies going to an appointment with a psychiatrist, psychologist, or some other type of behavioral health specialist. We have got to figure out a way to eliminate this stigma that is keeping those Soldiers from getting the help that they need. We must all be a part of the solution.

But, even more important, we need our junior officers, NCOs, and enlisted Soldiers at the unit level to help change the culture of our Army as it relates to this particular issue.

I and the sergeant major of the Army or a brigade or battalion commander can talk to young NCOs and Soldiers about the importance of these subjects, but it will have far more impact if they hear it firsthand from a fellow Soldier or a trusted NCO.

It is not unlike the environments we operate in today in-theater. We cannot direct change from above by ordering villagers in Afghanistan to tell us where the Taliban is hiding. To be effective in these environments, we must win the trust and confidence of the Afghan people. In the same way, we cannot order young leaders and Soldiers to erase the stigma. This must be achieved at the unit level where relationships between NCOs and Soldiers provide the foundation for making positive, needed change.

That's not to say we can solve this problem solely from the bottom up. The reality is that we must also continue to tackle it at the more senior levels of command. As Soldiers look out for each other, commanders must ensure they create a command climate in their unit that reduces stigma today and eliminates it in the future.

In today's brigade-centric Army, this is where the synergy for change exists. Brigade commanders counsel their battalion commanders, who in turn counsel their company commanders, who then counsel and interact daily with their lieutenants. The same chain exists in the NCO channels.

At every leadership level, there needs to be an emphasis down the chain, encouraging help-seeking behavior for Soldiers who are struggling, until it reaches the first-line leader level, where true intervention most often occurs.

For all the programs we can put into place throughout our Army, there is no substitute for caring leaders who know their Soldiers and their families well enough that they can see the signs of stress and intervene appropriately.

Leader involvement has helped change the culture of our Army in the past, and leadership will be a critical component in the days ahead with respect to behavioral health issues. Leaders set the tone and the example that others emulate.

Success will require individuals at all levels of command to help inform, help educate, and help eliminate the stigma associated with seeking and receiving help.

This is the great challenge of this generation. How we all respond will impact not only the Soldiers who serve today, but those of future generations. The Soldier's Creed states: "I am a warrior … member of a team.... I will never leave a fallen comrade. I am disciplined, physically and mentally tough...." This code should remind all of us of our responsibility to help ourselves and each other during times when we may be struggling. It's all part of being Army Strong. ★

for his group counseling sessions, and if he doesn't show up his counselor follows up—not that he avoids attending the sessions. "Just being around guys sharing the same experiences I had, it helps balance me out," he said. "It's all about finding the balance, to even the playing field in your life."

Building Resiliency

Perhaps the most innovative strategy for fighting suicidal behavior is DoD's attempt to build psychological resiliency in individuals. Rather than merely preventing suicidal behavior, said Dr. Bates, "We would prefer to strengthen our servicemembers and family members so that they never get to the point where they think about suicide as an option. We're dealing with a variety of initiatives to understand better how people are resilient in the face of very challenging circumstances, and then to enhance those characteristics in our population."

DCoE defines *resilience* as "a process that involves how a person or group responds to acute and accumulative stressors and the interaction of internal and external factors for adapting to the most challenging of situations, establishing a new normal, and realizing one's potential for growth." Dr. Bates breaks it down as follows:

- "A group" can be a unit or a family.
- "Acute and accumulative stressors" include not only experiencing atrocious events—whether deployed or at home—but also the chronic wear and tear of separations and op tempo both on duty and at home.
- "Internal factors" are the psychological, physical, and spiritual resources the person or group brings, while "external factors" include an environment that reduces stigma as a toxic threat to getting help.
- "Adapting to the most challenging of situations" is more than merely adjusting to a change. "Sometimes you have to change the way you do business if a situation is challenging enough, and we use the word *adapting* to make that distinction," Dr. Bates said.
- "Establishing a new normal" recognizes that everybody who goes through a deployment is changed somehow.
- "Realizing one's potential for growth" refers to the fact that many people grow from being exposed to

'A NORMAL LIFE . . .OR SO WE THOUGHT'

AIR FORCE RESERVIST GRAPPLES WITH THE STRESS MILITARY DUTY BRINGS TO HER OWN FAMILY AND CIVILIAN LIFE WHILE WATCHING SIMILAR STRESS DESTROY LIVES AROUND HER.

By 2Lt Angie L. Serrao, USAFR

ERIC MINTON/ROA PHOTO

2Lt Angie L. Serrao

When I joined the military, I never dreamed I would have the type of experiences my military career has afforded me. Not all of them were good, but I learned something from each of them.

In February 2003, when I received the call that activated my Reserve unit, I, a master sergeant with 11 years in the Air Force, thought I finally got the chance to do my job. But at that time, my business had been open five months; I was working on my master's degree; I had a 7-year-old child at home; and I had a rocky marriage at best. My head was heavy with stress as I had five days to prepare my business and family for my absence. The first week in March, I departed for Germany with no return date in sight. I was hopeful that my family and business would survive without me.

It was not long before the unit that I deployed with became my extended family. We became good friends, helping each other through the separation anxiety, supporting each other during blue times, and getting to know each other's families through sharing stories and pictures. Everyone had difficult times, whether it was losing a grandparent, receiving a Dear John letter, or missing a kid's birthday. Separation is hard, even though it is expected as part of military life.

After five months, I returned home to find my marriage disintegrated, my child confused, and my business struggling. To make matters worse, I was home less than three weeks when I was notified that I was leaving again, this time going to the desert. My daughter was devastated. I missed her first day of school and was not able to meet with her teachers. In addition, I had to have my soon-to-be ex-husband move back into my house to take care of her while I was gone.

I returned home in December 2003. Now I was a single parent and was struggling to balance work, a home, and my child. Mental health and wellness were not in the front of my mind or anyone else's. Everyone assumed that because you were home now, everything would be OK.

The next two years involved demobilization, re-integration back to civilian jobs, and an unbelievable amount of loss. A good friend, one in that original "extended family" that deployed in 2003, was diagnosed with colon cancer and died a year later at the age of 31. Another extended family member was diagnosed with a brain tumor and died two weeks later. Worse yet, a young Airman from our extended family murdered his young child and committed suicide. Since then, several others have lost their lives to diseases, and additional suicides have occurred at our home station.

trauma. It's called post-traumatic growth (see story, page 32), and this can be encouraged, even trained.

There is not a single U.S. military leader who believes the services will ever get to a suicide rate of zero-per-100,000. All manner of prevention efforts and resiliency programs—and even the cessation of hostilities—will not wipe out suicidal behavior among all individuals. But the steps DoD and VA have taken to stem the rising trend, the studies they've undertaken, and the initiatives on building resiliency they've engaged may have an end result of improving the mental health of the entire nation, another example in a long tradition of military medicine being the leading edge.

When asked if he saw the rising suicide rates in the military as an "epidemic," MG Kasulke said no. Even with the rising numbers, the rate is still close to that of the civilian population, he pointed out. "I think the issue here is that, for the [military] leadership, every one is a significant event. Even if it were just one suicide a year, it would be a significant event."

ROA: Advocacy and Education on Mental Health Care

Wounded Warrior support, especially for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), is one of ROA's Top 10 legislative priorities. Over the past year, ROA has advocated for follow-up screenings and access to local mental health providers for Reserve Component members. ROA's legislative agenda for 2010 includes improving continuity of health care for all drilling reservists and their families and improving post-deployment mental health evaluations for Reserve Component members. Visit www.roa.org/advocate.

ROA's Defense Education Forum (DEF) conducted a daylong program March 23 on "Mental Health Care Delivery to the Armed Forces," and presented a symposium Nov. 12 at Dupage Medical Center in Addison, Ill., in conjunction with the ROA Department of Illinois focusing on PTSD and TBI. Another mental health care–focused program with the Department of Illinois is scheduled for April 9. DEF also plans to initiate programs focused on emerging mental health technology. Visit www.roa.org/educate.

I am now an officer in the U.S. Air Force Reserve, and I still struggle with the side effects of years of stress. I had to fight to regain some sense of normalcy in my life. Just getting a good night's sleep is an ongoing struggle. I had to work extremely hard to rebuild my business, and I struggle with communication and relationships, especially with my children.

Last February, I attended ROA's annual conference in Washington, D.C., which included the panel of reserve chiefs, who spoke on the status of the military, especially re-integration and family involvement. As I listened, I thought about everything our extended family unit and home unit had gone through over the past couple of years and wondered how it could have been done better. I think we all would have liked to have had more support for our children, spouses, and businesses, and I don't mean just a phone call.

I thought of my own business; I own three daycare centers. It is our goal to focus on the entire family to support a child's growth and development. We bring in outside services, perform home visits, refer parents to mental health providers for assistance, and plan activities that benefit the entire family, not just the child. My agency brings it all together; otherwise, no one would use the various services that taxpayers provide.

I asked the reserve chiefs panel, "Why doesn't DoD use a social worker construct when taking care of families?" The suggestion was diverted to the Yellow Ribbon Campaign. After I returned from the conference and spoke with our Yellow Ribbon Campaign manager, I found out that money is still an issue, and the base is not able to do as much as they would like with the program.

So what is the answer? The answer is a support system, with social workers assigned to follow a member throughout his or her career and visit families of deployed members before, during, and after deployments. Re-integration should not start after a deploying member returns; it should start before, by preparing families for separation, preparing employers for separation, and preparing support services in local communities to be ready if needed.

The social worker would help provide services for the family to prevent the stresses that research shows are precursors to suicide. The social worker would visit the deployed member's family while he or she is gone, and visit the children's schools to talk with teachers and counselors about the stress the child will experience and how it will affect the child's school work.

Yes, these services are all out there through one agency or another, but none of them is tied together and committed to each deploying servicemember. This system, which would incorporate Yellow Ribbon, the Veterans Administration, civilian providers in local communities, and a full-time military social worker assigned to each station, could help place responsibility back on the military units.

When I look back, it would have been nice for someone to visit my home to check on my daughter, to visit her school, to make sure my business was doing OK. That didn't happen, but we still turned out all right. Unfortunately, several servicemembers did not turn out alright. The barriers to this kind of individual attention are enormous. Laws would have to change, career fields would have to change, and money would have to be spent. But if it were one of your extended family members or friends, wouldn't it be worth it?

2Lt Serrao is assigned to Youngstown ARS, Ohio. The views expressed in this article are solely those of the author and do not necessarily represent those of the Air Force Reserve, the Department of the Air Force, or the Department of Defense.

DEALING WITH STRESS AT THE SOURCE

DEVELOPING ARMY DOCTRINE PUTS COMBAT STRESS CONTROL TEAMS AMONG FAR-FORWARD TROOPS.

Combat stress is not a new phenomenon. It goes back at least to the Trojan War. The U.S. Army's attempt to control stress among the troops goes back to the Civil War. The 883rd Medical Company (CSC)—with the CSC standing for Combat Stress Control—is an Army Reserve unit based in Boston, Mass., that goes back more than 20 years and next year is scheduled to deploy to Southwest Asia for the third time since 2003.

What seems to be a new phenomenon is a military culture that now accepts and deals with the manifestations of combat stress more readily and effectively. That's what members of the 883rd have noticed.

"The Department of the Army's interest in what we do has filtered down to line-unit commanders at a level it has never filtered down to before," said the 883rd commander, LTC Richard Toye, USAR, in a phone interview with THE OFFICER. "The Army at large is just now recognizing the importance of what we do," said SSG Robert Davis, USAR, a behavioral health specialist with the 883rd, in the same interview. "Our mission has often been misunderstood by commanders and Soldiers in other disciplines."

LTC Toye listed two factors for the CSC's increased credibility among the ranks. One is increased exposure with U.S. forces having been in-theater in Afghanistan and Iraq for more than eight years. "Line commanders have learned that we are useful assets. They had not had a lot of exposure to us in the past because they've been doing missions other than war and small-scale conflicts where perhaps we were not deployed in enough strength." And that leads to the second factor: new and various stress-related issues have surfaced over the course of the long, chronic mission, and commanders are turning to CSC expertise in dealing with them.

SSG Davis also believes there's a generational factor. While increased awareness and dealing with stress have been top-down directives, "the culture of younger leaders coming through the ranks now is more open and accepting, probably a reflection of society as a whole: better understanding of treatment and better understanding of our ability to maintain combat readiness rather than decrease combat readiness by taking Soldiers away." But any insinuation that older Soldiers are not on board with stress-reduction initiatives would be untrue, he said. "I think there are younger people who don't understand what we do; I think there are older people who don't understand what we do. It's about exposure and it's about how open-minded they could be."

CSC officers are licensed providers in psychology, psychiatry, social work, occupational therapy, and psychiatric nursing; the enlisted are behavioral health technicians and occupational therapy assistants. In addition to providing unit-wide briefings and offering counseling sessions, the officers will powwow with unit leaders to get a full assessment of stress issues in that unit. Meanwhile, the enlisted members of the team, along with providing their own expertise, pal around with the unit's enlisted, getting their own assessments from the ground up and offering peer-to-peer ears and advice. "The regular Soldier is willing to talk to another staff sergeant or another sergeant, where they might not be willing to talk to a colonel," said LTC Toye.

SGT JASON P. MIKEWORTH/U.S. ARMY PHOTO

CPT Michelle Selcke, an occupational therapist with the 883rd Medical Company Combat Stress Control team, teaches a class aimed at improving working and family relationships for Soldiers at Forward Operating Base McKenzie in Iraq.

SSG Davis also likes to hook up with the combat medics. "They are typically the first line that the Soldiers will talk to, or [the medics] will notice concerns among their Soldiers," he said. Being a firefighter and emergency medical technician in his civilian life for the city of Newton, Mass., gives SSG Davis credibility with the combat medic cadre, too.

While so much media interest has focused on post-traumatic stress disorder (PTSD) and traumatic brain injury, the CSC's mission is to work in the entire spectrum of stress, of which PTSD and acute stress disorders are at one end. "What we're organized for, our ideal function, is to

manage normal reactions to an abnormal situation," said LTC Toye, who as a civilian is a neuropsychologist at Fort Stewart, Ga., handling post-concussive cases. "It's a really hard thing to keep clear in people's minds that not all stress reactions are one of these stress disorders the public is so concerned about. I'm stressed most of the time—I have to travel a lot—but I don't have a stress disorder. Knock on wood."

The public is not alone in having trouble discerning the difference. Soldiers are, too, and at the vanguard of the CSC's mission is building trust among the ranks. "War is stressful and you're supposed to be stressed by it if you're a normal person," LTC Toye said. "To the extent we can convey that to Soldiers, and they know we think they're normal, we get a lot better results. At the same time, we're in there making sure somebody's not having an abnormal reaction to the situation they're in. If they are, they need behavioral health treatment to get over it."

It helps that all CSC members have another occupational specialty: Soldiering. "Inherent in the way the Army has put us together, and really critical in people's acceptance of us, is that we are Soldiers first and behavioral health providers second," LTC Toye said. "To the extent we project that, to the extent we live that, and to the extent we go out and do our job the way it's meant to be done, it's a whole lot easier for people to accept that we know what we are talking about when we talk about combat stress."

It bears mentioning here that reservists from two CSC units, the 467th from Wisconsin and the 1908th from Kansas, were the targets of the Nov. 5 shootings at Fort Hood, Texas.

The 883rd deployed to Kuwait in 2003 for the initial entry into Iraq and had its teams supporting 3rd Infantry Division and 101st Airborne units all the way to the Baghdad Airport. Its second deployment was to Baghdad supporting 13 teams working throughout Iraq supporting all types of U.S. and coalition forces.

Up until 2008, the CSC doctrine was to break into two types of teams, ranging from a dozen people or so who staffed restoration centers—where individual troops can retreat for 72 hours to catch up on sleep and meals, get some counseling, and carry out Soldiering tasks before returning to the company—to a couple or three people supporting Soldiers on the ground. "We go out as far forward as feasible," said LTC Toye.

A new mission model will be in effect for the 883rd's next deployment. LTC Toye plans to create six-person teams that can move about in the field with maximum flexibility and still break down into smaller teams as necessary. "The mission requirements will dictate what I actually have to build," he said.

One goal of the new doctrine is to train Soldiers in being stress buddies. "We want to see if we can find people organic to the units we support who can learn some of these tactics and procedures for helping their buddies handle stress," LTC Toye said. The idea is that Soldiers will be more willing to talk to each other than to strangers stopping by for a few days, but it's also not dissimilar from the practice of having Soldiers trained as combat medics along with their regular duties.

In another doctrinal shift, while the CSC will still support restoration centers, "The reality is we're pretty hard-charging in-theater right now, and commanders don't like to lose their troops for any length of time," LTC Toye said. So, the new model will have the company put a Soldier on a different type of duty where he or she is more likely to get a little more sleep but where that person can still support the company functions and be near his or her buddies. "After 72 hours of that, most of them are ready to go back into the fight," LTC Toye said.

"A good assessment is important in that case," said SSG Davis. "It depends on the needs of the Soldier and what the mission of the unit has been like lately." It also depends on whether the unit's command culture is conducive for such a strategy, he noted. "The guys who have the hardest time accepting guidance from us are often the command who are pushing themselves 20 to 24 hours a day," LTC Toye said. "They've got a commitment to their guys, and they sometimes have a hard time taking a break themselves. That's one reason you've got colonels in combat stress companies." ***—EM***

TSGT. FRANCESCA POPPU/U.S. AIR FORCE PHOTO

Maj. Laura Lien, 732nd Expeditionary Support Squadron Combat Stress Control outreach program manager, teaches a "One-Shot/One-Kill" Performance Enhancement Seminar to Soldiers of the Headquarters and Headquarters Company, 2nd Battalion, 12th Cavalry Regiment, 4th Brigade Combat Team, 1st Cavalry Division at Ali Base, Iraq. The class focuses on recognizing stress and taking the skills a Soldier learns in basic training to be a better person and enhance performance—physical and mental—in everyday life. Maj Lien, a psychiatric nurse by trade, is deployed from Shaw AFB, S.C.