

The American Institute of Stress

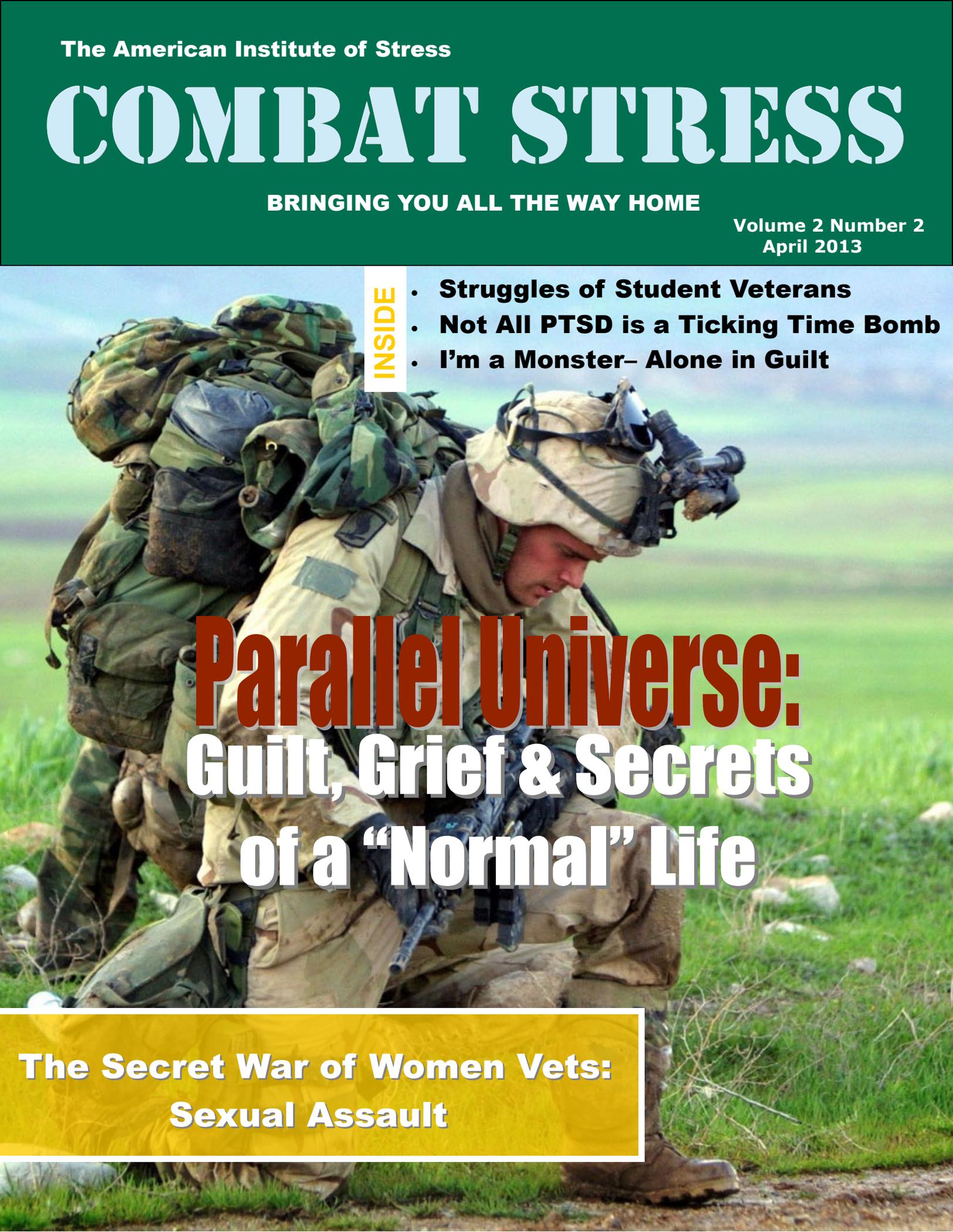
COMBAT STRESS

BRINGING YOU ALL THE WAY HOME

Volume 2 Number 2
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The mission of AIS is to improve the health of the community and the world by setting the standard of excellence of stress management in education, research, clinical care and the workplace. Diverse and inclusive, The American Institute of Stress educates medical practitioners, scientists, health care professionals and the public; conducts research; and provides information, training and techniques to prevent human illness related to stress.

AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.

Your source for science-based stress management information

COMBAT STRESS

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Combat Stress is a quarterly newsletter with news and advertising designed with Service Members, veterans and their families in mind. It appeals to all those interested in the myriad and complex interrelationships between combat stress and health because technical jargon is avoided and it is easy to understand. Combat Stress is archived online at stress.org. Information in this publication is carefully compiled to ensure accuracy.

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Parallel Universe

by Alison Lighthall, MSN, RN, FAIS
Editor, *Combat Stress*

Severe psychological trauma is a special kind of broken-heartedness. It takes up residency in us, sometimes making itself known in cruel ways, and other times taking a quiet nap from which it can be quickly and easily aroused. It is a permanent condition that, with time, eases up its grip on us or goes blessedly into dormancy, but never actually ends.

Because of this trauma, whether it is a singular event or arises from a kind of psychological repetitive stress injury, our world is sometimes ruled by huge emotional energy and struggles. Over time (much time, if you're doing it all on your own) we come into an entirely new way of living. Instead of returning to normal, as we were always able to do in the past from life's more typical trials, we find ourselves very much stuck in a universe that most others cannot see and do not understand, but one which inflicts a deep, throbbing ache. We slowly realize that the hole in our heart will not heal,

that this sadness, fear, or anger is our new normal. Whenever we confront such a thought, we quickly push it out of our minds because it is an intolerable thought—to live forever haunted by anguish.

Somehow, though, and quite inexplicably to us, the world continues. Time on the clock keeps passing, despite our being frozen back in that moment of excruciating pain when our world exploded. If we're lucky, over time we gradually learn more about what happened to us. We begin to organize the events a little better, our frontal lobe reopens communication with our limbic system, and we become fully conscious and in the moment once again.

We slowly release our grip on the reality that *was*—our pre-trauma reality—and we stop arguing with the universe about what *is*. Eventually, we accept the chronic pain as a stubborn compan-

ion. And gradually, we resynchronize with the world's clock.

Smiling isn't always forced anymore. We learn to ignore the ache and sorrow enough to actually forget about it sometimes. Then one day a sound jumps out of us that, both familiar and forgotten, startles us: a mirthful laugh. Slowly, carefully, we pick up speed. A new home. A new pet. A new job. Some new friends. It seems safe to start living a little bit again.

For a while, even this small amount of happiness is intoxicating and all-consuming. Color begins to fill in what has been seen as shades of grey. Life has meaning again. A sense of purpose, for so long absent, is now palpable. We realize we're not dead after all.

The new life eventually becomes just life, a set of patterns that are comforting and familiar and no longer new. And it is at that point, just when we think the mileage we've logged traveling from then to now has been enough to keep us away from that painful place forever, that something reawakens the trauma and without warning, the pain returns.

At first we are confused. *Something else has to be responsible for these feelings that are so out of time sequence...right? I must be coming down with something. It's probably all the stress at work. It must be my marriage. I guess I'm officially going crazy at long last.*

That slumbering, noxious companion—the memories of trauma—is now up and around and in need of attention after such a long nap. It parks itself in the

middle of our no-longer-new life, waiting for us to acknowledge it. We look at it in astonishment for several days or even weeks. But slowly the truth dawns on us; it's not going anywhere. We're going to have to make room for this thing; we're going to have to name it. And after years of ignoring it, we may even have to climb inside it.

Yet, we look around our life, and we can see the goodness that has managed to find its way in. This sadness, fear, and anger that are so deep inside us doesn't make the goodness go away. The goodness that surrounds us doesn't make the sadness, fear, and anger go away. We are simultaneously both happy *and* sad. We are both here *and* back there. These two universes exist for us, within us, at the same time. At the mo-

The people around us don't even know the other universe exists, much less what it's like to live in its fire.

ment we are happy, there is still a profound sadness. When we are lost in the pain of our traumatic sorrow, our other life—the good and happy life— still exists, waiting for us to re-engage in it.

The problem is, the world around us—the people who have not lived through what we have, and haven't suffered the terror, grief, and agony that we have—only see their universe, the normal universe. The people around us don't even know the other universe exists, much less what it's like to live in its fire. They don't know that sometimes we're so overcome with sorrow that we curl up into a ball and sob inconsolably, or we become so consumed



with rage that we think about violence. They don't know about the night terrors or the depression that we plummet into at certain times of the year or whenever we hear a certain song. They think what we tell them to think: that we're "fine."

Finally, we reach a breaking point and we share the details of our secret, parallel universe with someone. We tell him about our grief, the unwelcome companion that lives invisibly in our space. It might be a total stranger who is the first to hear of our true suffering: a Vietnam vet sitting next to us on the plane, a social worker at a neighbor's barbeque.

Afterwards, even if we are still vibrating from having relived our story, we're surprised to find that we actually do feel better for having told it to *someone*. We wonder if maybe sharing our truth with those who love us might not be such an ordeal after all. And maybe suffering in

this hell all alone isn't necessary... *Knowing* is a funny thing. It's different from sensing or suspecting or wondering. Once we know something, we can't unknow it. The act of speaking our truth helps us to actually know our truth. It brings the pain, guilt, sorrow, remorse, anger, shock, loneliness, embarrassment, and bereavement into the light, and once in the light they can never again crawl back into the dark corners of your soul.

The only true antidote I have ever found for surviving the pain and anguish I sometimes feel from living in these two parallel universes is the authentic, enduring loving-kindness of another human being, who wishes nothing more than to climb inside my world with me to keep me company while I figure out what to do with my broken heart. Only then does life become bearable and the clock begins to move forward again.

PSTD Vets Given Drugs Against Guidelines

IOWA CITY, Iowa, Feb. 12 (UPI) -- IOWA CITY, Iowa, Feb. 12 (UPI) -- Veterans with post-traumatic stress disorder are prescribed psychiatric drugs not supported by U.S. Department of Veterans Affairs guidelines, researchers say.

Dr. Thad E. Abrams and Dr. Brian Lund, both of the Center for Comprehensive Access and Delivery Research and Evaluation, Iowa City Veterans Affairs Health Care System, and colleagues analyzed fiscal year 2009 electronic pharmacy data from the Veterans Health Administration for 356,958 veterans with PTSD who were receiving medications from VHA prescribers.

The study examined veterans who had at least one VHA encounter with a diagnostic code of PTSD and evidence of continuous medication use. Medications of interest were selective serotonin-norepinephrine reuptake inhibitors, second-generation anti-psychotic medications and benzodiazepines -- Librium and also marketed as diazepam or Valium.

The study, published in *Psychiatric Services*, found in 2009, among all veterans with PTSD who had continuous VA medication use, 65.7 percent were prescribed selective serotonin-norepinephrine reuptake inhibitors; second-generation anti-psychotics were prescribed for 25.6% of these veterans; and benzodiazepines were prescribed for 37%. These were often in addition to approved drugs for pain, insomnia, anxiety any depression.

The findings indicated veterans with PTSD were frequently prescribed medications not supported by existing guidelines of the U.S. Department of Veterans Affairs and the U.S. Department of Defense.



KUDOS

INNER BALANCE STRESS REDUCTION APP

By: Paul J Rosch, MD, FACP

There is little you can say about "stress" that applies to everyone because it is different for each of us. Things like a steep roller coaster ride or bungee jumping are very distressful for some people but an exhilarating thrill for others. We also respond to the same stressor in diverse ways ranging from headache and low back pain to gastrointestinal and dermatologic complaints or palpitations.

Similarly, no stress reduction strategy is a panacea. Jogging, meditation, yoga, progressive muscular relaxation, cognitive-behavioral restructuring, visual imagery or listening to music may be very effective for some, but prove dull, stressful and boring when arbitrarily imposed on others. You have to find out what works for you so that you adhere to it because you want to, rather than comply with a recommendation that someone else is promoting for personal reasons rather than proof of efficacy.

There are over 50 stress reduction apps for smart phones and other mobile devices that promise to reduce stress by teaching you to breathe correctly, meditate, promote muscle relaxation, restful sleep, or even simply listening to music or playing games. These may provide transient placebo benefits, since, as Celsus noted over 2,000 years ago, "Part of the cure is the wish to be cured". However, they are unlikely to furnish sustained relief.



So, how can you determine if your symptoms are stress related, how much stress you are experiencing or whether an app or any other stress reduction intervention is really helping you?

Popular devices that measure electrodermal (GSR or Galvanic Skin Response) and thermal (Mood Rings) activities are notoriously inaccurate. Muscle tension (EMG), fingertip temperature and EEG feedback are superior for specific symptoms but are time consuming and expensive. The best barometer for assessing stress levels and monitoring their response to treatment is real time HRV (Heart Rate Variability) feedback. As also explained in previous Newsletters, this research, which was pioneered by HeartMath, culminated with the development of their handheld emWave device. Having just finished testing their recently introduced Inner Balance app based on this technology, I suspect it will also be a stunning success for the following reasons.

- Ease of Use And Superb Support – As can be seen to the left, the attractive multicolored screen displays your HRV level and other information. The device also monitors, records and saves each session so that you can easily review your progress. To start, simply connect the earpiece sensor to the fleshy part of your earlobe and tap in the space below the breath pacer to start your session. A finger sensor is also available. Follow the pacer and the prompts that appear, which teach you how to adjust your breathing pattern to obtain optimal results. This is very much like having a built in personal coach who provides constant guidance. Helpful books are available but there are also a host of free webinars at www.heartmathwebinar.com that allow you to zero in on specific topics such as depression, anxiety, insomnia, how to meditate, get into the "zone", and most importantly, promote psychophysiological coherence.
- A state of coherence is associated with a feeling of deep relaxation and inner calm but also increased focus and awareness due to synchronization between heart rate variability, breathing and brain wave patterns. One screen features a brightly colored circle that pulses at the best breathing pace for you to attain optimal benefits. Another has a soothing photo of a waterfall that you can replace with anything you choose and you can also select music to listen to during your sessions. You also determine the length of each session, which usually varies from three to ten minutes depending on how rapidly you learn. In that regard, you can increase the level of difficulty for each session to improve your skills. At the conclusion of each session, you will get a report on how you did, including an overall score measured as "coherence points."
- Inner Balance™ is the only technology I am aware of that measures HRV coherence, which could explain why, in its prelaunch debut at the 2013 Consumer Electronic Show, it earned two accolades in the top 25 apps for both the App Showdown award and the prestigious Last Gadget Standing award. Another reason may be that the Inner Balance iOS sensor for Apple's mobile operating system allows it to be used on an iPad, iPod Touch as well as iPhones. All these features are built in to the Inner Balance app so there is no need to access a computer to see your results or track your progress. This is a bargain at 99 cents, especially since technical assistance is readily available. An Android version should be available soon.

Women Vets' Secret War: Sexual Trauma

By Kim Ode, Star Tribune

66,342 female veterans reported assaults from 2002 to 2008 -- by their band of brothers.

Judy VanVoorhis knew that some men thought she had no business serving in the National Guard. How? She smiled fleetingly. "They told me." The military world often lacks the nuance of civilian life. She had enlisted in 1985 and moved steadily through the ranks, becoming an instructor at an officer training school. In 1999, while at a conference, a group of instructors went out for supper.

"One guy seemed like he was trying to get everyone drunk, without drinking too much himself," she recalled. "I left, but he cornered me and tried to kiss me and I said I wasn't interested." She went up to her room, only to discover that he'd followed her. She doesn't remember much about the assault that followed. "I was so shaken after it happened, I wanted to forget about it. You don't expect this from the people you're supposed to trust. I said no and that's all I had to say."



Judy VanVoorhis, a major in the Guard, groomed her horse after a ride. She has begun to heal from an assault at officer training school.

She might never have told anyone, had a male colleague not seen her flinch during a meeting when her attacker's name was mentioned. When he later pulled her aside to ask if she was OK, she told him everything. Turns out he had suspected as much.

"He told me, 'You're the fifth woman

who's told me this same story." According to the U.S. Department of Veterans Affairs, 66,342 female veterans reported being raped, sexually assaulted, or experiencing another form of military sexual trauma (MST) from 2002 through 2008. Almost 3,000 military sexual assaults were reported by men and women in 2008, with 163 sexual assaults reported in Iraq and Afghanistan. Another way to look at the numbers: More than 100 American women have died in Iraq; more have been sexually assaulted. As Rep. Jane Harman, D-Calif., a member of the House Homeland Security Committee, observed, "A woman who signs up to protect her country is more likely to be raped by a fellow soldier than killed by enemy fire." The problem has been evident for decades. One in three female vets from Vietnam through the first Gulf War said they were raped while serving, according to a survey by the American Journal of Industrial Medicine. Among civilian women, the rate is one in six.

For all veterans, the odds of developing post-traumatic stress disorder from sexual assault are higher than from exposure to combat, according to a report presented in 2008 as part of a Department of Defense conference for sexual-assault response coordinators. Get female vets together over coffee, and some of them will describe a culture that can, at times, be startlingly hostile, such as something as humdrum as marching cadences. (*I've seen her stripped / I've seen her bare / I've felt her over everywhere.*)

Helen Benedict, who last year wrote "The Lonely Soldier: The Private War of

Women Serving in Iraq," said that military culture is "as hypermasculine as you can get," having regarded women as prey or a spoil of war since biblical times.

The women in her book said they felt most uncomfortable around the older men, "men who may be just a decade older, but the type of men who don't believe women belong in the military," said Benedict, a journalism professor at Columbia University in New York City. "It's a sign of hope, really, in that once all those people have aged out and younger peers who are more used to seeing women as equal are in charge, there will be a generational change."

A father's warning

Here's another story. This woman, who attained the rank of lieutenant before leaving the service last year, would like to be more candid, but she doesn't want her young children to learn about their mother's trauma just now.

The day before she left for boot camp in 1992, all of 18 years old, her dad pulled her aside. He'd made a career of military service, as had much of her family. It was natural for her to enlist after high school graduation. "I was never raised that things were different for boys and girls," she said. "My father was, like, the original feminist."

Yet that day, her father felt like he needed to warn her. *Guys are going to like you*, he said. *A lot.*

"I'd never dated in high school, so I didn't know why he thought things would suddenly change," she recalled. "I was the youngest, so I figured he was just worrying."

Within a year of enlisting, his daughter became one of those statistics when her superior called her into his office, asking her to close the door. "That was my first mistake, but he was my superior and I never thought anything of it," she said. "He shoved me up against the wall and told me exactly what I was going to do to him. I kicked him where it mattered and ran from the room."

She reported the incident but was told that it came down to her word against his. "So it starts when you're young and carries over," she said. "You start watching your back, being careful who you're alone with. Which just increases the isolation."

She reported the incident but was told that it came down to her word against his.

So it went for several years. Lonely, she married a fellow soldier. They had a child, but later divorced. In 1999, when she was 26 and attending officer training school in Rhode Island, a friend of her ex-husband's showed up under the guise of checking on her. He raped her. She didn't report it because he was a superior officer; she feared that no one would believe her.

Rape? It feels more like incest
Among female vets with post-traumatic stress disorder, most were sexually assaulted or raped while in the service. The physical harm of sexual assault is clear, but it's the emotional damage that lingers. Attackers aren't the enemy, but

comrades -- battle buddies for whom they're prepared to sacrifice their lives. A woman can't help but wonder whether these guys also would be willing to die for her.

Reporting an assault takes a different sort of courage than that honed in boot camp. "Military sexual trauma isn't stranger rape, but incest," said the lieutenant, who is 36. "That changes things a lot. It's people we work with, people I thought of as brothers. No one [in a unit] wants to believe it, because if he turns out to be a bad guy, then it's like they've all been assaulted."

"Military culture is a part of American culture, but in many ways has its own values, rules, customs, and norms. Therefore, sexual assault in the Armed Services cannot be addressed in exactly the same way as it is in civilian society." So states the Defense Department's annual report on Sexual Assault in the Military Services.

Lt. Col. Cynthia Rasmussen says the culture is changing. She has seen it over her long career as a mental health nurse with the U.S. Army Reserves. She's currently the sexual assault response coordinator and director of psychological health for the 88th Regional Support Command in Minneapolis. She works with military personnel in 19 states from enlistment through reintegration. Her main task is helping a home community learn how to address the needs of its veterans. "If you don't understand the military culture -- that we'll die for each other -- if you don't understand that, how can you help?"

Rasmussen makes no excuses for the culture of the past, but says that "the military actually is talking about this more than people in general society." The official policy of the Veterans Health Administration is to provide veterans experiencing MST (military sexual trauma) with free care for all physical and mental health conditions related to MST.

More women coming forward
Rasmussen attributes the rise in reports not to an increase in assaults, but to more women (and men) feeling that it's safer to come forward because of a change in reporting policy. Before 2004, all reports of sexual assault were forwarded to law enforcement, which sometimes made the person complaining feel further victimized by others in their shattered unit.

With the Defense Department's own statistics indicating that only 20 percent of unwanted sexual contacts were reported, changes were necessary. In June 2005, the restricted reporting policy said that reports of sexual assault would be provided to a health care provider, the sexual assault response coordinator, or a victim advocate, but not reported to law enforcement without the victim's consent.

"We knew numbers would go up," Rasmussen said. "But we were happy," because it meant that more people were willing to come forward and seek help.

As to addressing the necessary culture change, the department's slogan "Hurts one. Affects all" equates a safer military climate with mission readiness.

As this year's Department of Defense report on sexual assault states: "In the

Armed Forces, sexual assault not only degrades individual resilience but also erodes unit integrity. ... Sexual assault is incompatible with military culture, and the costs and consequences for mission accomplishments are unbearable."

Seek help, no matter what.

Despite learning of her rapist's past, VanVoorhis told no one. "You're afraid [reporting] will ruin your career, like reporting sexual harassment," she said. "People become afraid of you. You're a whistleblower."

She grew depressed, retreating into herself. VanVoorhis, 44, who lives in a Twin Cities suburb, saw her work begin to suf-

"You're afraid [reporting] will ruin your career, like reporting sexual harassment," she said. "People become afraid of you."

fer; eventually she was diagnosed with post-traumatic stress disorder. Currently a major in the Guard, she is getting professional help to treat her PTSD and encourages others to seek help "no matter what," adding that it's important to find a therapist with experience in treating sexual trauma. She credits her own therapist, Colin Hollidge, "with saving my life."

She applauds the formal reporting procedure now in place, but says it's only a first step. "That only means that you can report something that's already happened. How to keep it from happening in the first place -- how to change the culture -- that's the bigger challenge."



'I'm a monster'

Vets 'alone' in their guilt

By Pauline Jelinek - The Associated Press

WASHINGTON — A veteran of the wars in Iraq and Afghanistan, former Marine Capt. Timothy Kudo thinks of himself as a killer — and he carries the guilt every day.

"I can't forgive myself," he says. "And the people who can forgive me are dead."

With American troops at war for more than a decade, there's been an unprecedented number of studies into war zone psychology and an evolving understanding of post-traumatic stress disorder. Clinicians suspect some troops are suffering from what they call "moral injuries" — wounds from having done something, or failed to stop something, that violates their moral code.

Though there may be some overlap in symptoms, moral injuries aren't what most people think of as PTSD, the nightmares and flashbacks of terrifying, life-threatening combat events. A moral injury tortures the conscience; symptoms include deep shame, guilt and rage. It's not a medical problem, and it's unclear how to treat it, said retired Col. Elspeth Ritchie, former psychiatry consultant to the Army surgeon general.

"The concept ... is more an existentialist one," she said.

The Marines, who prefer to call moral in-

juries "inner conflict," started a few years ago teaching unit leaders to identify the problem. And the Defense Department has approved funding for a study among Marines at California's Camp Pendleton to test a therapy that doctors hope will ease guilt.

But a solution could be a long time off.

"PTSD is a complex issue," said Navy Cmdr. Leslie Hull-Ryde, a Pentagon spokeswoman.

Killing in war is the issue for some troops who believe they have a moral injury, but Ritchie said it also can come from a range of experiences, such as guarding prisoners or watching Iraqis kill Iraqis as they did during the sectarian violence in 2006-07.

"You may not have actually done something wrong by the law of war, but by your own humanity you feel that it's wrong," said Ritchie, now chief clinical officer at the District of Columbia's Department of Mental Health.

Kudo's remorse stems in part from the 2010 accidental killing of two Afghan teenagers on a motorcycle. His unit was fighting insurgents when the pair approached from a distance and appeared to be shooting as well.

Kudo said what Marines mistook for guns

were actually “sticks and bindles, like you’d seen in old cartoons with hobos.” What Marines thought were muzzle flashes were likely glints of light bouncing off the motorcycle’s chrome.

“There’s no day — whether it’s in the shower or whether it’s walking down the street ... that I don’t think about things that happened over there,” said Kudo, now a graduate student at New York University.

“Human beings aren’t just turn-on, turn-off switches,” Veterans of Foreign Wars spokesman Joe Davis said, noting that moral injury is just a different name for a familiar military problem. “You’re raised ‘Thou shalt not kill,’ but you do it for self-preservation or for your buddies.”

Kudo never personally shot anyone. But he feels responsible for the deaths of the teens on the motorcycle. Like other officers who’ve spoken about moral injuries, he also feels responsible for deaths that resulted from orders he gave in other missions.

The hardest part, Kudo said, is that “nobody talks about it.”

As executive officer of a Marine company, Kudo also felt inadequate when he had to comfort a subordinate grieving over the death of another Marine.

Dr. Brett Litz, a clinical psychologist with the Department of Veterans Affairs in Boston, sees moral injury, the loss of comrades and the terror associated with PTSD as a “three-legged stool” of troop suffering. Though there’s little data on moral injury, he says a study asked soldiers seeking counseling for PTSD in Texas what their main problem was; it broke down to “roughly a third, a third and a third” among those with fear,

those with loss issues and those with moral injury.

The raw number of people who have moral injuries also isn’t known. It’s not an official diagnosis for purposes of getting veteran benefits, though it’s believed by some doctors that many vets with moral injuries are getting care on a diagnosis of PTSD — care that wouldn’t specifically fit their problem.

Like PTSD, which could affect an estimated 20 percent of troops who served in Iraq and Afghanistan, moral injury is not experienced by all troops.

“It’s in the eye of the beholder,” said retired Navy Capt. William Nash, a psychiatrist who headed Marine Corps combat stress programs and has partnered with

“There’s no day — whether it’s in the shower or whether it’s walking down the street ... that I don’t think about things that happened over there”

Litz on research. The vast majority of ground combat fighters may be able to pull the trigger without feeling they did something wrong, he said.

As the military has focused on fear-based PTSD, it hasn’t paid enough attention to loss and moral injury, Litz and others believe. And that has hampered the development of strategies to help troops with those other problems and train them to avoid the problems in the first place, he said.

Lumping people into the PTSD category “renders soldiers automatically into mental patients instead of wounded souls,” writes Iraq vet Tyler Boudreau, a former Marine captain and assistant operations officer to an infantry battalion.

Boudreau resigned his commission after having questions of conscience. He wrote in the Massachusetts Review, a literary magazine, that being diagnosed with PTSD doesn't account for nontraumatic events that are morally troubling: "It's far too easy for people at home, particularly those not directly affected by war ... to shed a disingenuous tear for the veterans, donate a few bucks and whisk them off to the closest shrink ... out of sight and out of mind" and leaving "no incentive in the community or in the household to engage them."

So what should be done? "I don't think we know," Ritchie said. Troops who express ethical or spiritual problems have long been told to see the chaplain. Chaplains see troops struggling with moral injury "at the micro level, down in the trenches," said Lt. Col. Jeffrey L. Voyles, licensed counselor and supervisor at the Army chaplain training program in Fort Benning, Ga. A soldier wrestling with the right or wrong of a particular war zone event might ask: "Do I need to confess this?" Or, Voyles said, a soldier will say he's "gone past the point of being redeemed, (the point where) God could forgive him" — and he uses language like this:

"I'm a monster."

"I let somebody down."

"I didn't do as much as I could do."

Some chaplains and civilian church organizations have been organizing community events where troops tell their stories, hoping that will help them re-integrate into society.

Some soldiers report being helped by Army programs such as yoga or art therapy. The Army also has a program to promote resilience and another called

Comprehensive Soldier Fitness to promote mental as well as physical wellness; some clinicians say the latter program may help reduce risk of moral injury but doesn't help troops recognize when they or a buddy have the problem.

Nash said the Marines are using "psychological first aid techniques" to help service members deal with moral injury, loss and other traumatic events. But it's a young program, not uniformly implemented and just now undergoing outside evaluation for its effectiveness, he said.

At Camp Pendleton, the therapy trial will be tailored to each Marine's war experiences; troops with fear-based problems might use a standard PTSD approach; those with moral injury may have an imaginary conversation with the lost person.

Forgiveness, more than anything, is key to helping troops who feel they have transgressed, Nash said.

But the issue is so much more complicated that wholesale solutions across the military, if there are any, will likely be some time coming.

Many in the armed forces view PTSD as weakness. Similarly, they feel the term "moral injury" is insulting, implying an ethical failing in a force whose motto stresses honor, duty and country.

At the same time, lawyers don't like the idea of someone asking troops to incriminate themselves in war crimes — real or imagined.

That leaves a question for troops, doctors, chaplains, lawyers and the military brass: How do you help people if they don't feel they can say what's bothering them?

GET INSIDE OUR HEAD

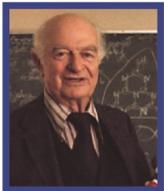


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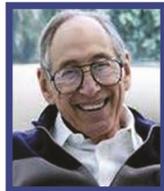
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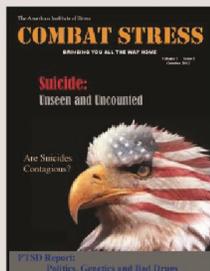
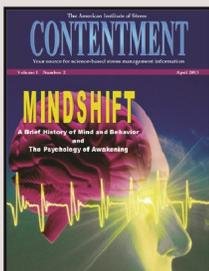
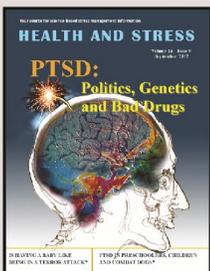
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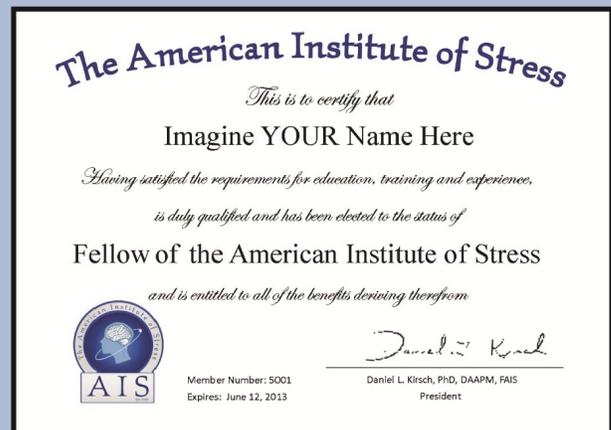
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Veterans' Stories

Traumatic Brain Injury In The Classroom

Filed by KOSU News in Public Insight Network.

The scars Sgt. Andrew Napier brought back from Afghanistan are mostly invisible, but they're still with him — and might be for life.

In 2008, Napier was a National Guardsman and college student studying medi-

cine. But after a semester spent buried under a stack of textbooks, he decided he'd rather be learning in the field. So he signed up for an overseas deployment and two months later found himself in Afghanistan, working as a combat medic and running convoy missions. During a convoy in Paktika Province, Afghanistan, in September 2008, Napier served as a combat medic in Afghanistan from 2008 to 2009 and is now applying to medical school in the United States. (Photo shared by Andrew Napier)

His deployment was literally a trial by fire. He survived his first ambush just three days after he arrived in the country: 27 minutes of mortars thudding down, rocket-propelled grenades streaking smoke trails across the sky, AK-47s firing "like popcorn," he says. The next day, a wounded Guard unit was brought into Napier's clinic. "The gunner had been ejected from the vehicle. Someone had lost a leg. One guy was dead. They brought all them in." A senior officer showed him how to clean the body of the soldier who was killed.



Andrew Napier stands in front of a supply truck that was ambushed

But it's an incident two months into his deployment that still haunts Napier.

He had been riding in a heavily armored vehicle, designed to withstand improvised explosive devices and land mines, when an RPG came through the roof and exploded in the seat next to him. "It knocked me out," he says. "I have no idea how long I was blacked out. I woke up to someone screaming that we were hit. When I woke up my nose was bleeding, I couldn't breathe, I was hacking out black stuff, I had migraines. I was a mess."

Napier was given 10 days off, working desk duty in a resting center. His nose stopped bleeding and his breathing got easier, but the migraines stayed. And he noticed "a big decline in myself mentally. I couldn't process things, I couldn't remember things, I had sleep problems. Directions were hard; I would get lost all the time. I had problems with speech and comprehension."

Napier was a medic: He had been trained to recognize the signs of a traumatic brain injury, or TBI, in his men. Now he was seeing them in himself.

Napier returned home in 2009 and returned to school as soon as he could. He was happy to be back in the classroom, but he was surprised by how challenging he found it. Before he deployed to Afghanistan, he had been earning a 3.9 GPA, with a full course load of advanced classes. The second time around, he was pulling a 3.0, taking remedial math and music appreciation courses as a part-time student. And while, in the past three years, Napier has slowly but surely improved — today, he's a Tillman Scholar applying to medical school — migraines

still bedevil him and he still sometimes struggles with memory and comprehension.

Napier's not alone. The number of traumatic brain injury diagnoses has increased markedly in the last decade. And TBI can be particularly problematic for student veterans, since, as it did for Andrew Napier, brain injury can impair the cognitive functioning that is crucial to academic achievement.

The Department of Defense reports that more than 250,000 traumatic brain injuries have been diagnosed in military service members since 2000. Along with post-traumatic stress disorder, TBI is one of the signature injuries of the wars in Iraq and Afghanistan. As we've reported, repeated traumatic brain injury can have devastating effects, on both short-term and long-term mental acuity.

As hundreds of thousands of service members leave the military, take advantage of their GI Bill benefits and enter higher education, colleges are starting to grapple with the challenge of how to best care for veterans on campus.

Editor's note: For more insight into the challenges that student veterans face, read "Ten Things You Should Know About Today's Student Veteran" at:

<http://www.nea.org/home/53407.htm>

PTSD Sufferers Are Not All Ticking Time Bombs

Blaming suspect's actions in sniper's death on disorder unfairly stigmatizes others.

By Kevin Sites

Eddie Ray Routh, an Iraq War veteran who has been charged in the killings of former Navy SEAL sniper Chris Kyle and another man at a Texas gun range, is widely reported to suffer from post-traumatic stress disorder.

Routh was placed in mental hospitals twice in the past five months, according to police records, the first for threatening to kill his family and himself and the second because someone called authorities fearful for Routh's own safety.

While these details paint a picture of a very troubled young man — he is undergoing a psychiatric examination to determine his competency to stand trial — inferences that PTSD somehow explains Routh's alleged actions risk making this kind of murderous violence synonymous with the condition and further stigmatizing those affected by it.

Though our knowledge of combat-related PTSD is growing, it's still a misunderstood condition. There are disagreements among mental health experts on both the number of troops affected (estimates as low as 4.3% to as high as 20%) and even the primary cause of the condition.

The clinical definition of PTSD cites wit-

nessing a traumatic event as the initiating factor. However, a 2009 study by the Department of Veterans Affairs posits the concept of "moral injury," that guilt about killing or not being killed in war might truly be the instigator. Studies also



Both suspect and victim apparently suffered from PTSD. But while one was a troubled man, the other lived a full, productive life. Which goes to show that wide variance of the condition.

show that people with PTSD can manifest the condition in many ways, both in symptoms and severity. Some might be mildly affected, while others can become incapacitated. Insomnia, depression, detachment, guilt, distrust, hypervigilance and aggression can all be symptoms of PTSD.

Though that aggression might be directed outward, too often it's focused inward. This could help explain the alarming increases in military suicides, which outpaced combat deaths in 2012.



If we scratch below the surface of Routh's tragic story, we may begin to see some instructive truths emerge. Though it might seem that Routh, 25, and Kyle, 38, were very different kinds of warriors, clinical experts believe both suffered from PTSD.

In his best-selling book *American Sniper*, which recounted his 150 confirmed kills, Kyle wrote that he struggled after his service, even going on prescription medications to help manage his post-war stress. Even so, Kyle lived a productive life, writing books, starting a business and a foundation to help others grappling with PTSD. By contrast, Routh did not seem to be coping at all. The fact that both men were affected by PTSD shows the breadth and variance of the condition.

Comprehensive solutions might be a ways off, but in the meantime we must not default to a narrative of fear in which a veteran with PTSD equals a ticking time bomb. When appropriate, we should honor the tradition of storytelling where warriors can share both the details and the burdens of what they did or didn't do in war. That way, we can help them get the specific treatment appropriate to their condition. As the soldier carried the burden of war, we as a society must now carry the soldier.

Kevin Sites, a veteran war correspondent, is the author of The Things They Cannot Say: Stories Soldiers Won't Tell You About What They've Seen, Done or Failed to Do in War.

Tell It Like It Is Myke Cole

www.mykecole.com



Editor's Note: While planning this issue of *Combat Stress*, I read the most remarkable blog by Myke Cole. Myke has served as a security contractor, government civilian and military officer, his career has run the gamut from Counterterrorism to Cyber Warfare to Federal Law Enforcement. He's done three tours in Iraq and was recalled to serve during the Deep-water Horizon oil spill. Myke is currently serving Coast Guard O3. Myke graciously allowed us to re-print his heartfelt words.

I've talked before about genre writers who have been very open about personal trials, particularly the kind of depression/anxiety conditions that I feel are a natural part of the uneven terrain all authors have to walk. I've always appreciated their willingness to go public with these issues, as the first (and false) thing that most people suffering from these sorts of things think is a.) that they're alone and b.) the problem is unique to them. When your literary heroes step into the spotlight and say, "hey, this is more normal than you think and you can figure out how to live with it," well, let's just say I wouldn't be surprised if there are more than a few folks still pushing air past their teeth because of a blog post they read.

The thought of talking about what goes on in my head in anything but the most general terms in the public square takes me way out of my comfort zone. But I reread the first paragraph of this post, especially that last line. Sometimes, you need to go outside your comfort zone, talk about a thing not because you need to get it off your chest, but because it might help others to hear it.

I was diagnosed with PTSD in August of '09, just after my third tour in Iraq. Of course my first concern (like everyone in my line of work) was losing my security clearance, and that kept me from going for help for a long time. But DoD did right by me, and I kept working for another 2 years before the book deal

got me out of the business.

I had a hard time admitting it to myself. There was a culture in my line of work, that PTSD was the province of the hard operators, the door-kickers who got into 2–3 fire-fights every single day. Like most cultures, you bought into it silently, it was simply a thing that was, not worth questioning any more than the law of gravity.

I mean, sure I'd supported certain specialized units, sure I'd been to some funerals, sure there'd been some danger close indirect rounds. Sure I'd had some misgivings about what I was fighting for, what my actions were contributing to. But, I'd seen the ads on AFN, showing young men with gunpowder still on their hands, often fresh off the battlefield, having trembling flashbacks of a fire-fight where their best friend went down right next to them. THAT was PTSD.

Except, it wasn't.

I kept seeing non-profit TV spots, charity pieces and solemn psychoanalytical essays. They all described a PTSD that I'd never seen in myself, and more importantly, in anyone else I knew who suffered from it. I'll never forget this one spot on AFN, where a soldier washes his hands, only to find blood pouring out of the faucet Stephen King's Shining style. He hears gunfire, looks into the mirror, the background is a desert battlefield strewn with corpses, glowing red.

I picked that apart with some friends for an hour. I'm not saying that there aren't people out there for whom PTSD is like that, but it sure as hell wasn't like that for any of us. As I thought about that spot, as I considered the

mounting reports of suicides, homeless vets, collapsing families, I began to get the uneasy feeling that PTSD is a lot like autism: A thing identified, but poorly understood. I read about the supposed symptoms, the heightened alertness, the re-experiencing of specific trauma, the going numb. It was all true. Up to a point.

When James Lowder invited me to write an essay for BEYOND THE WALL, we started brain-storming what it would be about. After a few rounds of back and forth, I realized that I wanted to write about PTSD, and how I saw it manifesting in fantasy characters. I used the Cooper Color System, talked about how living in the perpetual state of readiness known as "Condition Yellow," both enfranchised and hurt people. Constant vigilance has its uses, but it is exhausting and, over time, transforming.

After the book was published I realized that I hadn't gotten close enough to the issue. Arya Stark and Theon Greyjoy aren't real people, and so addressing their PTSD was tackling the issue at a safe remove. It was a toe in the water. It wasn't good enough.

Because the truth is, I've never heard anyone, medical professional, spiritual leader or otherwise describe the PTSD I know. What I see are people embracing a definition that explains PTSD using the vocabulary of classical pathology. It implies that, like a disease, you can prescribe a course of treatment and fix it.

But, in my experience, PTSD doesn't get fixed. That's because it was never about getting shot at, or seeing people die. It was never the snap trauma, the quick moment of action that breaks a person. PTSD is the wages of a life

spent in crisis, the slow, thematic build that gradually changes the way the sufferer sees the world. You get boiled by heating the water one degree each hour. By the time you finally succumb, you realize you had no idea it was getting hotter.

Because you kept adjusting.

Because PTSD isn't a disease, it's a world view.

War, disaster response, police work, these things force a person to live in the spaces where trauma happens, to spend most of their time there, until that world becomes yours, seeps through your skin and runs in your blood. Most of us in industrialized western societies live with feeling that we are safe, that our lives

death becomes commoditized, statistics that you use to make an argument for promotion, or funding, or to score political points.

Warrior cults (and, heck, most religions) were invented to give death meaning. Even if you look past the promise of immortality, they offer a tremor in the world, a ripple of significance in your passing. You do the right thing knowing that, somewhere down the line, you have a meaningful death. PTSD is what happens when you realize that you won't, that your survival will be determined by something as random as the moment you bent over to tie your shoelace.

Diseases are discrete things. But how do you treat a change in perspective? Joe Abercrombie captured it best in his description of

PTSD isn't a disease, it's a world view.

are singular, meaningful, that we are loved, that we matter. We know intellectually that this may not be the case, but we don't feel it.

PTSD is what happens when all that is stripped away. It is the curtain pulled back, the deep and thematic realization that life is fungible, that death is capricious and sudden. That anyone's life can be snuffed out or worse, ruined, in the space of a few seconds. It is the shaking realization that love cannot protect you, and even worse, that you cannot protect those you love. It is the final surrendering of the myth that, if you are decent enough, ethical enough, skilled enough, you'll be spared. The warriors that the media ascribes so much power are the first to truly know powerlessness, as

Ferro Maljinn's final revelation of the world of demons just alongside our own. Once seen, the creatures cannot be unseen. When you're quiet enough, you can hear them breathing.

Nobody talks about this. Nobody talks about the boredom, the impossibility of finding meaning in 8 hours work in an air-conditioned office after you just spent months working 18 hours a day on a battlefield where your touch altered history. Nobody talks about the surreal experience of trying to remember how you got excited about a book, or clothing, or even a car or house. On the battlefield, in the burning building, the ground trembled, we felt our impact in everything we did, until the world seemed to ripple at our touch. Back home, or off shift, we are suddenly the

subject of sympathetic glances, of silly, repetitive questions. The anonymity of the uniform is nothing compared the anonymity of comfort. We drown in it, cut off from what makes it worthwhile for others, unable to carve out a piece of it for ourselves.

Time helps you to shift back, but you never shift back all the way. You develop the dreaded "cop's eyes," where you see the potential threat around every corner, where you ask the waiter for the chair with its back to the wall. Where the trust essential to build relationships is compromised, because in the world you live in, everybody is trying to harm someone.

And this is why so many of us, even post diagnosis, go back to work in the fields that exposed us

to the trauma in the first place.

Because the fear is bone deep, and the only thing that puts it

to sleep is the thought that you can maybe patch a few of the holes in the swiss cheese net under the high wire. Because we are frightened from the moment we wake until the moment we sleep, and if we can stave that off for someone else, well, then maybe that's something to live for.

And that's for those of us who get off easy. In the worst cases, people aren't able to find meaning in a regular job, or in wealth-building, or relationships, or any of the things that modern societies tell us charts the course of a life. These are the people that PTSD takes, as they flail their way into suicide, or crime, or insanity, desperately trying to carve meaning out of a world where all the goal posts have suddenly moved, where the giant question that no one can answer is,

"why bother?"

The root of the treatment has to come from meeting those who suffer where they are. It isn't just hard operators. It's clerks and phlebotomists and chemical engineers. It's people who thought they were fine, only to wake up one morning and realize that the last few years have changed them in ways they don't quite understand. It isn't just soldiers and cops and ER nurses. Life in poverty can bring on PTSD. An abusive parent can have the same effect.

We need to treat the fear, address the world view, acknowledging that these aren't things you cure, maybe aren't even things you change. We need to tip our hat to the trauma, and look instead

I know this.

Because I did it, am still doing it, every day.

Don't give up.

at what the life after it looks like. We have to find a way to construct significance, to help a changed person forge a path in a world that hasn't changed along with them.

And if you're a vet, or an EMT, or a cop, or fire-fighter and you're reading this, I want you to know that you can't put the curtain back, but it's possible to build ways to move forward, to find alternatives to the rush of crisis. There are ways you can matter. There is a way to rejoin the dust of the world, to find your own space on the dance floor.

I know this.

Because I did it, and I am still doing it, every day.

Don't give up.

No Link Between Deployment and Suicide in the Military



Members of the Arizona Army National Guard 159th Finance Detachment, stand at attention during a deployment ceremony in 2011 in Phoenix.

Young, white men most at risk

By JASON KOEBLER

A recently released study has found that demographics, and the ending of a relationship—and not deployment status—are most closely associated with suicides in the Army National Guard.

Between 2007 and 2010, 294 members of the Army National Guard committed suicide. The suicide rate for members of the National Guard was higher than that of members of the active Army (1 in 3,225 National Guard committed suicide, compared to 1 in 4,000 for the Army.) The suicide rate in the general population is 1 in 5,000.

The report was published in *Armed Forces & Society*, a military studies journal, and was written by Army Research Psychologists James Griffith and Mark Vaitkus. "Primary risk factors associated with having committed suicide among the 2007-2010 [National Guard] suicide cases were age (young), gender (male), and race (white)," according to the report. People who fall into that group are also most likely to commit suicide in the general population.

The report found very little relationship between whether a soldier had faced active combat and whether they committed suicide, but the study suggests that problems at home that may be associated with Post Traumatic Stress Disorder could have an impact on whether a soldier takes his or her own life.

"Military-related variables, including having been deployed and combat exposure, showed little relationship to suicide," the report says. "There was some evidence that postdeployment stressors were associated with suicide intentions, namely, loss of significant other and major life change."

The report suggests that "with a loss of a significant other, the soldier could feel a lack of belonging and like a burden to others, and over time through habituating to pain, [will] commit suicide."

Suicide in the military has increasingly stumped experts—rates are increasing—but the study's authors suggest that there is a "personal, though not fully understood, disposition to being at risk for suicide."

"Having been deployed and combat exposure can be traumatic for some soldiers, often leading to behavioral health conditions, such as PTSD and depression," they write. "Yet, most soldiers will be exposed to such events without negative behavioral health consequences."

Jason Koebler is a science and technology reporter for U.S. News & World Report. You can follow him on [Twitter](#) or reach him at jkoebler@usnews.com.

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