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Anger and Aggression Found Related to PTSD Symptoms Among Veterans Returning from Combat Deployments

Researchers at the Seattle VA Puget Sound Health Care System announced the results of a study of 117 veterans of the wars in Afghanistan and Iraq in which they examined the relationship between symptoms of PTSD and anger, aggression, and hostility. The veterans were patients of the Center's Deployment Health Clinic. The authors, Matthew Jakupcak, Daniel Conybeare, Lori Phelps, Stephen Hunt, Bradford Felker, Michele Klevens, and Miles McFall, published their results in the December issue of the *Journal of Traumatic Stress* [2007, 20(6), 945-954].

Jakupcak, et al, reviewed the history of research into anger and its relationship to PTSD in Vietnam War veterans and noted the significance of findings that symptoms of PTSD that do not meet the threshold of the DSM-IV 309.81 diagnosis have been found related to anger, hostility, and aggression. They also noted that anger levels were found to be a predictor of PTSD severity and "emotional disengagement" (p. 946). The authors observe, "Overall, there is strong agreement among veterans, spouses, and clinicians that anger and aggressive behavior are major concerns in the families of veterans with PTSD..." (p. 946).

In their present study, Jakupcak, et al, sought to compare the symptoms of anger, aggression, and hostility with levels of PTSD symptomatology as found in treatment-seeking Afghanistan and Iraq war veterans. To this end they conducted a retrospective review of self-report responses in relation to combat exposure and symptoms. "It was predicted that veterans who screened positive for PTSD would report significantly greater trait anger and hostility, and be more likely to have reported aggressive behavior than veterans reporting subthreshold and nonclinical levels of PTSD. It was also predicted that the veterans reporting subthreshold PTSD symptoms would report greater trait anger and hostility, and be more likely to have reported aggressive behavior than the non-PTSD group" (p. 947).

Veterans participating in the study were patients at the Seattle VA Center's Deployment Health Clinic between May 2004 and June 2005. The veterans were mostly White (71%) men (97%) with a mean age of 32.7 (p. 947). Interestingly in relation to the symptom of anger, the authors found that nearly 70% of the veterans reported that they were on reserve status when called to duty.

In their analysis of the multiple assessment measures, Jakupcak, et al, found that 47 veterans screened positive for diagnosis of PTSD, 21 were classified as subthreshold PTSD (i.e., having symptoms as measured by the PLC-M between 35 and 49), while 49 veterans were classified as non-PTSD (p. 948). They found that the PTSD group reported significantly greater trait anger than the subthreshold PTSD group and the non-PTSD group, and that the subthreshold PTSD group reported significantly more anger than the non-PTSD group. A similar pattern was found with PTSD for the hostility variable. A similar but non-significant pattern was found for the variable of aggression, that is, the PTSD group were "more likely" than the veterans in the subthreshold and non-PTSD groups to report aggression, and the veterans in the subthreshold group were "more likely" to report aggression than the non-PTSD group (p. 949).

The authors discuss their results with several reservations that point out the limitations that cause them to caution restraint in interpretation. The most important reservation, they note, is that they were unable to determine the initial reason for seeking treatment on intake, and thus could not determine if the veterans in the study had requested mental health or other medical attention. Jakupcak, et al, report that their hypothesis was confirmed "that symptoms of PTSD are associated with anger, hostility, and aggression among Iraq and Afghanistan War veterans" (pp. 949-950).

(Continued on page 8, see *Vets' Anger*)

WDVA PTSD Program Contracts With WSU To Treat Veterans

Representatives for the Washington State University Psychology and Counseling Programs gathered with officials from the WDVA PTSD Program and Governor Gregoire's office on a windy Friday in October to sign a contract to provide psychotherapeutic services to the veterans who are students or residents of the surrounding communities. WSU estimates that it has around 600 veterans among the student body. Present at the ceremony, after a stormy flight over the Cascades were Tom Schumacher and Scott Swaim of the PTSD program, along with Dennis Clark and Mike Gregoire representing the Governor's office. Doug Lane, Ph.D., represented WSU. Mike Gregoire is the Governor's spouse and a Vietnam War veteran, who, like Harry Truman, was an artillery officer in combat. Six of the community's recently returned veterans of the Wars on Terror were also present at the signing. Scott Swaim, a counselor in Auburn for the King County Veterans Program, is an Air Force veteran of the first Gulf War and the current Wars on Terror. Tom Schumacher, the Director of the WDVA PTSD Program is also an Air Force veteran of the Vietnam War.

The WSU Psychology Department will offer counseling services to veterans from its community mental health clinic on campus and will function as other contractors throughout Washington State.

EE ##

Former Army Surgeon General And QTC Executive Becomes the New Secretary of Veterans Affairs

The Senate has confirmed Lt. General James Peake to become the next Secretary of the VA. President Bush cited General Peake's 40 years experience as a physician in the army. He replaces James Nicholson who resigned in October.

Also remarkable in General Peake's resume is that he is currently the medical director, chief operating officer and a director of QTC Management, a Diamond Bar California-based company that is under contract with the DVA to perform physical and psychiatric exams for veterans seeking service-connected disabilities. One newspaper (*Seattle Times*) reporting the nomination stated that QTC could earn more than \$1 billion in 2008 performing Compensation and Pension Exams. A previous QTC executive, Anthony Principi, preceded James Nicholson as Secretary of the Department of Veterans Affairs. It was during his tenure that the Department signed the lucrative contracts with QTC to take over Comp and Pension Exams. Mr. Principi has since returned to QTC as a member of the board.

General Peake is the first physician to run the Department that has 235,000 employees. EE ##

On PTSD Treatment—A reply to VVA Columnist Tom Berger

A long time ago a colleague came back from attending a lecture by Lenore Terr, MD, a San Francisco psychiatrist who has written profoundly about psychological traumas in children. She was reported to have wished that medicine could ablate the traumatic memory from the child's brain. I have often had a similar wish working with adults who have been traumatized. Tom Berger wrote a column in the last VVA newspaper [*VVA Veteran*, 2007, 27(6)] as a "PTSD/Substance Abuse Committee Report: Still Ineffective After All These Years." He was reporting on the National Academy's Institute of Medicine's Committee on Post-traumatic Stress Disorder report "Treatment of Post-traumatic Stress Disorder: An Assessment of the Evidence." As Mr. Berger's title suggests, the Committee's report was largely negative. No individual therapeutic system works well all the time. What is lost in such reporting, however, is that psychotherapy for an individual is individualized treatment, whereas research is conducted in a uniform way on select individuals. Researchers, by necessity have to eliminate confounding variables that muddle interpretations of the results. For example, a selection of veterans who participate in a randomly assigned design probably has eliminated veterans who have psychosis, recent substance abuse, comorbid diagnoses of affective or personality disorders. What is present in most research designs that are published in the peer-reviewed professional literature are studies that effectively test one hypothesis. What the mental health practitioner is faced with in the veteran's community is a client who most likely would have been eliminated from the study.

The distinct advantage that the community mental health therapist has is that he or she is not limited to one technique. The therapist is able to assess the veteran as a unique individual with a unique set of traumatic memories. The well-trained therapist can then apply one or several treatment techniques, including referral for medication or other specialized therapies, such as acupuncture or mindfulness training. The community mental health therapist doesn't have the luxury of referring away all but the purist candidate for treatment. What he or she does have is the power of the therapeutic *relationship*. Probably the most adaptable treatment technique that is prominently discussed is the system of Self Therapy, advocated by USC psychologist John Briere. Dr. Briere's system is outlined in *Principles of Trauma Therapy*, which he co-authored with Catherine Scott, MD.

Psychological trauma that causes PTSD is an individual experience. The chief ingredient of the trauma is memory and that places it in the heart of the veteran's personality. The memory of trauma cannot be ablated, as Lenore Terr would wish. All we can do realistically is learn to adapt and face the implications of trauma with a planful consciousness.

EE ##

DoD Longitudinal Study of Veterans' Adjustment Post-Combat Finds PTSD Worsens in Follow-up

Scientists from Walter Reed Army Institute of Research published a news-making article in the *Journal of the American Medical Association* [November 13, 2007, 298(18), 2141-2148] that reported on their longitudinal study of post-combat adjustment among soldiers returning from Iraq. Charles Milliken, MD, Jennifer Auchterlonie, MS, and Charles Hoge, MD, conducted a follow-up of a previous study in which soldiers returning from Iraq, both active duty, Reserves, and National Guard were screened for health issues. The first screening was called the Post-Deployment Health Assessment (PDHA). Their second screening was conducted 3 to 6 months post-deployment and was called the Post-Deployment Health Re-assessment (PDHRA). The follow-up study was intended to assess whether mental health problems had changes in status with time, and the effect of referrals made as a result of the first screening. They also examined differences found between active duty and Reserve and National Guard veterans. In all, the Walter Reed researchers compared 88,235 veterans, 56,350 active duty and 31,885 Guard and Reserves.

Milliken, Auchterlonie, and Hoge found that "soldiers indicated more mental health distress on the PDHRA than on the PDHA and were referred at higher rates.... Concerns about interpersonal conflict increased the most (active 3.5% to 14.0%, reserve 4.2% to 21.1%); other mental health concerns also increased substantially, including PTSD (active 11.8% to 16.7%; reserve 12.7% to 24.5%); depression (active 4.7% to 10.3%; reserve, 3.8% to 13.0%),..." (p. 2143).

The authors noted that the reserves and active soldiers reported similar rates of potentially traumatic experiences and hospitalizations during their deployments. They noted that the Iraq veterans who reported PTSD on the first screening reported "symptomatic improvement" by the second screening, "However, more than twice as many new cases were identified among soldiers who did not have high PTSD scores initially on the PDHA" (p. 2143). Milliken, et al, stated that "The study shows that the rates that we previously reported based on surveys taken immediately on return from deployment substantially underestimate the mental health burden. In contrast to the rates of mental health concerns recorded immediately on return, soldiers reported increased mental health concerns and were referred at much higher rates several months later at the time of the PDHRA. Reporting mental health concerns was also associated with attrition from military service" (p. 2145). They add, "Although soldiers' rates of PTSD and depression increased substantially between the 2 assessments, the 4-fold increase in concerns about interpersonal conflict highlights the potential impact of this war on family relationships and mirrors findings from prior wars" (pp. 2145-6).

The authors speculated about the differences that were found between active duty and Reserve and National Guard soldiers on the follow-up study. The concept of stigma regarding mental health concerns was primary among the active duty soldiers, because the survey was not confidential and broadly perceived to potentially damage a soldier's career. However, the perception of stigma is greater among active duty soldiers than among Reserve and National Guard. The latter return to their communities and jobs and have a greater concern about securing health care. Milliken, et al, observed, "Although stigma concerns may suppress reporting on the PDHRA among active soldiers, for Guard and Reserve soldiers, securing ongoing health care may be a more prevailing concern. Other potential factors unique to reservists may be the lack of day-to-day support from war comrades and the added stress of transitioning back to civilian employment" (p. 2146).

Comment

There is also a possible difference between Reserve and National Guard soldiers and active duty soldiers in what they encounter after combat. For example, the Reserve and National Guard soldiers, once returned from combat, are faced with a more virtually complete emersion in a world that is not military, implying a complex variety of attitudes and opinions about the war, employing far less understanding of the stresses of combat, which would make the demands of readjustment more difficult.

The authors' results imply that the reports of PTSD would be greater among active duty soldiers if the effects of stigma were neutralized and would be no different than the Guard and Reserve soldiers. In any case, both groups reported an increase in concern about interpersonal conflict, and both groups reported an increase in depression and PTSD 3 to 6 months after the first screening. Remember the old term for PTSD before the DSM-III? It was commonly called Delayed Stress, implying an incubation period that takes place after a soldier leaves combat. The passage of time allows a combat veteran to experience how he or she views the world differently than others. It also allows memories to turn into ruminations, for nightmares to disturb sleep, and guilt to influence consciousness.

The fact remains, as the authors stated, "The program documents a substantial increase in mental health needs several months after return from deployment" (p. 2147), and the trajectory of symptom increase is yet to be determined. Once the impact of psychological trauma is felt, habits form around coping. Relationships are affected, sleep deteriorates, and behavior proceeds down a rockier road than before combat. Milliken, Auchterlonie, and Hoge sound the alarm: "the 4-fold increase in concerns about interpersonal violence" is a measure of the pressure on combat veterans. EE ##

Anniversary Reactions to Trauma May Cause Increase in PTSD Symptoms Whether Conscious Or Not

Memory is an essential component of PTSD. Memory itself has a continuum that we often think of as a division in the form of implicit and explicit, unconscious or conscious. Memory can be both accessible, consciously known, and forgotten. There may be totally unconscious memory as well, although it must be inferred from empirical evidence, as, for instance, hyperarousal caused by very early trauma for which no conscious memory exists.

The so-called anniversary reaction to psychological trauma may be an example of implicit memory. It is difficult to identify anniversaries of traumas in persons who were repeatedly traumatized, but often there are dates associated with traumatic events. Many combat veterans remember the date they were wounded or the approximate date of a major battle. Persons who were traumatized on holidays find those periods to be marked forever with dark memory. Anniversaries of traumas, although known, are readily forgotten. A person becomes involved in the exigencies of daily living so that an anniversary of having been traumatized passes unnoted. Another set of symptoms, besides repetition and hyperarousal, is avoidance, leading many to forget anniversaries of traumas.

Morgan and others conducted a 6-year follow-up of a group of Gulf War veterans. [Morgan, C. A., III, et al., Anniversary Reactions in Gulf War Veterans: A Follow-up 6 Years After the War, *American Journal of Psychiatry*, 1999, 156(7), 1075-1079.] The researchers gave a questionnaire to the veterans and their spouses, asking them to rate their moods and symptoms for each month of the year. The dates of traumas for the 32 veterans were already recorded from previous research. Twelve veterans identified anniversary reactions involving mood changes and an increase in PTSD symptoms. Interestingly, one veteran had mis-remembered the date of his traumatic experience, but his wife correctly identified his increase in symptoms for that month. The authors write, "The most frequently endorsed symptoms of PTSD that were identified by veterans as being associated with an anniversary reaction were irritability, sleep disturbance, intrusive memories, efforts to avoid thinking about the war, emotional numbness, and reactivity to reminders of the war related events" (p. 1077). The authors observed that the events most likely comprising an anniversary reaction are those involving loss of life (p. 1078).

Morgan, et al, conclude that "the empirical evidence for anniversary reactions is robust," but they are uncertain whether such reactions are the result of a conditioned response or an unconscious time-keeping process" (p. 1078).

Example of Anniversary Reaction

Joe, for example, awakens one morning in a foul mood. He grows angry, noticing every mundane irritation. His wife asks him to stop shouting. Her words make him angrier and he begins to destroy things that have sentimental value to him. He

has urges to do more damage, even considers suicide. When discussing his behavior later, Joe could not identify anything that might have caused his foul mood; no bad news, nothing terribly frustrating, no changes in medication or incipient illness. His relations with others were not unusually troubling. When his therapist asked him if anything significant in his life happened around the date of his outburst, he remembered that indeed, this was the date he went berserk after combat, firing his weapon at non-combatants and defying orders to cease, behavior that brought an end to his army career.

Consciousness of Trauma Dates

Is it insight or false attribution to conclude that Joe's violent anger was caused by an implicit memory of having been traumatized in combat? Scientists favor the most parsimonious explanation and a psychological trauma occurring many years past is not the first conclusion. But in the absence of any contemporary cause for Joe's prolonged outburst of anger, the anniversary of trauma seemed to be the more likely explanation. In any case, it would behoove Joe to be conscious of his trauma's anniversary and face the unpleasant memory with some sort of remembrance. Collective traumas become historical and, like 9/11 or Pearl Harbor, are acknowledged in the news. Collective memorials of war sometimes have that function. It would be better for Joe to make note on his calendar and plan something for that time as a personal memorial. He would not have to be morbid, but rather pragmatic. On the hypothesis that that time may affect his mood anyway, he is better off being conscious of its cause, giving him the opportunity to manage the emotions the anniversary evokes. Chances are that those emotions will in fact be less primitive if anticipated and given an opportunity for conscious control. Joe, for instance, might want to take a vacation that week. He doesn't want the physical arousal of traumatic sequelae to be triggered by some mundane everyday irritant causing him to overreact, so that something petty becomes a life-or-death issue. For the same reason, it is good practice for the clinician to keep track of those important dates of traumas to help the client identify and anticipate.

Morgan, et al, conclude their article by addressing this idea. "The current data are relevant to psychotherapy as well. Psychotherapeutic issues may also be approached with the concept of anniversary reactions in mind. Clinicians and patients might reasonably expect that at least 30% of trauma-exposed individuals have a likelihood of experiencing or exhibiting significant psychiatric distress (including more symptoms of PTSD) on the anniversary of their trauma. Clinicians and patients might acknowledge the trauma-related contemporary issue. This understanding might result in a therapeutic clinical focus on the index trauma and the corresponding symptoms of re-experiencing..." (pp. 1078-9). (Continued on page 5.)

(Anniversary, continued from page 4)**Anniversary Reaction as Grief**

In 1972 Phillipp Bornstein, MD, and Paula Clayton, MD, contacted 92 persons from a 1968 prospective study of randomly selected persons who had recently lost spouses. They were evaluated for depression. The subjects had been interviewed the first time one month after the death of their spouse. "One question which was asked during the follow-up interview at 13 months was 'How did you feel on the anniversary of your husband's (wife's) death?' Responses were scored as minimal reaction, mild reaction, or severe reaction" (p. 470). The authors published their findings in *Diseases of the Nervous System* [The Anniversary Reaction, 1972, 33, 470-472]. They found that 67% of the 92 persons interviewed "described a mild or severe reaction to the anniversary of their spouse's death ..." (p. 470). Bornstein and Clayton warn physicians to be alert for depression disguising conjugal bereavement.

Bipolar Disorder

In 1994, three authors from the University of Patras Medical School in Greece described a case study that seems comparable to a modern combat casualty and gives emphasis to the observation of Morgan, et al, that loss of life was a frequent variable involved in anniversary responses. Stavroula Beratis, Philippos Gourzis, and Joanna Gabriel published their case study in the journal *Psychopathology* [1994, 27, 14-18]. Their case concerned a "Mr. N." who "had no family history of mood disorder or other psychiatric disorder. In 1979, when he was 12 years old, he was involved in a drowning accident. This occurred on July 12. That day, the patient and a close friend of the same age were fishing in an irrigation canal, when the other boy lost his balance and fell into the water, pulling the patient down with him. The canal was deep and the banks straight and slippery. The other boy drowned, while the patient managed to get out of the canal 3 hours later. As he was struggling to save himself, he heard the voice of his friend calling for help, but he did not respond, afraid that any effort to save his friend might jeopardize his own chances to survive" (p. 16).

The authors point out that in the first years after the accident, the patient was symptom free, but also happened to be away on a work assignment during the anniversary. For the next four years, when the patient was home, he had four episodes of clinical depression. Then, for two years, he was on active army duty away from home, and was again symptom free. After returning from the army, when again residing in his home town, the patient experienced manic episodes of psychotic proportions on the month that the accident took place. Beratis, Gourzis, and Gabriel note that "the depressive and manic episodes in our patient occurred during the same months of the year and only when

he was residing in his home town, the place of the traumatic accident. He remained symptom-free, however, when he moved to another place close by, which was under the same climatic conditions as his home town" (p. 16).

The case example illustrates the seemingly essential ingredient of the anniversary reaction as articulated by Morgan, et al., which is loss of life. The case also illustrates the awful experience of surviving when others are dying, and making the terrible decision to save oneself. The boy was also highly vulnerable at his age to being traumatized by the experience. The unique twist to this case was that the boy was apparently symptom free when he was away from his home town, leading to the conclusion that the proximity to the site of the trauma triggered his response. Guilt seemed to be a major component. In one of his depressive episodes he reported the delusion that he was Jesus Christ and could save everyone.

"The Body Keeps The Score"

What then are the cues that trigger an anniversary response, especially for those who have forgotten to remember the anniversary dates? In 1994 Bessel van der Kolk published his oft-referenced article, "The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress" [*Harvard Review of Psychiatry*, 1994, 1, 253-265], in which he presented cases of childhood traumas which caused physical disruption in the form of pain and illness. The psychodynamic schools of thought postulated that unconscious memories influence the behavior of those who have been traumatized. In the world dominated by cognitive-behavioral terminology, unconscious memories have become implicit, still influencing the feeling state, where timing is everything. There seems little doubt that, however it is termed, memories of trauma influence our behavior whether conscious or not.

Dr. van der Kolk states explicitly that "Research into the nature of traumatic memories indicates that trauma interferes with declarative memory (i.e. conscious recall of experience) but does not inhibit implicit, or nondeclarative, memory, the memory system that controls conditioned emotional responses, skills and habits, and sensorimotor sensations related to experience" (p.252).

Dr. van der Kolk reinforces the argument that trauma dates are best kept conscious. "The goal of treating PTSD is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past. Psychologically, this means that traumatic experiences need to be located in time and place and differentiated from current reality" (p. 255). It seems that one benefit of repeatedly going over a traumatic experience in psychotherapy is to fix in consciousness the orienting facts of the events, making it less likely that the disturbing emotions will sneak up on the survivor and be acted out unconsciously. EE ##

Mild Traumatic Brain Injury and Symptom Management

According to Katherine Helmick and her co-authors, mild traumatic brain injury has been recognized as the “signature wound” of the current Wars on Terror. Writing in the *Federal Practitioner* [October, 2007, 58-65] they report that the injury is often undiagnosed. “More than 1,700 American service members have sustained a traumatic brain injury (TBI) since the beginning of Operations Enduring Freedom and Iraqi Freedom” (p. 58). They note that “over the past 15 years, between 14% and 20% of surviving casualties of armed conflicts have been left with TBI. This injury was not diagnosed and reported as it is currently. “In previous conflicts, trauma to the head and neck commonly was reported as battle injuries, but often only in the context of penetrating or severe brain injuries and fatalities. Mild to moderate closed brain injuries during war typically have not been well documented” (p. 59). All military personnel “who are medically evacuated from Iraq and Afghanistan after being injured in explosions or blasts, falls, gunshot wounds to the head and neck, or motor vehicle accidents are screened for TBI” (p. 59).

Helmick, et al, define traumatic brain injury as “a traumatically induced physiologic disruption of brain function as indicated by at least one of the following: (1) any period of loss of consciousness..., (2) any loss of memory for events immediately before or after the accident, (3) any alteration of consciousness... or mental state at the time of the accident, and (4) focal neurologic deficits that may or may not be transient” (p. 60).

Most TBI casualties return to full functioning, but some require symptom management and educational intervention. The authors observe that the co-morbid presence of posttraumatic stress disorder can be a complicating dynamic to any injury recovery. “For a veteran with a brain injury of any severity, the combination of cognitive and emotional compromise of PTSD or a substance abuse disorder can jeopardize optimal recovery” (p. 64).

Screening

The screening of casualties covers the following questions, which the authors summarize on page 62, which might well be applied to all war veterans who are psychotherapy clients in the community.

“Did any injury received while you were deployed result in any of the following?”

- Being dazed or confused or “seeing stars”
- Not remembering the injury
- Losing consciousness (knocked out) for less than a minute
- Losing consciousness for 1-20 minutes
- Losing consciousness for longer than 20 minutes
- Having any symptoms of concussion afterward (such as headache, dizziness, irritability, etc.)
- Head injury”

Helmick, et al, observe that veterans with TBI constitute “a population that has an increased risk of ‘falling through the cracks’ due to deficits in organizational and executive functioning, care coordinators provide an essential safety net for patients with TBI” (p. 63).

There is no cure for TBI that does not remit spontaneously. Once brain injury is established, one can only adapt, and a community therapist can be helpful in assisting the veteran in making the adjustment to civilian life. Again, the authors present a table that provides “tips” for veterans who have sustained TBI (p. 64), advice that might well apply to all clients and therapists alike.

“Get plenty of sleep at night and rest as needed during the day.

“Return to normal activities gradually, not all at once.

“Avoid activities that could lead to a second injury, such as contact sports or riding a motorcycle.

“Refrain from drinking alcoholic beverages (alcohol and other drugs may slow recovery and increase risk of further injury).

“If you are easily irritated, remove yourself from challenging situations.

“If it’s harder to remember things, write them down.

“Use relaxation techniques to help manage irritation or to give you restful breaks during the day.

“Consult with your family before making any important decisions.

“Be patient—healing from a brain injury takes time.”

Comment

As Helmick, et al, noted, TBI is the “signature wound” of the current Wars on Terror. In previous wars, the wounds that were unique were provided by the innovations in technology or battlefield tactics. In World War I, the injuries were from the deployment of poison gas and the head wounds from gunshots and shrapnel—the head being the body part that was most likely to protrude above the top of the trench. The Vietnam War was unique in providing defoliating agents that poisoned combatants leading to symptoms that were slow to develop, but profound in their morbid course. Operation Desert Storm gave us the Gulf War Syndrome, similar to Agent Orange contamination in that its symptoms were difficult to identify at the time of the conflict, but probably were caused by chemical contaminants. The constant that cuts across all wars across time is the emotional damage of what we now call posttraumatic stress disorder.

Community psychotherapists may well be encountering war veterans with undiagnosed TBI and might include in their initial assessments the kinds of questions raised by the author’s screening. Because we focus on psychological problems, we tend to be less detailed about what the veterans encountered during combat where they may or may not have been physically injured, by blasts or falls, and sustained period of unconsciousness, etc. EE ##

British Re-examine the History of Shell Shock in Light of the Modern Diagnosis of Mild Traumatic Brain Injury

The recent increase in the diagnoses of traumatic brain injury as a result of combat in Iraq and Afghanistan has led British researchers to re-examine the phenomenon of shell shock, which became the signature diagnosis of World War One. Edgar Jones, Nicola Fear, and Simon Wessley of Kings College in London published their findings in the *American Journal of Psychiatry* [2007, 164(11), 1641-1645]. They write: "In 1915, shell shock was initially conceived as a neurological lesion, a form of *comotio cerebri*, the result of powerful compressive forces.... However, doubts soon arose about the contribution of direct cerebral trauma to shell shock, and some expressed the view that the symptoms were more psychological than organic in origin, even to the extent of characterizing them as 'traumatic neuroses'.... Some military doctors went so far as to state that the disorder was environmentally or contextually determined and that the way in which health care and compensation were organized served to reinforce both symptoms and disability. A vigorous debate ensued between the various schools of thought that led to a series of novel managerial interventions designed to limit what had become an epidemic of patients and war pension claims" (p. 1641). The authors noted that 50% to 60% of the casualties admitted to the base hospital had been concussed.

For the record, Jones, Fear, and Wessley noted that the term shell shock was first used in 1915 by Capt. C. S. Myers, writing in the journal *Lancet*, to describe cases that arose in the context of exploding ordinance, but were not linked to obvious organic lesion. During World War One, 10% of British battle casualties were categorized as some form of shell shock or neurasthenia and comprised one-seventh of all the discharges from the British army. By the end of 1917 the British government banned publications concerning shell shock and eventually, at the start of WWII, banned using the term. By 1941, the term "postconcussion syndrome" had come into the jargon. "The disorder was characterized by headache, dizziness, fatigue, tinnitus, memory impairment, poor concentration, and nervousness," symptoms that could not be distinguished from "postconcussion neurosis" (p. 1643). The separation between postconcussion syndrome and postconcussion neurosis was found in the recovery rate. Symptoms of the former "were immediate and severe with a trend to progressive recovery, while in the latter there was often a delay in onset and a tendency to get worse rather than better" (p. 1643). However, it was decided that the distinction between the two, neurosis and syndrome, was "unprofitable and misleading." The British "retained soldiers with shell shock in the armed forces and offered occupational therapy and vocational training based on aptitude tests. Given the debilitating effect of the shell shock label, the key, it was thought, was to return service personnel to purposeful activity without paying too much attention to causation" (1643). The authors observed that in the current Wars on Terror, "in the status of uncertainty, it may be

that contemporary service personnel prefer to be labeled as suffering from mild traumatic brain injury than any psychological disorder, just as shell shock in its initial quasi-neurological formulation was very popular. It may be that such labels reduce stigma and encourage help seeking, a major issue for the present generation of service personnel.... But, on the other hand, it may divert attention from more easily treatable disorders, such as depression and posttraumatic stress disorder" (p. 1644).

Jones, Fear, and Wessley discussed their conclusions. "In revisiting the debates on shell shock and postconcussional syndrome of the two World Wars, we had a contemporary purpose—to introduce some historical context to the current debate on mild traumatic brain injury, a context that has been conspicuous by its absence. While not seeking to prejudge the status of mild traumatic brain injury, we note that the U.S. military currently committed to serious fighting in Iraq and Afghanistan faces a situation similar to that of the British Army engaged in the Somme offensive of July 1916. Both campaigns have developed into wars of attrition in which head wounds and concussion are common battle injuries. The high casualties of the Somme battle brought the issue of shell shock to the fore when, as traumatic brain injury had done today, it caught the popular imagination and the attention of the media. The British Army struggled to define shell shock without a clear understanding of what it constituted and failed to produce a coherent management plan. The postwar ramifications were enormously expensive, with escalating war pension claims and a series of costly initiatives designed to treat chronic cases. So troublesome had been the disorder that the term 'shell shock' was proscribed on the outbreak of World War II and draconian policies introduced to try to prevent its reappearance" (p. 1644).

Comment

The situation that faces the psychotherapist in the community who treats war veterans is the likelihood that postconcussion syndrome is to be co-morbid with PTSD, mood disorder, or other psychological disorders. It then becomes a problem of attribution when symptoms such as poor concentration or irritability are manifested. How many of our clients are hard of hearing? What? A blast close enough to cause chronic tinnitus and posttraumatic stress disorder, may also have caused mild traumatic brain injury, and unless the client has been screened carefully, the "preferred" diagnosis may not be in the clients record.

There is also logical error in the report (p. 1644) that implies chronic disorders are chronic because the client learns that they are permanent. The experimental design to test that hypothesis has not been published. EE ## (See page 9 for further discussion of this issue.)

Vets' Anger, Continued from page 1.

Jakupeak, et al, assert that their findings contribute to the overall understanding of research on the relation of anger with PTSD among combat veterans. "First, the strong associations between PTSD and anger, hostility, and aggression have been consistently demonstrated among Vietnam combat veterans, although assessment of these factors was conducted decades following military service.... The current study suggests that anger, hostility, and aggression associated with symptoms of PTSD are present in Iraq and Afghanistan War veterans within the first few years after returning from combat duty and that these associations are significant even after accounting for other factors such as combat exposure and problem drinking. As such, early intervention may be particularly important in this population given that rates of severity of PTSD may increase over time..." (p. 950).

Subthreshold PTSD

Jakupeak, et al, assert that their study "confirms previous research indicating that subthreshold-PTSD is associated with clinically significant impairment among treatment-seeking Vietnam veterans..." (p. 950). They add, "Although rates of PTSD among soldiers serving in the Iraq and Afghanistan Wars have been estimated to range from 10% to 20%..., an additional percentage of returning soldiers are likely experiencing subthreshold levels of PTSD symptoms, which may contribute to difficulties with anger and aggression. Clinicians may underestimate the impairment associated with subthreshold levels of symptoms and subthreshold-PTSD veterans may be less likely to seek mental health services than those with PTSD.... This has important implications for the Department of Veterans Affairs and community health care providers, underscoring the need to screen for symptoms of PTSD in settings such as primary care clinics...and to encourage appropriate mental health services" (pp. 950-1).

Jakupeak, et al, point to the introduction of anger management training for returning veterans. "The results of the current study suggest that introducing anger management skills should also be a priority in treating Iraq and Afghanistan War veterans with symptoms of PTSD" (p. 951). The introduction of anger management skills does not imply that the anger is not warranted, so much as training the veteran to think it through, and hopefully be able to separate the past from the present, or at least question whether the anger is memory.

Comment

When opening the Vet Center in Seattle in 1979, we took the cork out of a pressured bottle of anger that charged the atmosphere. Most of the veterans were 8-12 years back from combat. The anti-war demonstrators had left their mark on the meaning veterans applied to their efforts. They were labeled as misunderstood heroes or dupes, victims or aggressors, but the meaning was fixed on their return to the USA. Our groups fairly rocked with the anger of 30-year-old men and their anger was infectious. It is an Achilles heel of mental health therapists that they are opposed to war and have

political opinions about how their country should be conducting its foreign policy. Insofar as the therapist elicits images of combat anger and insult to human dignity from the veteran, the therapist is vulnerable to the contagion. The Vet Center of 1979-80 was a ossuary of the emotional bones of the Vietnam War. Regardless of its political correctness, the citizens of the USA had been caught in the back blast of its own shadow. The sentiments of the veterans of the current Wars on Terror are similar to the Vietnam War veterans, that they joined not with the wish of becoming society's pariah, but rather with some personal romantic idea of doing the right thing under conditions that test one's courage. And then to experience the outrage at being questioned upon return about morality.

The problem of PTSD in combat veterans is also a concern for veterans who were exposed to traumatic combat conditions but do not qualify for the diagnosis, yet who have symptoms that are conducive to engendering anger and fostering social alienation. The purpose of anger management training is to guide the veteran to a better understanding of his or her anger, so that it becomes a known quantity and is not a surprise. Becoming conscious of the anger is the first step to knowing how anger can be directed as a motivating force into political or social action, into artistic creativity, or insightful reflection. Becoming conscious of anger, knowing its source and manifestations, means that one can direct the energy willfully, rather than misdirect it impulsively.

Anger is such a primitive emotion in terms of human evolution that it can catch even the most sophisticated of us by surprise. Witness in the halls of academia the viscous battles for territoriality. Anger associated with combat traumas, however, is associated with death and dismemberment. It contains the imagery of rolling a hand grenade down the aisle that drives combat veteran to distraction at sophisticated gatherings, as one veteran put it years ago.

PTSD symptoms imply two main generators of angry energy—limbic system hyperarousal and traumatic memory, both conscious and implicit body memory. Anger management therapy tries to drive a wedge between the angry impulse and the behavioral response that teaches the veteran to step away from the urge to kill and think about it. EE ##

RAQ Retort

The Journal of Traumatic Stress doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the RAQ may play a role. Your contributions will make a difference. Email the editor or WDVA.

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Illness Perceptions and Outcomes

The observation made at the end of page 7, this *RAQ*, questioned the issue that is sometimes raised, that if PTSD is believed to be chronic, then it will sure enough become chronic. The issue was raised in the British article on Shell Shock in which the authors referred to another recent British study of post-concussion syndrome [Robert Whittaker, Steven Kemp, and Allan House, Illness perceptions and outcome in mild head injury: a longitudinal study, *Journal of Neurology, Neurosurgery, and Psychiatry*, 2007, 78, 644-646].

British researchers Whittaker, Kemp, and House followed 73 patients from the time of emergency treatment after head injury, diagnosed as mild traumatic brain injury, and 3 months later interviewed the patients for follow-up. The patients were administered diagnostic measures to assess symptoms. The authors report that “all patients were symptomatic at time 1.” (Presumably symptomatic of post-concussion syndrome.) “However, 18 patients (25%) met the criteria for persisting PCS [post concussion syndrome] at follow-up.” The authors add, “measures of the severity of head injury were not associated with either symptomatic or functional outcome.”

Whittaker, Kemp, and House concluded that “Patients who believe that the symptoms they experience following a mild head injury have serious negative consequences on their lives and will continue to do so, are at heightened risk of experiencing enduring post-concussional symptoms. Notably, severity of the post-concussion symptoms in the initial post-injury period, while an important variable in the model, was not an independent predictor of outcome—it is the interpretation of their symptoms as serious and enduring that puts patients at risk of PCS. Adding information about severity of the original injury, levels of anxiety, depression and post-traumatic stress symptoms did not significantly improve the model.”

The authors of the “Shell Shock” article reviewed on page 7, this *RAQ*, stated “Labels themselves affect prognosis. For example, a study of postconcussional syndrome by Whittaker et al. ...suggested that subjects who believe that their symptoms have lasting deleterious effects are at higher risk of experiencing an enduring disorder of this kind. In other words, strongly held negative beliefs play a part in maintaining symptoms and functioning—exactly the reasoning that led the British Army to ban the use of the term ‘shell shock’ in 1917” (p. 1644).

Comment

Whittaker, et al., noted that “post-traumatic stress levels,” along with anxiety and depression, were frequently found to be comorbid with post concussion syndrome. This suggests that the meaning of the traumatic experience and the personality of the patient played a role in influencing the symptomatic outcome.

It is a prevailing assumption among PTSD therapists that chronic PTSD is not reversible, that is, cannot be cured. If the veteran is told that PTSD is chronic, the information may influence the long term expression of symptoms. On the other hand, it is naïve to believe that memories of traumas are not long-lasting and influential, and that, given the evolutionary inheritance of our genes, hyperarousal is also long-lasting. The two combine to produce enduring albeit episodic symptoms of PTSD. The best information the therapist can give a veteran with chronic PTSD is a realistic assessment of his or her condition and strategies for its recognition and management. But as Whittaker, et al, suggest, the patient’s understanding of the implications of the trauma influences, to some extent, the long term expression of symptoms.

We also hear older war veterans express their regret that they did not know about PTSD after their return to civilian life. Instead, they took jobs that compounded the symptoms and acted out avoidance and re-experiencing symptoms that shaped their social and professional lives. The dilemma then for the therapist and diagnostician becomes one in which both labeling and not labeling affect outcome.

It would be unethical to deceive a patient about the prognosis of a disorder. Many veterans with PTSD would feed into the ambiguity, get information from the Internet or PTSD literature, and arrive at their own conclusions about the reality of the disorder. Ambiguity on the part of the therapist or diagnostician would only lead to mistrust of health care professionals.

The advantage of long-term psychotherapy, (or episodic as-needed psychotherapy by the same therapists over a long term) is that a sophisticated, individually applied understanding of the posttraumatic symptoms can be established that could lead the veteran to an effective management of the reoccurring symptoms. Thus, it is not that the disorder is chronic, but rather that its deleterious effects are minimized by effective management.

The fact that long term or episodic psychotherapy is expensive is part of the cost of war and the return of the veteran to a stressful society. The cost to society of not properly treating PTSD is enormous but spread out over the lives of the veteran and his or her family.

What is suggested by the term “strongly held negative beliefs,” just quoted, is that the meaning of the traumatic event influences the posttraumatic outcome. If the survivor of trauma carries guilt about surviving the event, that so-called negative belief may be the sense of fate—that one will pay for what one did or didn’t do.

Veterans returning from war are wont to admit that they have posttraumatic symptoms that will last for the long term. More likely they are subject to the wish that the symptoms will recede and the veteran will return to normal. The therapist’s position in the early stages of treatment is to promote the idea that recovery is expected and that residual symptoms, while not unexpected, in fact are normal too. EE ##

Movie Review:***No Country For Old Men*— War Veterans Pursued**

Reviewed by Emmett Early

No Country For Old Men is directed by the Coen brothers, who here return to the tradition of their first suspense film riddled with dark humor, *Blood Simple*. After their opening scene, the Coens cut to a hunter stalking a herd of antelope on the south Texas desert. He wounds one, and in tracking the herd, he happens upon another blood trail, which leads him to a scene of human carnage, a drug deal gone deadly, bodies and vehicles in a standoff. One survivor, still alive in his truck, begs for water. The hunter replies with a grunt: "I got no water." One blood trail leads off to the bush and the hunter follows to find yet another corpse, this one with a satchel full of hundred dollar bills.

Josh Brolin plays the hunter, Llewelyn Moss, who takes the money back and hides it under his mobile home. There he has a brilliant comic exchange, a much welcomed relief, with his wife, Carla Jean, played with spark by Kelly Macdonald. At night he cannot resist the call of the dying man, and returns to the scene of the carnage with a plastic bottle of water. His compassion is his downfall. He is shot and chased by gunmen and their pit bull. He escapes, however they have his truck and therefore his identity. Moss has to hurriedly gather up his wife and his money and flee. He sends his wife to her mother and he hits the rode, with Anton Chigurh, the morbid professional killer close behind.

There are two exchanges that tell us that Moss is a Vietnam War veteran. In one exchange, a second killer on his trail, this one a more friendly fellow veteran, seeks to help Moss by taking his money and sparing his life. He is played by Woody Harrelson. Later, Moss, after crossing the border into Mexico, is quizzed by the officious border agent on his return in hospital gown and cowboy boots, and is admitted back to the U.S. only after he identifies himself as a 2-tour infantry veteran of the Vietnam War. There have been several narrow escapes and sudden shootouts intervening and to follow.

No Country For Old Men is also about the local sheriff who decides to retire. He also is on the trail of Llewelyn Moss. Sheriff Bell is played by Tommy Lee Jones who expresses his character with a wry, slow, unambitious, unenthusiastic pace. His young deputy is also a welcome, if stereotyped, provider of bumptious comic relief.

The Coen brothers are masters at casting minor characters that are absolutely right. They are so convincing that they seem almost to have been filmed on their job. Throughout the movie we feel their naïve vulnerability as they encounter Moss stalked by his relentless killers. Javier Bardem plays the killer, Anton Chigurh (Moss mockingly calls him Sugar), as a relentless demon who uses a cattle-slaughtering stun gun to blow out door locks. He has an unstoppable, unfeeling remorselessness of a supernatural being, reminiscent of a character of the Terminator once performed by the Governor of California.

The war veteran quality of Llewelyn Moss gives his character a ready believability. His wary, stalking approach to the crime scene in the beginning, his unemotional survey of the corpses and his rough response to the dying man. Later he displays his dogged courage as he challenges the killer. Ironically, his downfall is his compassion and perhaps a sense of duty, when he returns with water for the dying man. The killer and Sheriff Bell both track Moss through his wife, who has fled to her crabby comic mother.

The number of innocent victims in this two hour film is astounding. If this is a film about collateral damage, it is successful. Managing hotels is definitely a career to be avoided. Sheriff Bell, in a way, is caught up in the damage. The experience pushes him into retirement. The title of the film comes from the WB Yeats poem "Sailing to Byzantium," which begins with "That is no country for old men." Yeats' poem is about dying, passing into a spiritual realm.

"Consume my heart away; sick with desire
And fastened to a dying animal
It knows not what it is; and gather me
Into the artifice of eternity."

The Coens have given us a bit of a paradox in following Moss on his path of destruction. He takes the satchel of 100 dollar bills, money that obviously brings death, but is caught literally in the headlights only when his compassion compels him to return with water for the dying man.

No Country For Old Men was very faithfully adapted by the Coens from a novel by Cormac McCarthy. Dialogs were lifted whole from the novel to the movie. It seemed almost that McCarthy had written it for film. Two important elements were missing in the adaptation, although they seem not to have impaired the movie version by their absence. In the novel, the sheriff is also a war veteran, and apparently has been a sheriff for 38 years *because* of what happened in his war. He had been a squad leader in France in World War II. He had won a Bronze Star: "I was supposed to be a war hero and I lost a whole squad of men." In the closing pages of the novel, Sheriff Bell visits his invalid uncle and tells him, for the first time telling anybody, how he had won the Bronze Star, holding off Germans after a mortar blast. His squad was buried under rubble, and some were crying out. He held off the Germans with a .30 caliber machine gun and then at night fled, because he knew they would creep up and lob hand grenades. When his uncle heard this, he said: "Well, in all honesty I can't see it bein all that bad. Maybe you ought to ease up on yourself some."

The Coen brothers' adaptation also left out a sequence of scenes in which Moss picks up a teenaged runaway girl who enjoys the fact that he is a wounded fugitive from she knows not what. She is drawn to the folly like a moth to the flame and becomes, in the end, another of the film's collateral damage.

McCarthy refers to Anton Chigurh as a ghost. His archetypal power becomes the summary of the war veteran motif— that ours is no country for old men. ##

Movie Review:

Blessed By Fire—Argentine film presents the fated veterans of the Malvinas Island War of 1982

Reviewed by Emmett Early

If there is a Universal Soldier, than there must be a Universal War Veteran. The Argentine film *Blessed by Fire* presents another story of the aftermath of war, which is played out in the lives of the war veterans. During the opening credits we see a political demonstration and a reporter at work in the streets documenting the event. The scene cuts to an ambulance, siren blaring, that navigates the city streets.

Later Esteban, the reporter, receives a phone call in his office and is stunned by the message. Esteban is a veteran of the 1982 war in the Malvinas Islands that the British claimed and called the Falklands. Esteban experiences a series of flashback memories as he rushes to the hospital ICU where Vargas has been taken. Vargas is a fellow veteran who has attempted suicide. Esteban had struggled mightily to save Vargas during the war, when he was severely brutalized by abusive officers and wounded in the final days of the battle.

Esteban, played by Gastón Pauls, is confronted by his memories as he assists Marta (Virginia Innocenti), who found Vargas and called Esteban. Vargas had overdosed on alcohol and drugs. Esteban narrates voice-over that more than 290 veterans had committed suicide, more than were killed on the island during the war. As memories occupy his consciousness, we learn why there were so many suicides. As Esteban states, "The Malvinas came back again—and covered everything."

Esteban is unable to sleep. His memories describe the suffering of the men who were drafted and sent off to the islands to await the British landing. Argentina had seized the Malvinas from Great Britain, just as the British had seized the island 150 years previously and called it Falkland. The Malvinas Islands are close to Antarctica. The soldiers dig bunkers, three-man fighting holes that guard the shoreline. They live in the mud and cold without adequate food or protection from the elements. Three soldiers, suffering together, capture and kill a sheep. They cook and eat the meat, and when one soldier, Vargas (who is played by Pablo Ribba), tries to bury the sheepskin, he is discovered by the sergeant. As part of Vargas' punishment, he is beaten and staked out in the rain and mud until he becomes ill.

Esteban talks to Vargas, who is unconscious and sustained on life supports in the hospital ICU: "Since I've seen you, I keep going back to the islands." In the battle that finally comes, the Argentineans are routed in a brutal slaughter. In announcing the surrender to the assembled mud-spattered, weary survivors, the colonel, after praising them for their deeds, foretells their fate: "What you have experienced here will be with you forever."

Blessed by Fire, (*Luminados Por El Fuego*), was directed by Tristán Bauer. The reporter's flashback memories are about three hapless grunts, Esteban himself, Vargas, and Juan (César Albarracín). Juan, the youngest and a recent father, is killed in the battle. Vargas, who suffers from the torture and abuse of the officers, is severely wounded. All three suffer the deprivation of the long period of desolate watch on the coastline, living in a muddy hole without adequate clothing. Every once in a while a British Harrier jet would rush by and drop a bomb, an ominous omen of the overwhelming superiority of their opponent. The officers commanding them are presented as brutal cheerleaders, taunting and goading the soldiers with demeaning epithets.

After Vargas dies, Esteban takes his identity tag back to the Malvinas. He visits the twisted wreckage of the battle and finds the bunker above the beach where he lived and suffered with his friends. He discovers the artifacts that remained: a stashed photograph, Juan's treasured watch. The movie ends with Esteban sobbing, crouched in the abandoned fighting hole.

The role of Marta is one of a war veteran's mate, another universal character. She is Penelope waiting for Odysseus. Her face shows an impressive range of expression. Although she is overshadowed in the drama by Esteban's nightmarish flashbacks, she relates her long, patient struggle to cope with her lover's self-destructive postwar habits.

The suffering, begun in war, continues in the war veterans, and the meaning that they give to their suffering is irrevocably tied to the meaning of the war. The fight for the Malvinas was lost by Argentina. It was a one-sided fight and an ignominious defeat that was the doomed product of their President's ambition. The chaos of the brief battles, which were depicted as nightmare scenes reminiscent of Goya, are bracketed by the ordeal of anticipation and the panic and fatigue of the final rout and defeat. What positive meaning can be given to such an experience? Esteban, who has struggled so mightily to save his friend, sees him let go of his own life, as if his near death struggle years before had locked him into a life fated to finish this way. Marta, Vargas' mate, is drawn into his suffering. Esteban can only grieve for his friends who never left the island, and for the memory he bears that is tied to their fates. ##

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The PTSD Program is committed to outreach of returning veterans of our current wars. We work closely with the National Guard, military reserves, and active duty members and families to promote a healthy and supportive homecoming.

To be considered for service by a WDVA or King County Contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used to prove the veteran's military service. You are encouraged to call Tom Schumacher for additional information, or if eligibility is considered a potential issue.

It is always preferred that the referring person or agency telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a monthly budget. All PTSD Program Contractors are skilled at using various funding resources should the State or King County funds be in short supply.

Some of the program contractors conduct both group and individual/family counseling. ##

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