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PTSD and Health Functioning Before & After Iraq Deployment

The Department of Veterans Affairs and the U.S. Army collaborated in a study of non-treatment-seeking Army personnel who were tested before and soon after their return from deployment to Iraq. The study examined symptoms of PTSD and general health, including health functioning and risk behaviors, such as smoking and alcohol use. Jennifer Vasterling and her colleagues evaluated 800 active duty and National Guard soldiers. The premise of the study was to inquire into the health risks for persons with PTSD. Publishing their results in the *Journal of Rehabilitation Research & Development*, [Posttraumatic stress disorder and health functioning in a non-treatment-seeking sample of Iraq war veterans: A prospective analysis, 2008, 45(1), 347-358], Vasterling, et al, stated: "Health symptoms and health risk behaviors may be particularly important mediators of the relationship between PTSD symptomatology and health-related functional outcomes. PTSD has been linked both to increased risk of somatic symptoms such as dizziness, fainting spells, pounding or racing heart, or shortness of breath...and to medical illnesses such as cardiovascular disease...nervous system disease, and gastrointestinal disorders.... Although several psychological...and biological...mechanisms may explain associations between PTSD and health outcomes..., health risk behaviors such as alcohol use..., tobacco use..., and poor sleep hygiene...stand out as potentially modifiable risk factors for poor health outcomes in individuals expressing high levels of PTSD symptoms" (p. 348). The authors referred to a VA Normative Aging Study that "suggested that PTSD is associated with functional outcomes independently of alcohol consumption and smoking" (p. 348).

Vasterling, et al, hypothesized, first that "PTSD symptom severity at postdeployment would be inversely related to change in health functioning." They added, "We further predicted that in addition to direct relationships between PTSD symptomatology and physical health-related functioning, the relationship between PTSD symptoms and physical health-related functioning would be partially mediated by health related risk behaviors and postdeployment health symptoms" (p. 349). The Army units sampled were described as representing "combat arms, combat support, and combat service support functions and were drawn from both the regular active duty...and the National Guard..." (p. 349). The authors noted that the sample contained few females and officers. The predeployment assessment took place between 2003-4 and again between 2005 and 2006 after the troops returned.

Vasterling, et al, found that at postdeployment PTSD symptoms were again directly associated with drinking behavior. Moreover, this relationship was maintained even after controlling for predeployment drinking, suggesting that higher levels of postdeployment PTSD were associated with increased drinking from pre- to postdeployment" (p. 353). Further, the authors found that "A large positive relationship was also observed between postdeployment PTSD and postdeployment health symptoms" (p. 353).

Vasterling, et al, added, relevant to their second hypothesis: "In the presence of PTSD, neither postdeployment drinking or postdeployment smoking behaviors were associated with postdeployment health symptoms or physical health functioning" (p. 353). The authors suggested that the health risk behavior such as alcohol use and smoking may become more significant over time.

Vasterling, et al., examined the implications of their findings: "To our knowledge, this is the first study to examine longitudinal relationships between PTSD symptomatology and health-related functioning. In a sample of 800 U.S. Army soldiers deployed to Iraq, we found an indirect relationship between PTSD and health-related functional outcomes. Specifically, postdeployment PTSD symptom severity was only weakly related to day-to-day health related functioning if the influence of health symptoms was controlled. Instead, PTSD symptoms seem to adversely impact physical health functioning via their negative effect on health symptoms, which in turn negatively influence day-to-day functioning. While it seems intuitive that the impact of health on day-to-day functioning has much to do with the number and frequency of somatic symptoms, particularly for military veterans and other trauma victims seeking treatment for PTSD, such health symptoms appear to be set in motion by PTSD" (p. 354).

Vasterling, et al, asserted that the value of their study was in emphasizing the need for early health intervention for persons at risk for PTSD, given the implication of health problems increasing with time post-trauma. They add in conclusion, "The findings have significant implications for the reduction of personal burden and societal costs among military veterans and other trauma-exposed populations who develop PTSD symptoms after exposure to extreme stress" (p. 355).

EE ##

Book Review:

The Dumbest Generation: How the Digital Age Stupefies Young Americans and Jeopardizes Our Future, by Mark Bauerlein, Ph.D.

Reviewed by Tom Wear, Ph.D.

As some of you know I have been concerned about the psychological and cultural effects of “screen time” on the developing minds of children. In 1995 I published an article in *Adbusters* magazine entitled “Teletrance”, outlining how the passive trance-like state induced by electronic media (at that time television and computers) results in neurological re-wiring and competition with reading for psychic energy of children. Also in 1995 a book by Charles Sykes, *Dumbing Down Our Kids: Why American Kids Feel Good About Themselves But Can’t Read, Write, or Add.*, was published. Dr. Syke’s carefully documented concern that the arrival of computers in the classroom, coupled with the child centered, as opposed to learning centered attitude in education, would result in an educational system that had dumbed down its curriculum, diminished its standards, and produced a nation of underachievers who lack basic academic skills. Now, 13 years later, comes Mark Bauerlein’s book, *The Dumbest Generation*, which amplifies and confirms fears raised by Charles Sykes, Jane Healy (*Endangered Minds*), and others, about the damage being done by the ever-widening, unquestioning embrace of electronic devices.

Dr. Bauerlein is a professor of English at Emory University in Atlanta, GA. More importantly, he worked as director of research and analysis at the National Endowment for the Arts where he reviewed studies concerning culture and American life. From this perspective he had access to research accumulated in the important peer reviewed journals across a wide variety of academic and research disciplines. The result is an extremely well researched and carefully documented analysis of the attitudinal, cognitive, and educational changes which the digital age has wrought. Dr. Bauerlein limited his focus to the under-thirty-year-olds and excluded other aspects of cultural change (faith, diversity, sexuality, etc.) to concentrate on the intellectual condition of young Americans. He admits that trying to document the insidious changes taking place inside the heads of young people is difficult, but the empirical evidence is in and, when taken as a whole, presents a bleak picture. The overwhelming conclusion is that the “digital revolution”, the “information super-highway,” and the “knowledge based economy”, in short, the overhyped promises of the “wired” society, have not only failed to deliver educated, informed citizens, but paradoxically have closed the minds of the millenials (those born between 1980 and 2000). Dr. Bauerlein does not see the young people of today as any less inherently intelligent, less energetic, idealistic, or ambitious than those other generations. He is alarmed that the cell-phones, I-Pods, video games, e-mail, blogs, Myspace, Facebook, Blackberries, etc., have rendered the millenials “so intensely mindful of and present to one an-

other, enabled in adolescent contact. Teen images and songs, hot gossip and games, and youth-to-youth communications, no longer limited by time and space, wrap them in a generational cocoon reaching all the way into their bedrooms. Instead of opening young American minds to the stores of civilization and science and politics, technology has contracted their horizons to themselves, to the social scene around them.”

Dr. Bauerlein’s chapters follow a systematic structure. He highlights various aspects of the “new social and mental life” and, armed with empirical data, explores these new mental horizons and the implications for education and a functioning democracy.

In a section called “Knowledge Deficits” he summons evidence regarding time spent on reading and studying for class. From the 2006 high school survey of student engagement involving 81,499 students in 110 schools in 26 states: “when asked how many hours each week were spent reading/studying for class, almost all of them, fully 90% came in at a ridiculously low five hours or less, 55% at one hour or less.” Or, a report from the U.S. Dept. of Education, “2004 Trends In Academic Progress,” which sampled thousands of 17-year-olds: “when asked how many hours they had spent on homework the day before, the tallies were meager. Fully 26% said they didn’t have any homework to do, while 13% admitted that they didn’t do any of the homework they were supposed to do. A little more than one quarter (28%) spent less than an hour and another 22% devoted one to two hours, leaving only 11% to pass the two hour mark.”

The 2001 National Assessment of Student Progress measuring historical knowledge of high school seniors revealed that 57% scored “below basic” while only 1% reached “advanced” levels of historical knowledge. The same NEAP exam in 2006 given to 29,000 students, for seniors the “below basic” category tally dropped to 54%, the “proficient” category recorded 12%, while those reaching the “advanced” level remained at 1%. Dr. Bauerlein amplifies: “two-third of high school students couldn’t explain a photo of a theater whose portal reads ‘Colored Entrance.’”

A July 2006 Pew Research Center report on newspaper readership found that only 26% of 18-to-29-year-olds could name Condoleeza Rice as Secretary of State. A 2006 project by the Intercollegiate Studies Institute involving 14,000 freshman and seniors at 50 colleges and universities from Harvard to less known institutions asked questions regarding American history, government, foreign relations, et., and yielded disappointing results: the average score for freshman was an F, 51.7% out of 100% possible, the seniors, after 4 years of immersion in college curricula and much money spent on their behalf, scored 53.2%—still an F. At Berkeley the students actually regressed from a 60.4 in their freshman year to 54.8% their senior year.

(Continued on page 6, see *The Dumbest Generation*.)

Prospective Longitudinal Study Examines PTSD Developmental History

A group of New Zealand researchers published the results of their longitudinal look at the developmental history of PTSD. Karestan Koenen and her colleagues found that nearly all the adults in their study with current or lifetime PTSD had a history of prior mental disorders, “most before the age of 15.” Koenen, et al, published their results in the May 2008 issue of the *Journal of Abnormal Psychology* [“The developmental mental-disorder histories of adults with posttraumatic stress disorder: A prospective longitudinal birth cohort study,” 117(2), 460-466.]

The authors “examined developmental mental-disorder histories in an unselected sample of adults with PTSD, using data on mental disorders assessed across the first 3 decades of life among members of the longitudinal Dunedin Multidisciplinary Health and Development Study” (p. 461). They explained that such a research method avoids focus on treatment-seeking individuals, because clinical samples may inflate the probabilities.

Koenen, et al, note that “this birth cohort was first evaluated for current and lifetime PTSD at 26 years of age, as part of a comprehensive psychiatric assessment. Other mental disorders were assessed starting at age 11” (p. 461). A total of 1037 individuals were members of the cohort and the authors assert that the cohort represents the “full range of socioeconomic status in the general population of New Zealand’s South Island and are primarily White” (p. 461).

The authors found that the lifetime prevalence of PTSD at age 26 was 9.6%. They describe their data-gathering procedure: “PTSD was assessed via the same procedure at 32. Participants were queried as to whether they had had a ‘frightening or horrible’ experience since the age 26 assessment. (...) Those who endorsed such an experience were then evaluated for PTSD” (p. 462). The authors observed that the research subjects reported a variety of single event traumas, such as death of a close family member or friend, personal assault, hearing about or witnessing a close friend or family member experiencing an assault or personal injury, personal illness. Less than 2% of the respondents had experienced natural disaster or war (p. 462).

Koenen, et al, report that “In total, over 93% of participants diagnosed with lifetime PTSD and 100% of those with current PTSD at age 26 had received another mental-disorder diagnosis by age 21. Adults with PTSD at age 26, whether assessed as lifetime or current, were significantly more likely to have been diagnosed with major depression, an anxiety disorder other than PTSD, conduct disorder, marijuana dependence, or alcohol dependence by age 21 than trauma-exposed adults who did not develop PTSD” (p. 462). They add that “Among new cases of PTSD at age 32, 96.3% had a prior mental disorder diagnosis, and most (77.8%) had been diagnosed with another disorder by age 15” (p. 644).

The authors discussed the difficulty of following diagnostic criteria over time in longitudinal studies, especially with PTSD. For instance, they observed that 40.7% of new cases of PTSD at

age 32 had received a conduct disorder diagnosis by 15 years of age (p. 644).

In discussing their conclusions, Koenen, et al, write: “Finally, our findings have implications for the treatment of PTSD in adults and the prevention of the disorder. Clinicians who serve clients with PTSD commonly collect information about other current psychiatric difficulties, such as major depression and substance use disorders. However, our data suggest that adults with PTSD are also likely to have a history of other mental disorders and for many individuals this history extends back to early adolescence. PTSD clinicians may, therefore, find their treatment approach informed by integrating information on client’s developmental mental health histories into their case conceptualization. Moreover, the majority of adults with PTSD met criteria for a juvenile mental disorder. Juvenile mental-disorder histories may provide information on which individuals are most at risk of developing PTSD in populations at high risk of trauma exposure, such as military personnel and first responders” (p. 466).

Comment

We noted in the New Zealanders’ report that most of the traumas described in their data gathering were single event traumas, such as witnessing the death of someone close. It seems reasonable to speculate that single event traumas are more likely to cause those with histories of mental illness to develop PTSD than those with more healthy backgrounds. It is different for those who participate in ongoing combat, which almost always results in multiple Criterion A exposures over a period of many months. In a population of combat-exposed persons, the likelihood of someone having a diminishing ability to cope with succeeding Criterion A events also seems likely. This, in most cases, would produce veterans with PTSD who do not have prior mental health histories. However, the onus is still upon the veteran with PTSD to disprove that he or she was made vulnerable because of poor developmental histories. Such a bias is used by those who would romanticize war and wish to minimize the mental health consequences of continuous fighting.

There is some history to the debate over the etiology of PTSD. Recall that the U.S. Army after World War II commissioned movie director John Huston to make a documentary about GIs returning with combat fatigue. He made the film at a real New Jersey Hospital with real doctors and patients. The Army didn’t like the implication that combat conditions led to combat fatigue. They shelved the movie, asserting that proper releases had not been obtained, although Huston claimed he had releases and offered to recontact the patients. The Army remade the film using another director and actors playing doctors and patients, and turning a mixed race cast into an all white cast. The gist of the new “documentary” was that poor child rearing, the fault falling mainly on the mothers, was the root cause of combat fatigue. EE ##

Hyperarousal in PTSD: Aggression, Numbing, and Restlessness

Researchers in 2007 found the hyperarousal symptom of PTSD was associated with aggression in Vietnam War veterans. Casey Taft and others published the results of their research in the *Journal of Abnormal Psychology* [Posttraumatic Stress Disorder Symptoms, Physiological Reactivity, Alcohol Problems, and Aggression Among Military Veterans, 2007, 116(3), 498-507]. In reviewing literature of previously published research on veterans, Taft, et al, speculated that hyperarousal (such as hypervigilance, difficulty with sleep and concentration, and exaggerated startle response, was predictive of anger, and that alcohol problems would serve as an additional mediator between hyperarousal and aggression.

Taft, et al, examined 1168 Vietnam War veterans who were engaged in treatment at the Veterans Affairs Boston Healthcare System. Research subjects were assessed with the PTSD module of the Structured Clinical Interview, along with measures of alcohol use, aggression and physiological arousal in response to stress. They concluded their analysis by stating, "taken together, these results suggest that the relationship between PTSD symptoms and aggression are best explained by higher hyperarousal cluster scores. In addition, hyperarousal symptoms were associated with a greater frequency of aggression through their relationship with alcohol problems. Findings for the mediational role played by alcohol problems are consistent with self-medication conceptualizations of PTSD-related alcohol problems that highlight the role of hyperarousal...." (p. 504).

In a related report published in the *Journal of Traumatic Stress*, [Unpacking the Relationship Between Posttraumatic Numbing and Hyperarousal in a Sample of Help-Seeking Motor Vehicle Accident Survivors: Replication and Extension, 2008, 21,(2), 235-238], Sarah Palyo and colleagues examined and confirmed the relationship between hyperarousal and posttraumatic numbing in a sample of 345 persons involved in motor vehicle accidents. Subjects with head injuries were excluded. Researchers selected only those who met Criterion A for PTSD.

Palyo, et al, assessed their subjects with the Clinician Administered PTSD Scale and the Beck Depression Inventory. They reported, "Similar to previous studies, the current study found evidence for a robust association between hyperarousal and numbing, even while accounting for the influence of related constructs such as re-experiencing, avoidance, and depressive symptoms. This suggests that neither reexperiencing nor avoidance symptoms have a direct association with emotional numbing after accounting for the influence of depression and hyperarousal. Moreover, despite any overlap between numbing and depression, depression only partially explained the variance in numbing" (p. 237).

Comment

The associations made by the above research which connect hyperarousal with aggression and numbing, leave us with an entirely negative sense of what hyperarousal is about. There is also a positive manifestation of hyperarousal, which, because it is not a problem producing symptom, understandably does not receive attention from researchers.

A combat veteran may experience the negative effects of hyperarousal, such as feelings of anger and rage, may experience restlessness and disturbed sleep, yet may also be able to direct his or her arousal in a creative direction. Such veterans, of course, do not necessarily come to the attention of clinicians.

It is a challenge for psychotherapists to take the content of the veteran's report, for example, that he or she rages at the encounter with poor driving on the highway, and consider what positive applications there are for that restless energy. I recall once sitting after dinner at the home of a Vietnam War veteran. Our families were soporific from dinner and it was late, approaching 10 o'clock in the evening. We were about to head home when the combat veteran host suggested that we might want to drive up into the Cascades to see the Pleiades shooting stars. This was after an afternoon of fishing and basketball.

Hyperarousal is not necessarily the most prominent symptom of PTSD in many veterans, but for some it presents the ultimate challenge. Early in post-war adjustment, the veteran may change jobs and residences, may build a house and then move to another, may start a project to have in waiting when he finishes the one he's on now, but as the veteran ages, that abundance of energy generated in the hyperarousal symptom is likely to grow less troublesome. Provided that the veteran's life is not already trashed, he may be able to sense that the wild horses that pulled his chariot were—while not yet normal—slowing some.

So the veteran gets up at 4 or 5 AM. Awakes alert, even with a start, but what then can he do with his time? One veteran I know, who would otherwise be driven to self destructive guilt, has taken up a religious discipline that directs him to focus on the present, to do charitable acts, and find a busy positive direction for his energy.

Aggression, numbing, alcohol and drug use, are symptoms associated with PTSD that hold our attention because of the problems they cause. Disconnecting that energy from the traumatic source, for hyperarousal and memory do not have the same source in the brain, can allow the veteran to give his energy a direction that has some creative outlet. The veteran's creativity may not take the form that the therapist might wish, their values being different, but the outcome could be positive. The veteran may be playing the horses at Emerald Downs, or fishing at the mouth of a salmon stream, or writing a book about the war, or reclaiming and replanting acres of clear-cut land, but the only important variable is that the veteran *feels* something of value is happening. A symptom may be a source of psychopathology or it may be a resource for restoration. EE ##

Symptom Complexity and Accumulated Childhood Trauma

Bedeveling diagnosticians and front-line mental health workers is the problem of persons presenting with multiple childhood traumas showing multiple symptoms that defy easy categorization. John Briere and others, including Judith Herman, have asserted that clients with accumulated traumas that start in childhood present in clinics and medical offices with a shotgun pattern of symptoms. There has been a general agreement with this hypothesis, but so far no research evidence. Briere, together with Stacey Kaltman, and Bonnie Green have now presented evidence they have gathered on their thesis. They published their results in the *Journal of Traumatic Stress*, [2008, 21(2), 223-226].

"We tested three hypotheses regarding trauma complexity in this study: (1) After controlling for potentially relevant demographics (age and race), there would be a linear association between cumulative childhood trauma exposure and extent of symptom complexity; (2) child abuse (e.g., physical or sexual maltreatment) would be associated with more symptom complexity than other forms of childhood trauma; and (3) cumulative childhood trauma exposure would predict symptom complexity even when controlling for those significant individual traumas identified in the evaluation of Hypothesis 2" (pp. 223-4).

Complex PTSD

To test these hypotheses, the authors gathered data from 2496 women who were in their second year of college or university study. They were administered sleep and trauma symptom inventories. Briere, Kaltman, and Green found that their analysis confirmed a linear, positive relationship between number of trauma types and extent of symptom complexity. Furthermore, they found that child rape and child physical abuse uniquely predicted symptom complexity (p. 224).

"The current study suggests a linear relationship between (a) cumulative childhood trauma, as measured by the total number of different types of childhood traumatic events experienced by university women, and (b) symptom complexity, as indexed by the total number of simultaneously elevated TSI (Trauma Symptom Inventory) scales" (p. 225). The authors proceed to assert "multiple traumas may lead to multiple symptoms when specific effects of various trauma exposures summate time. However, the finding for accumulated trauma also suggests a role for the general experience of repeated traumas per se, above-and-beyond specific trauma exposures" (p. 225). The authors reiterate their observation that "although cumulative trauma appears to increase symptom complexity, childhood rape and physical abuse were also unique predictors" (p. 225).

Briere, Kaltman, and Green make note of the theoretical spiral of persons with multiple traumas in their histories: "not only may multiple traumas produce multiple symptoms,

but also highly symptomatic individuals may be more vulnerable to trauma exposure" (p. 226).

Comment

The confirmation of Briere's long held thesis adds to the knowledge of the line therapist who sees clients every day who present with the symptom complexity of a somaticizing borderline personality disorder. It does provide a justification for including so-called complex PTSD as a diagnosis. There is little help, however, regarding how to treat an adult with multiple traumas in the history.

It seems that the first chore is for the therapist to attempt to understand the number of traumas as specific events, avoiding the client's own inclination to generalize and avoid. What symptoms are attributable to what trauma? The question probably cannot be answered definitively, because the genesis and attribution of a particular symptom itself may shift with circumstances. The issue of anniversary triggering of symptoms becomes a chore to understand when traumas accumulate over the years, overlapping each other in time-of-year.

Traumas that are both early and severe contribute symptoms that develop with personality and may take on psychotic dissociative strength. Such patients rarely present without a cumulative medical track record including a variety of diagnoses and a list of medicines, tried and interacting.

There is the additional facet of persons with multiple childhood traumas displaying cumulative symptoms coming disguised as veterans of the Wars on Terror, with new layers of attention-getting recent traumas, most of which have meaning far beyond the current wars.

We see in the office clients whose traumatic experiences evoke childhood feelings that are a challenge to separate. One ends up proceeding gingerly, like walking in a spooky graveyard carefully to avoid stepping on the deceased.

Briere, Kaltman, and Green capitalized on a ready pool of female college sophomores and rightfully warn us to be cautious about generalizing their results. They conclude, however: "Nevertheless, the current findings suggest that even in a sample of presumably high-functioning women, multiple trauma exposure is not uncommon and is associated with relatively complex symptomatology" (p. 226).

It may be the function of many therapeutic encounters to spend sufficient time dwelling on the symptoms as they are provoked in current activity, unraveling the various knots of complexity, to finally be able to lend some perspective about how the client might predict, cope, and hopefully ameliorate the symptom presentation. It takes a sophisticated understanding to make a case, particularly to institutions of funding, that taking time to unweave the pattern (as Odysseus' Penelope did her father-in-law's funeral cloak) is required, until the time is right to let the work be completed. EE ##

The Dumbest Generation, Continued from page 2.

“The 2006 American Freshman Survey found that only .05% of first year students intended to major in physics, .08% in math and 1.2% in chemistry, although engineering improved to 8%.” The American Freshman Survey 2005 reports that 71% of students attend college “to be able to make more money, up from 46.6% in 1971.” The most popular major is business. International comparisons also present troubling trends. A 2003 survey by the Programme for International Student Assessment, testing 15-year-olds in 42 countries in math and science, emphasizing the application of concepts to real life problems, found the U.S. student ranked 27th.

After citing more data demonstrating deficits in knowledge of the fine arts and geography, Dr. Bauerlein personalizes it (at least for those of us entering geezerhood) by comparing the after school time of the teenager of the 1950s and 60s with today’s “wired” generation. The “old time” bedroom contained a few books, a radio, a writing desk, etc. The TV was in the living room, under the parents’ control, as was the telephone. Social life essentially ended as he/she entered the house. Family meals, household chores, homework, and family TV viewing typically rounded out the evening. Contrast that with today’s “wired” youth who arrives home chatting on her cell phone, goes straight to her room, closes the door, checks her e-mail, turns on the TV, sends a text message to a friend (with whom she has spent the day), checks her blog and fires off a couple of witty rejoinders, next, her MySpace needs some updating, etc., spending several hours floating in a kind of multi-tasking heaven of communication.” No longer bound by time and space the perennial needs and concerns of adolescence are given free reign. Staying in close contact with friends, identity issues (you can be anyone you want to be in the chatroom), absorbing the latest trends in music, dress, etc., tend to crowd out more serious and remote concerns such as reading assignments, mastering homework, and developing intellectual curiosity. “Digital natives are a restless group, and like all teens the young adults are self-assertive and insecure, living in the moment but worrying about their future, crafting elaborate e-profiles but stumbling through class assignments, absorbing the minutiae of youth culture and ignoring works of high culture, heeding this season’s movie and game releases as monumental events while blinking at the mention of the Holocaust, the Cold War or the War on Terror.”

Writing habits suffer, teens stick to phonetic spelling, low diction, simple syntax, all in the name of speed and ease. I suspect that if a teenager were to become too loquacious or given to prolixity on her blog conversations, she would suffer ridicule and would soon learn to bring it “down.” Dr. Bauerlein points out that to the average 17-year-old the significance of the web is not that it puts the universe of knowledge at his fingertips, but that it promotes non-stop peer contact where *his* concerns, not those of adults, parents or educators, are addressed. Besides, only an idiot would spend his time learning to spell correctly when spell check can do it for you, and why would anyone learn dates, places, and specific events when

they are only a few clicks away? The same applies to complicated math equations. If it is not immediately relevant to his life, what’s the point of wasting time on non-entertaining and uninteresting stuff when he has more important things on his mind--like can he afford a new I-Pod? When the web is used for homework, however sparingly, cognitive scientists raise questions about what kind of intelligence is being developed, an information retrieval model is not the same as a knowledge formation model of intelligence.

Dr. Bauerlein has a chapter called “The Betrayal of the Mentors,” wherein he spends many pages describing how prominent educators, journalists, and other digital cheerleaders have confused the potential of the digital revolution with the way it is actually used by today’s young people, and mistaken e-literacy for knowledge, resulting in the intellectual deficits which he so copiously documents.

Dr. Bauerlein’s final and perhaps most distressing concern is that as the millenials come to dominate the voting population, “From their ranks will emerge few minds knowledgeable and interested enough to study, explain and dispute the place and meaning of our nation,” and there goes what’s left of our democracy.

From a more personal perspective, I have witnessed, not without duress, my children, current ages 25 and 23, progress through high school and college very much a product of the different social and mental life that Dr. Bauerlein cogently describes. I high recommend this book. ##

VA Suicide Prevention Line Receives Up to 250 Calls Per Day

The Department of Veterans Affairs suicide prevention hotline has been well-used, according to an Associated Press story by Katharine Euphrat [*Seattle PI*, 7/29/2008]. More than 22,000 veterans have called the hotline, according to a RAND Corp. study. The Department has spent \$2.9 million on the project.

The AP reports that the VA estimates that every year 6,500 veterans take their own lives, that is about 18 veterans committing suicide every day.

The VA Suicide Prevention hotline (1-800-273-8255), according to the national suicide prevention coordinator for DVA Janet Kemp, “was put in place specifically for those veterans who don’t get enough help until it’s too late.”

Ms Kemp stated the veterans “have indicated to us that they are in extreme danger, either they have guns in their hands or they’re standing on a bridge, or they’ve already swallowed pills.”

The AP story reports that “in April, two veterans groups sued the VA, citing long delays for processing applications and other problems in treatment for veterans at risk for suicide.” ##

Movie Review:

***Dark Heart*—A film to avoid.**

Reviewed by EE

Dark Heart is a dark independently made film that does not warrant viewing. Directed by Kevin Lewis, it stars Greg Joelson as an Iraq War veteran who visits his sister only to find out that she has cancer. At a local bar, “The Stuck Pig,” he meets an old friend and they drink beer together. The lighting on the sets is dark and the dialog stilted. The film cuts between moody close-ups showing the Iraq veteran and other men at the bar watching him. One of the observers turns out to be a Vietnam War veteran. Both men, as happens, are veterans of the Army Special Forces. The Vietnam War veteran and his friends overhear the Iraq War veteran describing the capture of a huge sum of money, millions of dollars in cash. The observers assume that the Iraq War veteran has some of the cash. They proceed to ambush him, beat and torture him to get him to talk. The scenes of brutality are usually cloaked in darkness and go on a long time.

Dark Heart is cynical and brooding. It is an example of a cheaply made exploitation of war veterans. The good war veteran has to endure hostility, pain, and brutal torture from the bad veteran of the previous war.

A common motif among war veteran films is the meeting of representatives of wars past and present. Usually the encounter results in tension, often the older war veteran diminishing the importance of the current war by comparison with his war. In *Dark Heart* the Vietnam War veteran engages in a monolog about how badly he was treated by the American public, and how it turned him into a criminal. “We both fought in wars, but I got blamed for mine. My dream became a nightmare.”

Other recent Iraq war films, *In The Valley of Elah* and *Stop-Loss* dealt with the veteran coming home to dark times. *Elah* presented the relationship of the Vietnam War veteran father and the Iraq War veteran son, dealing with hard anger and grief. *Stop-Loss* and *Elah* tackle the subject of injustice as the major theme. The two films, however, have the distinct advantage of having well composed plots, good acting, and dramatic direction that carries the story to a satisfying, if dark, conclusion. What makes *Dark Heart* so bad is the terrible script, the poor direction, moody dark photography, and the unabated cynicism.

War veteran films frequently deal with the challenges the veteran faces in his homecoming. The theme is as old as Homer’s *Odyssey*. One of my favorite films that depicts the dark time for the war veteran is Ingmar Bergman’s *The Seventh Seal*, which features the arrival of a knight home from the Crusades wrestling with doubt about the meaning of the war. He is confronted by Death, who is going to take him away. He challenges Death to a chess game and they play throughout the movie as the knight and his squire travel through their homeland that is in the throes of the Black Plague and religious torment.

Dark Heart takes this archetypal theme and becomes wrapped up in the darkness so thoroughly that the viewer wants to flee to light, any light. ##

King County Veterans PTSD Contractors Get VA Briefing



The King County PTSD Contractors met for their quarterly meeting on July 11, 2008, at Building One of the Seattle Puget Sound Health Care System. The 10 Contractors attending received a briefing from Steve Hunt, M.D. (pictured above) who outlined the treatment processes that are being administered by the VAMC Post-Deployment Clinic.

Dr. Hunt estimated that 15% of the veterans seen at the Deployment Clinic have PTSD, and many more have symptoms amounting to subsyndromal PTSD, but not the symptoms to qualify for the diagnosis. He noted that hearing loss, depression, musculoskeletal and dental problems were the most frequent reasons for veterans returning from deployments to seek clinic services.

Dr. Hunt observed that some veterans were re-deployed who had been diagnosed with PTSD, and that their symptoms improved when they returned to Iraq.

Contractors discussed with WDVA PTSD Program Director their wishes for future meetings to discuss mutual needs in providing services to war veterans and families. ##

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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Trauma Memory and Hyperarousal

An Associated Press story out of Tucson is instructive regarding the nature of PTSD in combat veterans. The story is by Arthur Rotstein, [5/14/2008, "Marine who died after police chase had PTSD," posted on marinecorpstimes.com]. Travis 'T-Bo' Twiggs shot and killed his brother, Will, before committing suicide. They had been on the run from the police in a chase that ended on the edge of the Grand Canyon.

Travis Twiggs had been a sergeant in the Marine Corps. He had served three deployments in Iraq and one in Afghanistan. Before his death he wrote an article for the *Marine Corps Times* about how his PTSD had developed. He wrote in his article, according to the AP story, that he began noticing PTSD symptoms after his second tour of duty. He described the symptoms as paranoia, sleep disturbance, difficulty being around people, irritability, and difficulty with concentration. He wrote that the symptoms disappeared when he returned to the combat zone, only to worsen when he again returned home. The pattern repeated when he returned for his fourth tour.

When he died, Sergeant Twiggs was AWOL from his duty assignment at the Marine Corps War Fighting Laboratory in Quantico. He had been treated for alcohol abuse.

Comment

One can only speculate as to what Sergeant Twiggs and his brother were doing when they fell victim to what the reporter described as a murder-suicide. They had been chased from the border. Had car-jacked one car and crashed it near the top of the Grand Canyon. They escaped with large backpacks and carjacked another vehicle.

Perhaps the motive had to do with the same symptoms that kept Sergeant Twiggs going back into combat. When he returned to the combat zone, he said, his symptoms dissipated. Only in the conditions mimicking a combat zone is the present commanding enough to draw attention away from traumatic memory.

Sergeant Twiggs had some status in the Marine Corps, given that it's magazine published his article and he held a position at the War Fighting Laboratory at Quantico. But a peaceful interesting life was apparently not salient enough to quiet his memories—the disturbing dynamic combination of hyperarousal and traumatic memory, one triggering the other, the two basic sources that generate all the symptoms of PTSD, would not leave him in peace.

When someone with PTSD encounters a scene that is threatening, the memory of trauma takes second place to survival and the adrenalin-charged symptom of hyperarousal is put to appropriate use, like the sailor who loves sailing in a storm.

The possibility that Sergeant Twiggs and his brother were engaged in smuggling across the border, at least fits the motif of seeking situations that mimic combat. Why the murder-suicide, is another matter, perhaps more to do with their family dynamics than combat.

The Romans gave their retiring Legionnaires land on the borders, where combat conditions could be mimicked. Here we expect our warriors to settle down and find someplace to fit. EE ##

Suicide Among War Veterans

Suicide among war veterans has been an issue, at least since the Vietnam War veterans returned. It seemed like an urban legend developed in the form of rumor that a disproportionate number of war veterans were committing suicide. The current epidemiological data that has emerged is from the journalistic discussions of suicides among the veterans of the Wars on Terror. CBS News featured a sensational program in November 2007. They took 2005 data from 45 states and came up with rates for veterans around twice that of non-veterans.

The problem with gathering statistics on suicides, as CBS noted, is that some states do not report the veteran status. There is also the Departments of Defense and Veterans Affairs reporting of suicide rates, active duty personnel usually distinguished from deployed Reserve and National Guard data.

To complicate the problem, the veterans themselves find ways to commit suicide that appear to be accidental deaths: such lethal actions as single car "accidents," drug and medication overdoses, firearms mishaps, drownings, SWAT team shootouts, etc. Such events have always been suspect as to the deceased's motivation.

The issue with war veterans and active duty combatants is the daily proximity and acceptability of death. Tens of thousands of men and women with firearms and dangerous equipment participating and witnessing firefights and violent deaths of all sorts, while separated for long periods from loved ones, gives temptation for impulsive acts such as suicide. The return of the veteran to a peaceful environment elicits a feeling of alienation from those not so exposed to death. The alienation sets in because the veteran has conscious memories of recent deaths and the saliency of those memories suggest that death is an option.

It is said that suicide runs in families, and the Hemingways are an example. Ernest Hemingway's father, his uncle, his daughter, and the author himself all committed suicide, not because suicide is provoked by genetic transmission, although the mood disorder may be, but because death is present as a conscious option.

We have heard plenty of stories about how the perception of death changes as a result of prolonged combat. The process of emotional numbing blunts the fear and empathy responses. When death becomes a frequent event, expectation of death and a sense of fate in relation to death become real. A soldier takes chances he or she would have avoided in training. A veteran takes chances to see if fate is still relevant. Soldiers who escape death when others have died, the wounded who almost died, have an awareness of death's proximity.

The DVA National Center for PTSD published a "Fact Sheet" that expanded yet further the ambiguity of causality. The studies cited addressed the question of other psychiatric disorders that are co-morbid with PTSD, chief among them being mood disorders and substance abuse, contribute to motive for suicide. The risk factors the Fact Sheet lists point to the combat veteran as a prime risk: male gender, alcohol abuse, family history of suicide, older age, poor social-environment support, possession of firearms, and, we would add, exposure to death as a way of life. EE ##

Book Review:**Walt Whitman's Memoranda
During the War**

Reviewed by Emmett Early

Walt Whitman published his collection of poetry, *Leaves of Grass*, in 1860. Between 1863 and 1865 he worked as a volunteer visiting Union and Confederate wounded in hospitals in and around Washington DC, as well as field hospitals near battlefields. He would visit wards with small gifts of tobacco, candy, books, writing supplies. He would write letters for the patients or simply sit and visit, passing many nights as patients suffered and died. During these visits he took notes that he kept and collected in little notebooks. His *Memoranda* is a selection of those collected notes.

He writes: "In my visits to the Hospitals I found it was in the simple matter of cheer and magnetism, that I succeeded and help'd more than by medical nursing, or delicacies, or gifts of money, or anything else" (p. 30). He referred to this period, the three years of witnessing so much suffering as "The most profound lesson and reminiscence, of my life" (p. 101).

Whitman describes men in great detail, both patients and many soldiers he met on the streets of D.C. His writing is rich in detail and flows with a sense of modernity. He is both admiring of others and humble in his self description. Apparently he had a network of citizens who contributed money, food, and brandy for him to distribute.

Whitman captured vivid scenes of the Nation's Capital during that time, with parades of troops, particularly the buildup to the Battle of Gettysburg and the huge influx of troops after the surrender, including bedraggled prisoners and Southern deserters. His own brother was in the Union army and was captured and held in the notorious Andersonville Prison. Whitman was appalled at the conditions that caused so many starvation deaths. His brother was eventually able to escape and return to the North.

Abraham Lincoln frequently passed by Whitman on his way to his office at the White House accompanied by a phalanx of Union cavalry with drawn sabers. He described Lincoln's inaugural ball, which was held at the Patent Office, which had served as a hospital for many wounded men. Whitman writes in a manner that is like many returning combat veterans whose memories of trauma intrude on their civilian experiences.

"I have this moment been up to look at the gorgeous array'd dance and supper-rooms, for the Inauguration Ball, at the Patent Office (which begins in a few hours;) and I could not help thinking of those rooms, where the music will sound and the dancers' feet presently tread—what a different scene they presented to my view a while since, fill'd with a crowded mass of the worst wounded of the war, brought in from Second Bull Run, Antietam and Fredericksburg. To-night, beautiful women, perfumes, the violins' sweetness, the polka and the waltz; but then, the amputation, the blue face, the groan, the glassy eye of the dying, the clot-tered rag, the odor of wounds and blood, and many mother's son amid strangers, passing away untended there, (for the crowd of the badly hurt was great, and much for nurse to do, and much for surgeon.)" (p. 79). EE ##

**Health Influence of Sexual Harassment
and Assault Among Reservists**

Amy Street and her colleagues at the Boston VA examined the incidence of sexual harassment and assault among reservists and looked at correlates in health compared to those who were not assaulted. They published their results in the *Journal of Rehabilitation Research & Development* ["Sexual Harassment and Assault Experienced by Reservists During Military Service: Prevalence and health correlates" 2008, 45(3), 409-420].

Street, et al, used the federal definition of sexual harassment: "'unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature' that occur in a work setting" (p.409). Previous studies of the subject among active duty military reported 78% of women and 38% of men reported at least one event of sexual harassment or assault in a 1995 survey. A similar figure was found among women serving in the First Gulf War. They reported 69% positive for sexual harassment and 7% reported sexual assault (p. 410).

Street, et al, surveyed 3946 former reservists of all branches of the military (2318 females and 1628 males) who had completed military service by the end of 2000 and who had not served any significant time on active duty. The authors explained, "A participant was considered to have experienced sexual harassment if he or she self-reported at least four separate potentially harassing experiences or at least one experience presumed to be more severe (i.e. extortion of sexual cooperation in return for job-related considerations)" (p. 412).

Results reported by Street, et al, are similar to the earlier results reported in studies of active duty military. "As expected, higher proportions of female reservists reported sexual harassment (60% vs 27.2% for males) and sexual assault (13% vs 1.6% for males)" (p. 416). The authors noted (p. 414) that the sexual assault percentages were included in the sexual harassment figure.

Regarding health correlates, Street, et al, reported finding "Almost a decade after service (on average), reservists with these experiences reported significantly poorer health status than other reservists" (p. 416). The authors observed "While the experiences of reservists have been overlooked in previous investigations, these prevalence estimates indicate that despite part time service, experiences of sexual harassment and assault are likely to impact a substantial number of members of Reserve Forces, perhaps with long-lasting deleterious effects. This issue is important to VA healthcare providers because public law allows reservists who experienced military sexual trauma to seek free care for associated mental and physical health considerations from VA hospitals regardless of whether they would otherwise be eligible for VA care" (p. 417).

Comment

The consistency of the findings in sexual harassment surveys among military personnel is in itself validating. The added perspective of the health consequences adds concern for long term care. It seems unlikely that less healthy persons are selectively harassed or assaulted such that it would skew the health correlates. EE ##

Identifying and Meeting the Needs of Returning War Veterans

By Tom Schumacher

Guiding the PTSD Program is not always a self evident venture. One might think that offering services to war exposed veterans and their families should be a simple matter. Select contractors and create funds for them to do what they are expected to do: offer the best counseling services possible and just wait for things to happen, and clients to come for care.

Reality paints a much more complex picture. It is also not a simple matter to know by way of needs assessment studies or by intuition where and how to create services. The Vietnam War veteran subculture had several years to develop and evolve before treatment programs were created.

Today we have a steadily emerging need to develop services that can be located by the returning veteran or their family members. Individuals with PTSD are in many cases not yet aware that they are having problems. WDVA and approximately 30 other agencies have connected to offer event-driven services where teams of agencies converge on the local National Guard Armory. This method has had great success in some settings, and at critical times such as the point of deployment, the period during the deployment, or the opportunity soon after deployment. During the longer periods between deployments, interest in services seems reduced, although offered steadily via special events and family activities. During these in-between periods it is the individual veteran or family member who seeks out help. Sometimes they know just where to look, as on the internet, or the VAMC Post-Deployment Clinic, a Vet Center, or the WDVA PTSD Program.

Colleges and University—Veteran Students

The WDVA PTSD Program is working on new ways of helping veterans with war related issues. These methods include one effort to connect with community and technological colleges and universities, and especially on-campus counselors and faculty. Peter Schmidt, Psy.D., has been visiting selected campuses around the state when free from his regular job, offering in-service training and consultation help. At last count he has provided 13 such on-campus in-service events ranging from 2 to 4 hour presentations. In a recent event at Evergreen College in Olympia, Tracy Simpson, Ph.D., Co-director of the Women's MH Clinic, VAMC, joined the effort and added important information about military sexual trauma. Steve Tice, M.Ed. Liza Tice, MSW also contributed to this effort.

Returning veterans may face challenges of going from combat to classroom in a very short period of time. Loss of one's unit support remove one of the few social supports that helps the veteran manage combat experiences. This loss of social support and the memories of combat may have proven too difficult for some.

An estimated 6,500 hundred veterans take their own lives each year in the US. That is approximately 18 per day, about one-half of these are Vietnam War veteran age and older veterans. The remainder are believed to be younger veterans. I know of two veteran-students on Washington campuses who have died in 2008. The need for more outreach in Washington is apparent, and the effort to reduce the stigma of obtaining services must be stressed. Family and friends must know what to do if they suspect someone is depressed or running out of options for living.

The recent expansion of the GI Bill of Rights will result in many new veterans coming home to start or resume pursuing their academic goals. The campuses of Washington State need to do their own *homework* in this regard, and prepare for the expanding need to be more veteran oriented. Peter Schmidt is helping us connect with agencies of higher education to help create the culture changes needed on campuses, and to reduce the stigma of seeking help.

The Veteran Court—When will we have real justice?

While some of the areas needing change in the effort to reach individual veterans and family members involve services before real harm is done to themselves or others, other interventions must come from a change in the way society *manages* its reactions to our returning warriors. This includes the way we interpret behavior and form opinions. Even more fundamental questions of cause and effect arise; how combat influences behavior in the post-war life of a veteran, and the need to consider the differences in revenge, sufficient treatment, or real justice.

During and after every war, there is ample proof that lives are altered by combat and war exposure. One only need watch *PBS Mystery Theater's* offering of *Foley's War*, to see the true-to-life changes that occur for the vast majority of combatants. Anyone with even limited powers of observation would conclude that people are changed by exposure to the rigors of combat and killing. Killing, losing comrades, being wounded, heavy personal responsibility, post-combat struggles with memories and images, smells, and the taste of war, are huge factors for many people returning from combat.

When war veterans come home, many continue to live as though they are absorbed by the experiences of war. Each war era has a set of unique features that continue to elicit veteran responses that are essentially classically conditioned to cope with the actual trauma event. Without treatment, these response patterns can be re-elicited by a single or complex set of stimulus events resembling the actual trauma.

For the current war we see cases wherein the veteran is impelled to corrective or neutralizing action that does not turn out well on the home front. A veteran engaged in con-
(Continued on page 11, see *Meeting War Veterans Needs*)

Meeting War Veterans Needs, Continued from page 10.

voy duty for many months or doing foot or vehicle patrols must learn what is safe and what is certainly a life-and-death trap engineered to ensnare a unit or individual.

When a human being survives one or many of these situations, it is only natural that a repeat of key circumstances surrounding the combat response will have the potential to elicit the same survival measures. Rapid and unthinking responses are essential for survival in combat, but pose significant trouble for the veteran once home.

In Washington State we have had a number of cases arise wherein veterans were doing what they do best—react, survive, and defend the unit and themselves. However, some of these reactions represent a major failure on the part of the veteran to read the context of the situational features, and therefore the legitimacy of their reactions. This loss of perspective is costing some veterans dearly.

When trigger events re-create a war time scenario, the veteran may react in a way that would be perfectly correct in a combat zone—behavior that would win the soldier praise and awards *in-country*. However, once home, these same attributes are now deemed illegal, a menace to the public good, dangerous, and requiring legal action and harsh legal sanctions. Or as one prosecutor recently said, “I want to make an example of this veteran.”

The courts failure to consider alternative approaches to behavioral and mental health issues facing our warriors, adds huge costs to the management of these individuals. Sending an honorably discharged and decorated combat veteran to prison for 10 years costs over one-half million dollars. His or her family is left to fend for themselves, children lose a parent, and we create layers of shame and hardship for this entire family. This same veteran could be treated for the war trauma issues, returned to the community, and become a productive citizen for less than 5% of this \$500,000. The veteran would also be able to have a career, become a contributor to society and his family, be a tax payer, and with treatment may actually turn the negative impact of war into a personal and societal victory.

There is no treatment for PTSD in prison. And as of today, unless there is an enlightened judge, a wise prosecutor, and an vocal community, a war veteran who gets into trouble with the law, may end up in prison. He will come home after serving extensive time in prison with even more layers of treatment resistant problems related to war, loss of identity, loss of family, personal meaning and purpose, and now suffering institutional trauma at the hands of his own country. This, only because no one in the local legal system was able to put together the well known facts that war veterans suffer as a result of combat and other traumatic experiences, and that these experiences (when not treated) may result in major behavioral problems once home.

It is time that our state and nation consider another way of helping war veterans. I believe that we need a *veteran court* established in state law similar to other special courts for mental health and underage offenders. Presently there are no standards for considering a veteran’s case, no required evaluations by experienced professionals, or other special reviews or consultations.

My unscientific observation *senses* that rural counties generally do a better job of managing these cases than do larger cities and counties. In counties where judges or prosecutors are themselves veterans, there appears to be more balanced and considered outcomes. These local courts often use a local knowledgeable treatment provider rather than prison to resolve these cases.

SAMHSA and Washington State

In recent weeks, WDVA was invited to respond to an invitation by SAMHSA (Substance Abuse Mental Health Service Administration). All states were requested to respond to a competition that asked “What does your state do to reach OIF and OEF veterans and their families, especially the National Guard members?”

Ten applications from the states would be selected and invited to create teams that would then go to Washington DC for three days in order to put together a best practices policy for finding and helping returning OIF and OEF veterans and their families.

Washington State was selected from among 35 states that applied, and over the past three weeks we have been preparing as a team to work on this project. We also met with a federal site visit team to help structure our unique approach to services. From 11 to 14 August, teams of 12 representatives each from 9 states and one US territory will work together to create approaches that other states might copy and employ on behalf of veterans and family members affected by the GWOT. We hope that this effort will result in improvements in the way all states conduct the important work of reducing stigma to seeking help and truly coming home from war. ##

The International Society for Traumatic Stress Studies To Meets

ISTSS meets in Chicago November 13-16, 2008. Those attending will witness live on stage the writers of next year’s scientific articles about PTSD discussing their ideas among a lively audience of their peers. Ideas will sprout in this fecund environment that will grow and flower. A harvest of up to 20 credit hours of CE could be stored for the winter. For more information go to istss.org. ##

**King County Veterans Program
Contract Therapists**

WDVA Contract Therapists

Laurie Akers, MA, Everett... 425 388 0281
 Clark Ashworth, Ph.D., Colville... 509 684 3200
 Wayne Ball, MSW, Chelan & Douglas... 509 667 8828
 Bridget Cantrell, Ph.D., Bellingham... 360 714 1525
 Compass Mental Health, Mount Vernon... 360 419 3606
 Paul Daley, Ph.D., Port Angeles... 360 452 4345
 Duane Dolliver, M.S., LMHC, Yakima... 509 966 7246
 Jack Dutro, Ph.D. Aberdeen/Long Beach 360 537 9103
 Sarah Getman, MS, LMHC, Longview... 360 578 2450
 Dorothy Hanson, M.A., LMHC... 253 952 0550
 Adrian Magnuson-White, MA, LMHC and
 Casper LaBlanc, M.A. LMHC Shelton... 360 462-3320
 Keith Meyer, M.S., LMHC, Olympia... 360 250 0781
 Brian Morgan, M.S., LMHC Omak... 509 826 0117
 Dennis Pollack, Ph.D., Spokane... 509 747 1456
 Dwight Randolph, M.A., LMHC... 253 903 7386
 James Sullivan, Ph.D., Port Orchard... 360 876 2322
 Darlene Tewault, M.A., LMHC Centralia... 360 330 2832
 Roberto Valdeze, Ph.D., TriCities... 509 551 7690
 Mike Yeager, M.S., LMHC, Clallam &
 Jefferson... 360 681 0585
 Stephen Younker, Ed.D., Yakima... 509 966 7246
 Washington State U. Psychology Clinic... 509 335 3587

WDVA PTSD Program Director:

Tom Schumacher, M.S., LMHC, NCC, CTC...
 .360 725 2226 Cell 360 791 1499

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

Other Veterans' Mental Health Services offered by the Federally funded VA

Seattle Vet Center 206 553 2706	Yakima Vet Center 509 457 2736	Seattle Puget Sound Health Care
Tacoma Vet Center 253 565 7038	Spokane Vet Center 509 444 8387	System (VA Hosp.) 206 762 1010

Dan Comsia, M.A., King County... 253 840 0116
 Dorothy Hanson, M.A., LMHC Fed Way 253 952 0550
 Laureen Kaye, MA, LMHC, Duvall... 425 788 9921
 Ron Lowell, MSW, LMHC, Seattle ... 425 338 0939
 Diane Nakamura, Ph.D., Renton... 253 852 4699
 Mike Phillips, Psy.D., Issaquah... 425 392 0277
 Dwight Randolph, M.A., LMHC Seattle... 206 465 1051
 Karin Reep, MA, LMFT, Duvall... 425 788 9921
 Steve Riggins, M.Ed., LMHC Seattle... 206-898 1990
 Scott Swaim, MA, LMHC, Auburn... 253 661 6634
 Terry O'Neil, Ph.D. Bellevue... 425-990-9840
 Tom Wear, Ph.D., Seattle... 206 527 5382

King County Veterans Program, provides vocational guidance, and emergency financial assistance. The office is located at 123 Third Ave. South, Seattle, WA
 206 296 7656

Jerry Towne, MBA is the WDVA Manager of the Jail Diversion Project and Homeless Veteran Program for King County... 206-296-7569.

Special Programs:

Community College & University Outreach to war veterans. Peter Schmidt, Psy. D. 425 773 6292

School Outreach Pilot, K-12, Thurston, Pierce and South King County. Contact Tom Schumacher ... 360 725 2226

The Repetition & Avoidance Quarterly (RAQ) is published each season of the year by The Washington Department of Veterans Affairs, PTSD-War Trauma Program. The PTSD Program's director is Tom Schumacher, who is also the publisher of the *RAQ*. The editor of the *RAQ* is Emmett Early. The *RAQ* is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to the WDVA website www.dva.wa.gov. Once you arrive at the website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo on the front page is a computerized drawing of a photograph of a discarded sign, circa 1980, discovered in a dump outside the La Push Ocean Park Resort. Comments and contributions to *The Repetition & Avoidance Quarterly* are encouraged. We also seek your offerings of literary references that you find meaningful, inspirational, or therapeutic in your work with trauma survivors, or as a student in the field of traumatology. Space may limit a large submission, however the reference and your thoughts about the submission will be considered for publication. ##