



Ombudsman Bulletin-Special Edition  
**Essential knowledge about PTSD and  
Combat/Operational Stress**  
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During OEF (Operation Enduring Freedom)/OIF (Operation Iraq Freedom), the issues of combat/operational stress and Posttraumatic Stress Disorder (PTSD) have come to forefront of the public eye. It is believed by most researchers that approximately 20% of US troops who have served OIF/OEF have serious symptoms of a combat/operational stress response (COSR), and as many as 50% or more have at least some symptoms of PTSD. However, despite these growing numbers, it is vitally important to remember two things:

- **Most people recover from their combat experiences with no long-term problems.**
- **Combat/operational stress responses, including posttraumatic stress, are *normal* reactions to the extraordinary stress of current military operations.**

Before we proceed, we need to define our terms. “Combat Stress” refers to the extent of stressors present in the combat environment. These may include physical stressors, such as dehydration or illness; environmental stressors such as lack of privacy, extreme temperatures, and, of course, IEDs (Improvised Explosive Device), firefights, and artillery; cognitive stressors such as uncertainty and unpredictability, and variable Rules of Engagement; and emotional stressors such as fear for one’s safety, grief, guilt, frustration, and worry about the family at home. “Combat Stress Response/Injury” refers to physical, behavioral, and social reactions experienced during or after a combat deployment, caused by these and other stressors.

By contrast, “Operational Stress” refers to the extent of stressors present in the operational environment because of the current operational tempo. These stressors include hard training requirements and long hours, garrison rules and regulations, and the knowledge that many friends and acquaintances are in harm’s way. “Operational Stress Response/Injury” refers to physical, behavioral, and social reactions experienced in response to operational stress not directly associated with combat.

*By definition, family members can experience operational stress as well.*

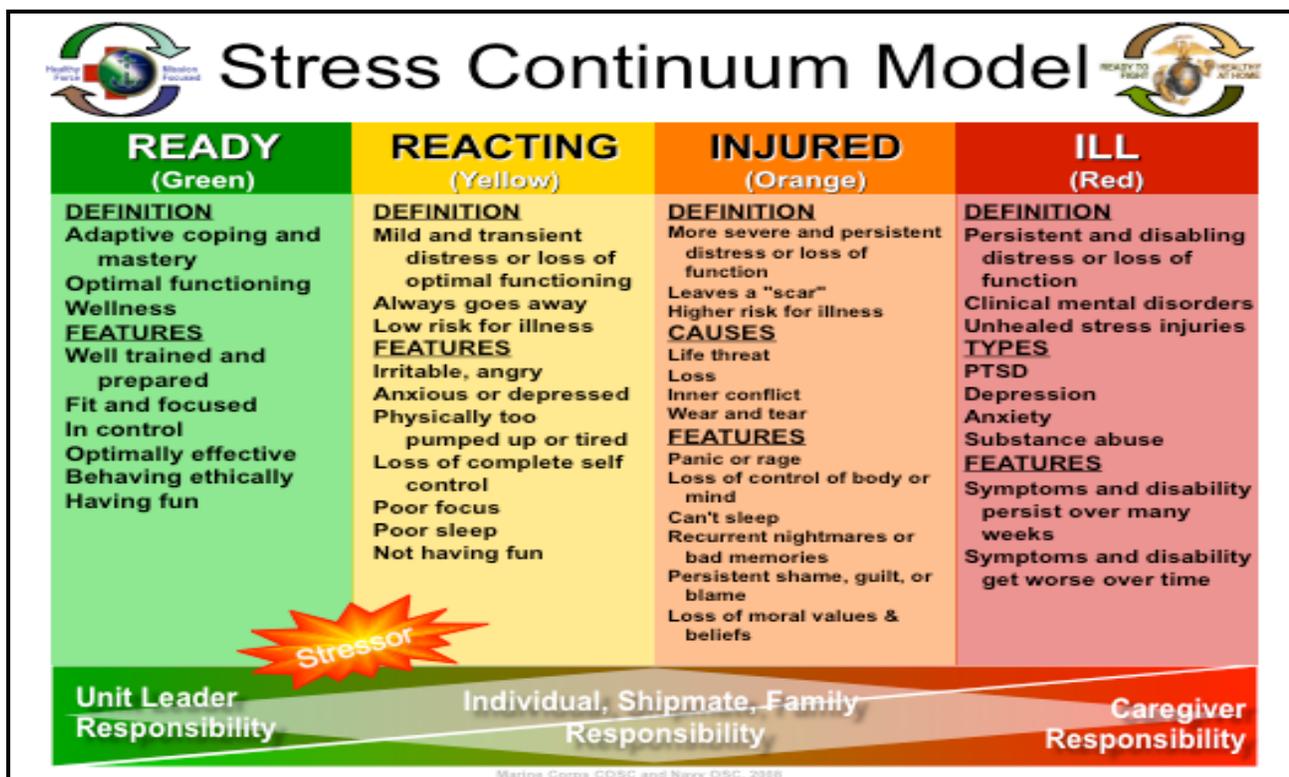
So far, the terms we have discussed are not psychiatric diagnoses, just descriptions of normal reactions to extraordinary events. Posttraumatic Stress Disorder—PTSD—is a diagnosis. So how do we get there?

One essential thing to remember is that combat/operational stress reactions are *necessary* to survive in combat. They result in the exceptional strength, endurance, courage, loyalty, and leadership needed to perform the duties of a combat deployment. They also lead to feelings of excitement, adrenaline, and social belonging, which protect service members from burnout and complacency. It is only when “traumatic events” occur, such as intense combat action, accidents or tragic events, or overwhelming operational wear and tear, that combat/operational stress injuries become expected and problematic.

The Navy and Marine Corps **Stress Continuum Model** illustrates the progression of combat/operational stress reactions. The “Stressor” is any of the stressors mentioned above that can occur during a combat deployment or in an intense operational environment.

Other signs you may see include physical complaints like headaches, muscle tension, chronic pain, stomach or digestion problems; also fatigue, loss of energy, changes in appetite, crying spells; behaviour such as social withdrawal or violent outbursts; and emotional responses like loss of confidence, indecision or confusion, emotional numbing or indifference. It is *only* when symptoms and features are in the “red,” meaning they cause *significant distress* and *interfere* with the service member’s personal and occupational activities, that an illness such as PTSD is considered and diagnosed.

Like all stress, “traumatic stress” causes the body to react physically, mentally, and emotionally to prepare itself for danger. Unlike other stressors, however, a traumatic event is so horrifying that it can damage deeply-held beliefs or values, contradict belief in one’s basic sense of safety, and shatter expectations about “how the world works” and “what’s right” (like “good things happen to good people”). Most people are able to resolve these mental and moral conflicts in a relatively short period of time. Essentially, often with support from their unit, friends, and family, they return from “Orange” or “Yellow” to “Green.” However, in some cases, the normal stress reaction that occurs after a traumatic event does not shut off as it is supposed to, and, rather than settling into recovery and relaxation after the trauma, these individuals live in perpetual preparation “just in case” the event happens again. This is PTSD.



PTSD is a treatable anxiety disorder that can occur when “Yellow” and “Orange” symptoms persist at least 30 days after traumatic event *and* disrupt normal functioning. Symptoms may also start months or years after the traumatic event when something triggers the old stress reaction. Individuals with PTSD will often go to any lengths to protect themselves and their loved ones against the threat, however unrealistic it may be. Since their stress reaction is still turned on, like it was in combat, this may include strong startle reactions after threatening noises (hitting the deck or looking for cover), avoidance of threatening places (pot-holed streets and crowded places), and often being reminded of the traumatic event because their brain is very attuned to warning signs (smell of BBQ or sight of helicopters). They may also engage in paranoid behavior like “clearing” the house before going to sleep and sitting with their back to wall in restaurants. To understand where these reactions come from, imagine being in a foreign country where the enemies sometimes dress like allies, and deadly force like an IED blast or a mortar attack can come out of nowhere. What would you do, even without training, to keep yourself and the people around you safe? What if you could not get yourself to believe, no matter how much you wanted to, that it was really over? This is PTSD.

Most people experience at least one event in their life that could be considered traumatic (e.g., car accident, mugging, sudden death of a relative), and in fact most people do not experience long-term consequences from these events. However, if all 6 of the following criteria are met, than PTSD can be diagnosed:

**Criterion A:** One or more “traumatic events” are experienced, which involve threats to the life or limb of the individual or someone he/she is associated with and cause a feeling of terror, horror, or helplessness.

**Criterion B:** The traumatic event(s) is “re-experienced” through dreams, nightmares, disturbing memories or thoughts, flashbacks that feel like the event is re-occurring, or even hallucinations.

**Criterion C:** Anything associated with the traumatic event(s) is avoided. Situations avoided might include noises, sights, and smells that trigger memories, conversation about the event(s), and people and places associated with the event(s) or that seem threatening (like crowds of strangers). Individuals may also avoid emotions because of the strong, negative emotions associated with their trauma(s), and may appear numb, “cold,” or detached.

**Criterion D:** The service member experiences increased and excessive arousal symptoms, such as difficulty falling or staying asleep, irritability or anger outbursts, concentration problems, suspiciousness or paranoia, and exaggerated startle responses to triggers of anxiety. They may feel agitated all the time and can’t calm down or relax. They may also increase impulsive or reckless behaviors in order to match their inner feelings, such as overspending, driving fast, or picking fights.

**Criterion E:** The symptoms last more than 1 month and have started or continued at least 1 month after the traumatic event ended.

**Criterion F:** The symptoms cause significant distress and problems in the service member’s social or occupational life

- Education and social support are two of the best medicines we have to address *and prevent* combat/operational stress. PTSD, however, will not go away on its own. Use the following resources to increase your own knowledge. **And ask for help if you need it!**

## Resources for Combat/Operational Stress and PTSD

### **Books:**

- Armstrong, K., Best, S., & Domenici, P. (2006). Courage After Fire: Coping Strategies for Troops Returning from Iraq and Afghanistan and Their Families. Berkeley, CA: Ulysses Press.
- Cantrell, B. C. & Dean, C. (2005). Down Range to Iraq and Back. Seattle, WA: Word Smith Books
- Grossman, D. (1995). On Killing: The Psychological Cost of Learning to Kill in War and Society. New York, NY: Back Bay Books
- Grossman, D. (2004). On Combat: The Psychology and Physiology of Deadly Conflict in War and in Peace. USA: PPCT Research Publications
- Hart, A. B. (2000). An Operators Guide to Combat PTSD: Essays for Coping. Writer's Showcase Press
- Kraft, H. S. (2007). Rule Number Two: Lessons I Learned in a Combat Hospital. New York: Little, Brown, and Co.
- Mason, P. H. C. (1990). Recovering From the War: A Woman's Guide to Helping Your Vietnam Vet, Your Family, and Yourself. New York, NY: Penguin Books.
- Matsakis, A. (2007). Back From the Front: combat Trauma, Love, and the Family. Baltimore, MD: Sidran Institute Press.
- Matsakis, A. (1996). Vietnam Wives: Facing the Challenges of Life with Veterans Suffering Post-Traumatic Stress, 2<sup>nd</sup> Ed. Baltimore, MD: The Sidran Press.
- Shay, J. (1995). Achilles in Vietnam: Combat Trauma and the Undoing of Character. New York, NY: Simon & Schuster.
- Shay, J. (2003). Odysseus in America: Combat Trauma and the Trials of Homecoming. New York, NY: Scribner
- West, B. (2005). No True Glory: A Frontline Account of the Battle for Fallujah. New York, NY: Bantam Books
- Williams, M. B. & Poijula, S. (2002). The PTSD Workbook. Oakland, CA: New Harbinger Publications
- Lanham, S.L. (2007). Veterans and Families' Guide to Recovering from PTSD. Annandale, VA: Purple Heart Service Foundation (FREE)

### **Websites:**

- Courage to Care Campaign: <http://www.usuhs.mil/psy/courage.html>
- [www.killology.com](http://www.killology.com) / [www.WarriorScienceGroup.com](http://www.WarriorScienceGroup.com) (Lt Col. Dave Grossman)
- Leaders Guide for Managing Marines in Distress: <http://www.usmc-mccs.org/LeadersGuide>
- Military One-Source: [www.militaryonesource.com](http://www.militaryonesource.com)
- National Center for PTSD: [www.ncptsd.va.gov](http://www.ncptsd.va.gov)
- Sesame Street Parents: <http://archive.sesameworkshop.org/tlc/> (education for kids)
- TogetherWeServed: [www.togetherweserved.com](http://www.togetherweserved.com) (find people you served with)
- Veterans Administration: [www.va.gov/rcs](http://www.va.gov/rcs), <http://www.vetcenter.va.gov/>
- Warrior Mind Training: <http://warriortraining.us> (meditation for warriors)
- Purple Heart Service Foundation: [www.pupleheartfoundation.org](http://www.pupleheartfoundation.org)

### **Mental Health/Medical Resources:**

**Mental Health Clinic** (NHCL): 910-450-4700

**FOCUS Project**: 910-330-7969

**Military and Family Life Consultant Program**: 910-546-1114/910-478-5039

**Community Counseling Center**: 910-451-2864/2865 (individual and marital counseling)

**MCCS/Semper Fit**: 451-2865 (health & fitness programs, martial arts, stress/anger management, communication classes, parenting classes)

**Tricare**: 1-800-tricare, and **Military One-Source**: 1-800-464-8107 (12 free counseling sessions)