Painful Stories Take a Toll on Military Therapists

By BENEDICT CAREY, DAMIEN CAVE and LIZETTE ALVAREZ

Many of the patients who fill the day are bereft, angry, broken. Their experiences are gruesome, their distress lasting and the process of recovery exhausting. The repeated stories of battle and loss can leave the most professional therapist numb or angry.

And hanging over it all, for psychiatrists and psychologists in today’s military, is the prospect of their own deployment — of working under fire in Iraq or Afghanistan, where the Pentagon has assigned more therapists to combat units than in previous wars.

That was the world that Maj. Nidal Malik Hasan, an Army psychiatrist, inhabited until Thursday, when he was accused of one of the worst mass shootings ever on a military base in the United States, an attack that killed 13 and left dozens wounded. Five of the dead were fellow therapists, the Army said.

Major Hasan’s motives are still being investigated. But those who work day in and day out treating the psychological wounds of the country’s warriors say Thursday’s rampage has put a spotlight on the strains of their profession and of the patients they treat.

Major Hasan was one of a thin line of military therapists trying to hold off a rising tide of need. So far this year, 117 soldiers on active duty were reported to have committed suicide. The Army has only 408 psychiatrists — military, civilian and contractors — serving about 553,000 active-duty troops around the world. As a result, some soldiers home from war, suffering from nightmares and panic attacks, say they have waited almost a year to see a psychiatrist.

Many military professionals, meanwhile, describe crushing schedules with 10 or more patients a day, most struggling with devastating trauma or mutilated bodies that are the product of war and the highly advanced care that kept them alive.

Some of those hired to heal others end up needing help themselves. Some go home at night too depressed to talk to their children. Others, like Bret A. Moore, a former Army psychologist at Fort Hood, ultimately quit.

“I planned for a career in the military, but I burned out” after about five years, he said.

The biggest problem, Dr. Moore said, was “compassion fatigue.”

“I thought that was a bogus phenomenon, but it’s true,” he said. “You become detached, you start to feel like you can’t connect with your patients, you run out of empathy. And the last thing you want to do is talk about it with someone else. It really puts a wedge between you and loved ones.”
Whatever the facts in Major Hasan’s case, some therapists who work with the military agree that the tragedy is likely to have a “lasting impact on how we look at mental health providers,” said Dr. Martin Paulus, a psychiatrist at the University of California, San Diego, and the Veterans Affairs San Diego Healthcare System.

The Army has added to their ranks in recent years, as the number of soldiers with the diagnosis of post-traumatic stress disorder has climbed to 34,000. But the shooting has raised a pressing question: Who counsels the counselors? Dr. Moore and other therapists who have worked in the military or for Veterans Affairs said that mental health evaluations of therapists themselves were virtually nonexistent.

“I have worked with the Army, the Navy, the V.A., and I’m not aware of any formal, systematic process to evaluate professionals,” said Dr. Andy Morgan, a psychiatrist at the National Center for P.T.S.D.

At Walter Reed, where Major Hasan was in training until recently, Lt. Col. Brett Schneider, a psychiatrist, described a complicated system of checks and balances, including a training committee with superiors and civilians who evaluate residents and mental health staff members.

“There is a lot more built into the processes to keep tabs on each other,” said Colonel Schneider, who spoke on the condition that he not be asked any questions about Major Hasan. “If somebody is starting to get to the point where these things are a problem, there are a number of ways we can intervene.”

Generally, though, the military, like many large civilian employers, relies on self-evaluation and voluntary employee-assistance programs.

“Once training is over, you’re basically on your own,” Dr. Paulus said.

At Fort Hood, the nation’s largest military base, Major Hasan, like other therapists, would have had to manage many patients with severe combat stress. At his relatively high rank, he would have been expected to seek help on his own if he thought he needed it, experts said.

The base sees continual traffic in and out of war zones, and the work conditions are especially stressful, according to at least one report provided to the Army.

Dr. Stephen M. Stahl, a psychiatrist at the University of California, San Diego, who worked on the report, said the base’s program for soldiers returning from war simply lacked the staff it needed. He said there were about 15 psychiatrists on staff, treating hundreds of inpatients and outpatients. Generally, the psychiatrists did not do therapy but prescribed medication.

“They’re so under-resourced that people just don’t end up getting enough care,” Dr. Stahl said.

He added: “It’s a pretty damn stressful place to be. I think it’s a horrible place to practice psychiatry.”

Soldiers described similar situations at many other installations. Jason Yorty, 34, an Arabic linguist with the Army who deployed to Iraq four times and Afghanistan once, said that when he returned to Fort Gordon in Georgia two years ago, the system appeared to be overwhelmed and resistant to diagnosing problems that would require multiple visits.
First, he said, he saw a physician’s assistant at the base, then a clinical social worker, neither of whom agreed that his nightmares and panic attacks amounted to post-traumatic stress disorder. “It took me eight months just to get an appointment to see a psychiatrist,” he said. “When I got there, he blew me off.”

A few weeks later, after he refused the Army psychiatrist’s prescription for a sleep aid, a nonmilitary mental health provider gave him a diagnosis of P.T.S.D.

Experts say that the military has made big strides in taking mental health issues seriously, but that military therapists are sometimes pressured to place the needs of the force above the needs of the patient. Indeed, they can be overruled by commanders who need soldiers in the field.

Since 2001, the military has deployed many soldiers with post-traumatic stress disorder or other ailments. “The focus in the military is readiness,” said Charles Figley, a psychologist at Tulane University. “There is an inherent conflict.”

And in war zones, the relationships between soldiers and mental health providers can be especially fraught. Therapists in Iraq said that they could often do little more than provide a few coping tips to soldiers, just enough to keep them functioning. There were simply too many people and not enough time, as Army officials have acknowledged.

Providing care has its own risks. In studies of therapists working to soothe mental distress in victims of violence, whether criminal, sexual or combat-related, researchers have documented what is called secondary trauma: contact distress, of a kind. In one 2004 study of social workers on cases stemming from the Sept. 11 attacks, researchers found that the more deeply therapists were involved with victims, the more likely they were to experience such trauma. The same associations have been found in doctors working with survivors in war zones.

Dr. Hasan was reportedly facing his first deployment — a prospect that scares even trained fighters, many of whom become increasingly frantic before going to war, according to surveys.

The workload itself is enough to give psychiatrists and psychologists pause. In Iraq, with sectarian violence at its peak in 2007, officials say there were 200 such specialists serving more than 130,000 troops, driving between bases on bomb-rigged roads.

The experience of Lt. Col. Reagon P. Carr was common. In six months with the Second Brigade of the 10th Mountain Division in 2007, he said he saw more than 700 soldiers. In one typical week, he visited three locations, meeting with 36 soldiers who came in for immediate help: 3 were contemplating suicide, a dozen were unable to sleep, 5 said they were apprehensive about returning to a dysfunctional marriage and 16 said they were disgruntled with their leadership.

Few who are deployed feel prepared for this punishing task.

Dr. Peter Linnerooth, a former Army psychologist who treated soldiers in Germany and Iraq and at Fort Hood, said that in Schweinfurt, Germany, he was the sole psychologist for a community of 10,000 people in 2005.

At Fort Hood, he treated a burly man whose job in Iraq was to recover the bodies of soldiers. His patient
was devastated by one particular loss, Dr. Linnerooth said.

“He had picked up this corpse that was so badly burned, it weighed about 20 pounds,” he said. “He was this big, tough, awesome guy. For him, it was like picking up his daughter. That was an extreme case. But you get those at least once or twice a week.”

If it turns out that Major Hasan did in fact break partly under the stress of the job and impending deployment, many veterans would not be surprised.

“If this guy can go over the edge, imagine what it is like for the actual combat troops who have been through four or five deployments,” said Bryan Hannah, 22, a disabled Iraq war veteran from San Marcos, Tex., who was stationed at Fort Hood until he was discharged a year ago because of post-traumatic stress disorder and other injuries.

He added, “There are a lot of others who are worse off than him.”

_Erica Goode and Gretel C. Kovach contributed reporting._