

Twenty-one months after the scandal broke at Walter Reed, the military is exploring **everything from talk therapy to yoga** in its struggle to better treat troops suffering from post-traumatic stress disorder.



Treating Trauma

■ By Sydney J. Freedberg Jr.

Robert Bartlett has post-traumatic stress disorder.

In that, the 35-year-old Army sergeant is no different from the tens of thousands of other military personnel with PTSD who have served in Afghanistan or Iraq. What makes him unusual is that he's talking about it. ■ "Group therapy does work," Bartlett told an audience of soldiers at the annual Association of the U.S. Army conference in Washington in October. "It has worked for me—just talking about it, getting it off your chest so you can get on with your life."

Since 2005, when a roadside bomb destroyed his jaw and the left side of his face, Bartlett has spoken publicly to soldiers, reporters, and even schoolchildren about how hard it can be to recover, both physically and mentally. (See sidebar, p. 33.) One friend who was also wounded in Iraq, Bartlett said, “is a step away from being on the street. He to this day has difficulty talk-

“They have to be courageous enough to raise their hand and ask for help,” he declared of troops—before adding, “That’s easy for me to say.”

Military mental health crusaders from Sgt. Bartlett to Adm. Mullen drive home three critical points.

- Anyone who spends months in a war zone, even without



■ BEFORE AND AFTER: Robert Bartlett was an Army sniper (opposite left) who witnessed multiple roadside bombings like this one in Iraq (center). On May 3, 2005, a bomb blew up his Humvee. He has undergone multiple reconstructive surgeries since then, but post-traumatic stress has taken a toll nearly as great as his physical injuries. In the photo at left is Bartlett with Michelle Hunter, his occupational therapist at Walter Reed Army Medical Center.

ing to me. He did not do group [therapy]; he did not seek help; he is afraid that he is going to be labeled ‘crazy.’ ” To break down those barriers, “the best we can do is lead by example,” Bartlett concluded. “I did seek help. I’m no less of a man for doing it.”

For generations, the military has upheld a code of stoic silence—backed by the fear, historically well justified, that seeing a therapist could destroy a soldier’s career. Until 1980, seven years after U.S. troops pulled out of Vietnam, “post-traumatic stress disorder” was not even a recognized diagnosis. The psychologically wounded were swiftly discharged and left to fend for themselves. The Veterans Affairs Department eventually built a system now hailed as a model, but not before some vets had suffered for decades with little help.

This time around, more and more senior officers are deciding that they have to do things differently for their troops. No less a figure than Navy Adm. Michael Mullen, chairman of the Joint Chiefs of Staff, began pounding his fist on the table at a recent press breakfast when he was asked about service members with post-traumatic stress. “The leadership is very focused on this, but I think it’s a bigger problem than we know,” he said.

coming under fire, should *expect* to show signs of stress and to have some difficulty readjusting to life at home.

- Most people who develop such symptoms recover on their own, without developing full-blown post-traumatic stress disorder.
- Proven, effective treatments exist—the best of them *not* involving drugs—to help people get over not only lower-level stress symptoms but also PTSD itself.

This gospel of optimism and openness has had a distinctly mixed reception so far in military ranks. “It’s hard admitting it,” said a sergeant who discussed his PTSD treatment with *National Journal*. “I never got help until my wife made me go.” He spoke of a hair-trigger temper at home and in traffic, of sudden awakenings in the night to check that his children were OK, of an obsessive desire to get back into the fight in Iraq. Today, after nearly six months of therapy combining medication and counseling, the sergeant said that his symptoms are much improved. His military superiors know about his diagnosis—in fact, military medical records cannot be kept confidential from the chain of command—but his peers do not. So this soldier, decorated for valor in Iraq, had one request: “Keep my name out of the article.”

“No One Ever Called Me”

Persuading troops to ask for mental health care is the first hurdle. Making sure it is available for those who do ask is the second. A 2007 study by the Rand Corp. estimated that of more than 300,000 troops with PTSD or depression, about half sought any form of care—and only half of those, one-quarter of the total, received even “minimally adequate” care.

Qualified caregivers are hard to find. Counting travel time across some sprawling military bases and the time spent waiting to be seen, “it would take at least half a day for me to go to an appointment,” said the decorated sergeant who asked not to be identified. He has his counselor call him on the phone instead of making formal appointments. “There are so many soldiers with symptoms of PTSD, it takes 60 days for the nurse to see you,” he added.

The military’s first line of defense is to get the troops to assess themselves. Questions about common signs of PTSD, depression, and other psychological ailments are now on the surveys handed out at several points before and after a war zone deployment. But many service members still do not report their symptoms.

Even those who ask for help do not always get it. “At the bottom of that form, on every one, I guarantee that I filled out that I wanted to see a mental health professional,” said Andrew Brown, a first sergeant in the Army Reserve, who suffered repeated flashbacks after fighting in Iraq in 1991 and 2004-05. “The fifth time I filled it out, I just lost my mind. No one ever called me.” Instead of using the military system, for which he is eligible, Brown sought care through the VA, with what he said were unsatisfactory results. The best therapy, he said, ultimately came from his renewed religious faith.

Despite its shortcomings, Veterans Affairs is far ahead of the Defense Department, which has much less experience treating PTSD. The military is working closely with the VA to staff the

■ Rough Road Back



new Defense Centers of Excellence, headquartered in Arlington, Va., to disseminate and standardize best practices across the armed forces.

On its side, the VA has set up coordinators for Iraq and Afghanistan veterans in all of its hospitals. Initially, “a lot of our work did take place in mental health units,” said Jackie Williams, the Iraq and Afghanistan program manager at the El Paso VA hospital just outside Fort Bliss in Texas. “But for a broad population of veterans, they don’t necessarily want to be hooked to ‘mental health’ right away—or ever. The move now is to integrate more mental health care right into primary care, so it just becomes an assumption.”

“We See Every Patient”

Like the VA, the military is striving to make mental health treatment routine, both to remove the stigma attached to receiving it and to prevent troops like Brown from falling through the cracks. Arguably the most thorough implementation is at

Walter Reed Army Medical Center in Washington, which treats the most-severe casualties. “We see every patient coming back from a war zone within 24 to 48 hours,” said Dr. Harold Wain, who oversees the hospital’s “preventive medical psychiatry service” program, which was recently renamed to emphasize that it provides routine treatment. “Everybody now expects us.”

Even well-resourced Walter Reed, however, has had problems treating outpatients receiving less-intensive care. It was the 2007

■ What Works

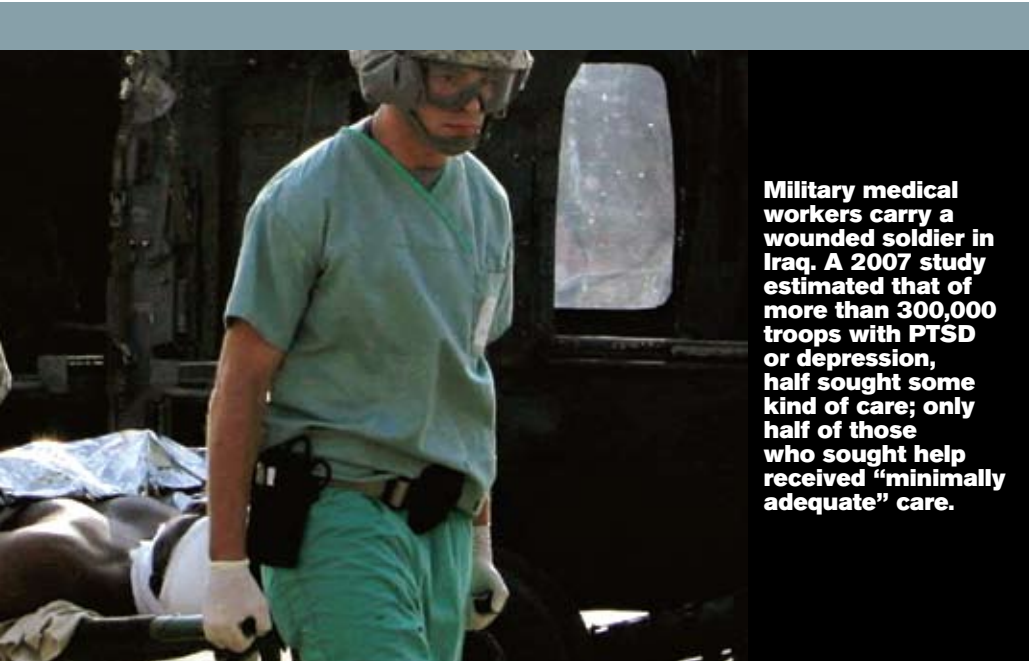


■ Talking about the specific incidents of stress and trauma, even **reliving them repeatedly**, can help.

■ **Group therapy**, although hard to document, seems to be particularly effective.

■ Some physical practices, such as **meditation and even martial arts**, appear to help some patients.

AFP/GETTY IMAGES/TIM SLOAN



REUTERS/THAYER AL-SUDANI

Military medical workers carry a wounded soldier in Iraq. A 2007 study estimated that of more than 300,000 troops with PTSD or depression, half sought some kind of care; only half of those who sought help received “minimally adequate” care.

scandal at Walter Reed over neglected outpatients that led the Army and Marine Corps to create “Wounded Warrior Units” specifically to support and monitor personnel in long-term care. These units combine civilian case managers with a cadre of veteran sergeants, many of whom are former or current outpatients themselves.

“Soldiers, they’re used to that platoon-sergeant, squad-leader structure,” said Sgt. 1st Class Eliseo Torres, a veteran of Afghanistan who helped set up Warrior Transition Units at Walter Reed in 2007 and now leads a platoon of about 30 soldiers in treatment, 25 as outpatients. “A little more than 50 percent do have some type of trauma,” Torres said. “First we talk to the soldier, find out what the incident was, make sure they’re not in a suicidal state. Then they report to us several times a day, seven days a week. Especially with the TBIs [traumatic brain injuries] and PTSDs, they can’t remember their appointments, and depending on the medication they’re on, they may be passed out, so somebody has to check up on them.”

Even less severely impaired troops in recovery need help arranging appointments, lodging, and other necessities. They are also assigned light duties to keep them occupied between appointments and to help rebuild their self-image as military personnel, not just patients. “A lot of these guys are going to have PTSD and they can still function,” Torres said. “If you’re diagnosed, OK. There’s still life after that.”

A Normal Response

Part of the military’s approach is trying to convey that psychological problems are routine for anyone coming out of a war zone. “We want to tell them that it’s a normal response to an abnormal event,” said Walter Reed’s Wain. “Almost 100 percent of patients exposed to trauma are going to show some form of psychiatric symptomology, usually short-term. We make it normal.”

Stress is part of the natural mechanism by which human beings mobilize themselves to survive. “You hop in a vehicle and go out in a convoy, and it’s natural that the gunner in that turret

is going to be very, very acutely on edge,” said Greg Reger, a psychologist at Madigan Army Medical Center at Fort Lewis, Wash. “That’s adaptive. That increases the likelihood of keeping himself alive and keeping his buddies alive.”

Nor can the human organism simply switch off such responses after coming home. It takes time to break any habit, let alone one learned under life-or-death pressure: driving aggressively to steer clear of ambushes or roadside bombs, avoiding public spaces for fear of an attack, waking suddenly to faint noises in the night, tamping down all emotions save hair-trigger anger. Most troops unlearn such responses after weeks or months of being back in a safe environment. Some do not. “They get kind of stuck,” Reger said. “Really, it’s a failure to readapt.”

Just ask Patrick Campbell, a sergeant with the Army National Guard whose civilian job is with the advocacy group Iraq and Afghanistan Veterans of America.

“The skills that help you over there tend to hurt you over here,” said Campbell, who has been diagnosed with PTSD. “Within three months of coming home, I alienated three of my best friends. I was numb to the idea that words hurt people. Words weren’t allowed to hurt people in Iraq; you didn’t have the luxury. And I got into two fights—both of the people I got in fights with deserved it, but I was *excited* to get in the fight. It took another year before someone sat me down and said they wouldn’t be my friend anymore if I didn’t get counseling. I realized I had been shutting my emotions off.”

Not every service member struggling with PTSD has such a moment of clarity, however. And many who do realize what they are facing cannot find counseling that works.

You Need to Process It

One of the standard treatments for post-traumatic stress disorder is drug therapy alone. The only medications approved by the Food and Drug Administration for PTSD are the antidepressants Zoloft and Paxil, which belong to a class of drugs called selective serotonin reuptake inhibitors. Rigorous clinical trials have shown that SSRIs can help patients overcome PTSD symptoms. But studies also show that even the proper medications, correctly prescribed, have lower rates of success than certain forms of counseling without drugs. And all too often, medications are misused.

Army Sgt. David Gilmore was diagnosed with PTSD after his first combat tour in 2003-04, 12 months in Iraq punctuated by the death of a friend and repeated nighttime mortar attacks. (See sidebar, p. 34.) He opted to take medication and to deploy back to Iraq for 15 months in 2006-07. “Take some Zoloft so I can drive on,” Gilmore summed up the decision. “That was my choice.”

Today, Gilmore is on his way out of the Army, awaiting a disability rating while assigned to the Warrior Transition Unit at Fort Bliss. The treatment for his PTSD includes weekly therapy sessions, but Gilmore sees little progress. “We talk about the day,

Patrick Campbell



COURTESY OF PATRICK CAMPBELL

“Within three months of coming home, I alienated three of my best friends. I was numb to the idea that words hurt people.”

talk about how I feel—it’s one of them touchy-feely-type deals,” he said. “Are you having a good day? Blah, blah, blah. Blah, blah, blah. My personal opinion, [the therapist is] a little bit overly happy, but that’s kind of the idea.”

In fact, the best-attested therapies for PTSD are anything but cheerful how-do-you-feel-today chat sessions. Instead, they require the patient to confront the traumatic experience over and over, in an intensive course of eight to 12 sessions, once or twice a week, plus homework assignments in between.

“These treatments really immerse the patient in the traumatic material,” said Dr. Matthew Friedman, executive director of the VA’s acclaimed National Center for Post-Traumatic Stress Disorder, which is headquartered in White River Junction, Vt. Friedman himself worked on a study, published in 2007, that compared one group of patients undergoing “prolonged exposure therapy,” in which they repeatedly told the story of their trauma in ever-greater detail, with another group in purely “supportive” and “present-centered” therapy, in which the therapist systematically steered discussion away from the past and toward how best to manage PTSD symptoms in the present. Repeated exposure to the past won handily.

“To actually recover from a traumatic event, you need to process it,” said professor Edna Foa, the University of Pennsylvania psychologist who pioneered exposure therapy for PTSD. “If people avoid thinking about the traumatic event, if they don’t talk about it with other people, they impede some kind of process that needs to take place in order to recover.”

The two PTSD therapies with the most evidence in their favor rely on confronting the past. Prolonged exposure, Foa’s brainchild, focuses on purging painful emotions. During sessions, the patient repeatedly recounts the traumatic events, remembering them in as much detail as possible. In between sessions, the patient gradually reacclimatizes to activities once abandoned as too stressful. The survivor of the roadside bombing will start out by driving around an empty parking lot, for

example, and work up to progressively more-crowded streets before trying the highway. By exposing the patient, in both imagination and real life, to reminders of the trauma, but this time in a safe environment, the therapy tries to train body and mind that these triggers no longer require a fight-or-flight response.

A related treatment, called “cognitive processing therapy,” keeps the patient more detached from the incident, making the person examine it in detail more analytically. “Somebody has a traumatic event, and they walk away with these huge conclusions: ‘I won’t trust anyone again,’ or ‘It’s all my fault,’” explained Patricia Resick, the psychologist who developed the treatment in 1988; she joined the VA’s National Center for PTSD in 2003. The therapist’s role is to help the patient challenge these destructive ideas, both in counseling and in written assignments. “You can’t say, ‘It’s not your fault.’ They’ll say, ‘What the hell do you know?’” Resick explained. The better approach, she said, is the Socratic question: “Hold on for a second. How could you have possibly prevented this?”

In practice, the two techniques overlap considerably. Cognitive processing tries to change how patients *think* about a traumatic experience, while prolonged exposure seeks to change how they *feel* about it. But either method will affect thoughts and feelings. It is hard to tell your story repeatedly in prolonged exposure therapy without rethinking it as well, and it is hard to think through a trauma without stirring up powerful emotions. Some evidence indicates that the different techniques may work better for different people. PTSD patients who express more anger or guilt than anxiety seem to respond better to cognitive processing, Resick said, while older patients do better with exposure therapy.

“We’re Going to Learn a Lot”

Much more research is needed. Both of the standard therapies for PTSD were developed for women who were raped or sexually abused, then branched out to aging veterans of Vietnam—two demographics very different from the younger, mostly male vets coming right out of the war zone today. Foa and Resick are launching separate large-scale studies of PTSD in the current force as part of a wave of research funded by \$300 million that Congress awarded the Pentagon this year for studies of mental health and brain injury. In Resick’s words, “We’re going to learn a lot in the next five years.”

Ongoing research is already refining the established therapies. In cognitive processing, for example, having patients write narratives of their traumatic experiences has been standard procedure since Resick invented the treatment 20 years ago—but a study that Resick herself published this year suggests that the writing exercise has no benefits. “We don’t actually need that written account at all,” Resick said frankly. “It was not what I expected.”

Meanwhile, Pentagon-funded experimenters are adding virtual reality technology to traditional repeated-exposure therapy. “Some people don’t get better from [the exposure therapy], and we think one of the reasons is a lack of emotional engagement,” explained Reger, the Fort Lewis psychologist, who leads the virtual reality program for the new Defense Centers of Excellence. “They start telling their memory, and

NationalJournal.com

Read more first-person stories from soldiers dealing with PTSD by visiting this story on NationalJournal.com.

it sounds like they're doing an after-action review." To slip past these patients' defenses, therapists at military, VA, and nongovernment clinics across the country are testing "virtual reality exposure" technology derived from commercial video games. Patients, wearing wrap-around goggles, see digitized images of Iraqi streets and wounded comrades, hear the sounds of gunfire, feel the rumble of their Humvee through a specially rigged seat, even smell the burning residue of an explosion—while a therapist carefully dials the intensity up and down. Reger himself, a former active-duty military psychologist, said that the simulation reached past his professional detachment to powerfully remind him of his tour in Iraq. "I had a very emotional reaction," he said. "It sparked my anger."

The pioneers of virtual reality therapy emphasize that it is a new tool for traditional therapies, not a replacement for them. "This is not like the orgasmatron in a Woody Allen movie, where you put somebody in a machine and the result happens," said Albert Rizzo of the University of Southern California's Institute for Creative Technologies, who developed one of the three virtual reality exposure variants that are now in trials. "This [requires] a standard psychologist doing what they should be doing."

Virtual reality exposure adds new technology to proven techniques. Other experiments are looking into low-tech alternatives to traditional psychotherapy. Military bases across the country have launched their own initiatives to treat PTSD—often incorporating alternatives to traditional Western medicine, from acupuncture to yoga.

"With Yoga, I Was Able to Relax"

Hugo Patrocinio was not getting the care he needed through the regular channels. The Marine sergeant had served out a seven-month deployment to Iraq, his second tour, with constant headaches that began after a suicide truck bomb loaded with a half-ton of explosives blew up near him. On his return to the States, he was diagnosed with moderate traumatic brain injury and post-traumatic stress disorder. "My mood would go up and down, from aggressive to depressed," said Patrocinio, whose marriage almost broke up. "I had a lot of cognitive problems, balance problems. I couldn't sleep, so I was given a lot of medication. If you saw me about eight months ago, I was sort of a zombie." He would stay awake for three or four days in a row, then drink himself into a short, restless slumber.

A military psychologist at Patrocinio's base, Camp Lejeune in North Carolina, got him into a two-week program that the base hospital had developed. Yoga was among the techniques it offered. "What really surprised me," Patrocinio said, "after five or 10 minutes of doing the breathing, I would be sound asleep. That was the only time I could get some decent sleep. With yoga, I was able to relax. I noticed a lot of improvement from that point on."

Patrocinio, now honorably discharged, continues to practice yoga. His enthusiasm for it was so great that he brought other marines with PTSD and traumatic brain injuries to yoga classes run by the civilian instructor he had met in the Lejeune program. At first the classes were "80 percent women," Patrocinio recalls, but male combat veterans soon became the majority.

Andrea Lucie, the yoga instructor, said, "Some of the guys

■ **Hugo Patrocinio**



The Marine sergeant's PTSD was resistant to most therapies until he discovered yoga through an on-base instructor.

approached me and said they knew that I did martial arts also." She had started practicing judo as an adolescent in her native Chile and later learned kickboxing. "They couldn't sleep, they were so anxious, they had these horrible anger outbursts," and martial arts offered a safe way to vent.

"It was a great way to unstress ourselves," Patrocinio said. "I just felt not as irritable anymore. And I reacted much better to the therapy" provided by the more traditional counselors.

As the ad hoc program grew, Lucie teamed up with the psychologists at the base hospital and also with Capt. Brian Stann, the Marine officer who commanded the holding unit to which nondeployable troops were assigned. Together they developed a multipronged approach that included meditation, yoga, and martial arts to supplement the traditional psychotherapy that was available.

"I had over 300 guys that were suffering from some sort of traumatic brain injury, PTSD, or combat stress," said Stann, an Iraq veteran himself. "We had only two psychiatrists on the entire base. It's not like you're going to get a weekly appointment." Instead, the martial arts classes turned into ad hoc group therapy. "Nobody's going to question my manhood," said Stann, who was awarded a Silver Star for his actions in Iraq and who fights in "extreme" cage bouts. "If I'm not afraid to open up and talk about certain things, then that kind of brought the guard down."

Anecdotally, the program is impressive. But the same grassroots improvisation that made it possible in the first place also makes it hard to measure—or to sustain. Stann has left the Corps to pursue his career as a professional fighter; Lucie's family is moving; and their sponsor at the base hospital, Navy Lt. Erin Simmons, is being deployed to Iraq. "I don't have the data compiled and organized," Simmons said. "It's been difficult to find the time and personnel to enter data, because we're so busy."

Institutionalizing the Experiments

Many grassroots experiments in new treatments for PTSD have neither adequate support nor adequate oversight from the military as a whole. At least one local initiative, however,

has gotten attention from the very top, including a visit from Adm. Mullen. This is the Restoration and Resilience Center at Fort Bliss, where Mullen spent several hours during a recent visit. The founder and director of the center is John Fortunato, a Vietnam veteran who worked as a civilian counselor at Fort Bliss, where the garrison is to grow by 28,000 troops by 2012. "In the first 1,250 soldiers that hit the ground here, we had 75 cases of PTSD," Fortunato said, "and we were swamped." With units under pressure to fill their ranks with combat-ready troops in time to deploy, troubled soldiers were being discharged faster than Fortunato and his colleagues could rehabilitate them.

So Fortunato wrangled \$2.2 million from the Fort Bliss commander to set up a program to return PTSD patients to frontline units. "We work very hard never to let them forget that they're

creasingly willing to try them. Walter Reed, for example, uses acupuncture and hypnosis as adjuncts to more-conventional therapy, and the Defense Department is funding further research into alternative medicine.

But even traditional psychotherapies are notoriously hard to evaluate in rigorously controlled, statistically solid trials. "It's much more difficult than medication research," said Friedman of the VA's National Center for PTSD. "You're given drug X or drug Y; you know what the person is taking. For psychotherapy research, you've got to videotape a certain number of the sessions and have impartial raters say how well the treatment was delivered."

Much of what makes for a successful psychotherapy resists measurement and standardization. "I watched Patty Resick doing cognitive-behavioral therapy with a veteran on a video," said

Dr. Jonathan Shay, a former VA psychiatrist who received a 2007 "genius grant" from the MacArthur Foundation for his work with Vietnam veterans. "It was amazing to watch—but the way she was working, I'm sure, is *not captured*" in the medical manuals.

Shay suspects that certain treatments accrue more evidence in their favor than others in part because those treatments are easier to study. Some of the treatments with less support may be genuinely inferior, but others

may be just harder to capture in a rigorously controlled clinical trial. "The absence of evidence is not the evidence of absence," Shay said. "The culture of government has a certain model of rationality, and that model says, 'Show me the data!' What rarely gets asked by the people who are pounding their fists on the table is what counts as data."

In contrast to the evidence for exposure therapy and cognitive processing, for example, the data on the value of group therapy are scattered and inconclusive. Yet groups have been a major tool of VA therapists such as Shay for decades. Anecdotally, veterans like Sgt. Bartlett see group sessions as central to their recovery. But the interactions of a half-dozen patients over months or years are even harder to study than one-on-one counseling.

"There has been very little research on the effects of community," Shay said. "But the ability to 'get over' what people have been through depends very strongly on the ability to communalize it, especially with surviving comrades." Whatever therapeutic technique is used, Shay argues, what is essential is to break the silence and have patients tell their stories.

"Right before we went to Iraq, [soldiers] said, 'The secrets you keep are the secrets that kill you,'" said Campbell, the National Guard sergeant. "Every time I feel scared to talk about something, I just have to say it—and that has kept me sane." ■

sfreedberg@nationaljournal.com



JENNIFER TREZZA FOR GOVERNMENT EXECUTIVE MAGAZINE

“They have to be **courageous enough to raise their hand** and ask for help.”

—Adm. Michael Mullen

a soldier,” Fortunato said. “They have to be highly motivated to stay in this program—it’s like [Army] Ranger School.”

Around that warrior ethos, Fortunato has built a distinctly eclectic program. It offers intensive psychotherapy—two individual sessions a week and four in group therapy, for six months—as well as art therapy, biofeedback, massage, meditation, yoga, and Reiki, a healing-hands technique originated in Japan. “They talk about chakras and medians,” Fortunato said. “I talk about the reduction of hyperarousal,” the constantly elevated anxiety of a veteran who cannot come back down from combat mode. All of these techniques, he says, help mind and body dial down the chronic, hair-trigger fight-or-flight reflex that characterizes PTSD.

In operation for less than a year, the center has so far returned 27 soldiers to active duty, a 64 percent success rate. The six-month course costs an estimated \$25,000 per patient, a fraction of what it costs to recruit and train a replacement soldier, let alone pay a lifetime of disability benefits. But it costs far more than psychotherapy alone, and the intense motivation of its patients, all of whom are volunteers, complicates comparisons to other therapies.

You Just Have to Say It

Some nontraditional treatments do have solid, if limited, scientific evidence in their favor, and the military system is in-