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PTSD Under Attack As DSM-V Approaches

- Critics Question Motives of Treating Clinicians & Traumatized Who File Claims
- DVA Claims Process, DSM Category Questioned
- Early Intervention of Returning Military Called Destructive of Normal Adjustment

A critical attack on those who diagnose and treat PTSD in returning war veterans was published in the April edition of *Scientific American Magazine* by David Dobbs ["Soldiers' Stress: What Doctors Get Wrong about PTSD: A growing number of experts insist that the concept of post-traumatic stress disorder is itself disordered and that soldiers are suffering as a result", April 13, 2009, *scientificamerican.com*].

The article begins with a story of a Vermont National Guard veteran of the war in Iraq who had doubts about PTSD. The article quotes him: "Clinicians aren't separating the few who really have PTSD from those who are experiencing things like depression or anxiety or social and reintegration problems or who are just taking some time getting over it." The veteran feared his peers returning from a combat zone were "being pulled into a treatment and disability regime that will mire them in a self-fulfilling vision of a brain rewired, a psyche permanently haunted."

The article goes on to assert that what happens to combat veterans upon returning home are normal readjustment problems that are pathologized by clinicians who "pull" the veteran into treatment, "imposing a trauma narrative" onto a normal process. Dobbs quotes Richard McNally that "we have a cultural obsession with trauma." The result of the introduction of the PTSD diagnosis was that liberals exploited "a vision of the war's costs that, by transforming warriors into victims, lets us declare our recognition of war's horror and absolves us for sending them for we were victimized, too, fooled into supporting a war we later regretted."

The article goes even further, quoting U.W. Psychology Professor Gerald Rosen, a forensic specialist, as "thinking of clinicians" when he asks, who gains from the PTSD diagnosis? It is a terrible charge to blame the clinician for the disorder, or to suggest that the caregiver is creating the disorder by providing the care. Surely all professionals, Dr. Rosen included, "gain" from a stimulating debate such as this.

David Dobbs' article suggests that the author has a fuzzy understanding of how psychotherapy for PTSD works in the real world. Psychologist Richard McNally, a "leading authority in the dynamics of memory and trauma and perhaps the most forceful of the critics" of PTSD, seems also to have a strongly biased stance. It is the gap created between clinical treatment of PTSD and the researcher's lofty, focused, and perhaps idealized view of the process. Psychotherapy clinicians treat the person who has PTSD, not separated from other pathologies or from life's problems. The veteran who has symptoms of mood disorder, who is uncertain of his job stability, whose wife is unhappy with the relationship, etc., has adjustment to peaceful civilian life intermingled with real life 21st Century challenges.

Those who treated Vietnam War veterans years after their return to civilian life were impressed with the wake left by their postwar struggles with readjustment. Retrospective analysis is always risky, but repeatedly the clinician is met with a history that is replete with broken marriages, erratic job histories, substance dependence, and social isolation. The article asks rhetorically, "how many of those 'early symptoms' were just normal adjustment?" What we see, however, in the veteran's personal narrative, are the consequences of experiencing "early symptoms". Ask a university professor what it means to stumble repeatedly early in one's career.

The gulf is great between those who charge clinical treatment for creating false PTSD that leads to inflated claims against the VA and the contention of clinicians that they can help a veteran navigate through early readjustment problems, regardless of diagnosis. Mr. Dobbs' quote is telling: "The idea that PTSD is overdiagnosed seems to contradict reports of resistance in the military and the VA to recognizing PTSD, denials of PTSD diagnoses and disability benefits, military clinicians discharging soldiers instead of treating them, and a dis-

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turbing increase in suicides among veterans of the Middle East wars. Yet the two trends are consistent. The VA's PTSD caseload has more than doubled since 2000, mostly because of newly diagnosed Vietnam veterans. The poor and erratic response to current soldiers and recent vets, with some being pulled quickly into PTSD treatments and others discouraged or denied, may be the panicked stumbling of an overloaded system." The logic here is crucial behind the speculation. The returning veteran is not getting enough attention from a VA system that is overloaded from the previous war. While some are pulled into treatment and misdiagnosed others are discouraged and denied, and no wonder there are suicides. Mr. Dobbs seems to be blaming the veterans, the VA, clinicians, everything but the war.

The *Scientific American* is a popular and prestigious magazine and to run what amounts to a polemic slandering working clinicians with innuendo, makes one wonder what is happening. It is true that the psychological cost of the wars on terror are born by the combatants and their immediate families. There isn't much suffering in the civilian population at home, but there is a lot of stress. The war in Vietnam that the U.S. waged for more than ten years has doubtless influenced the mental health community. It is certainly true that PTSD symptoms can be found in other disorders and, indeed, in normal daily life, but it is the purpose of the 309.81 DSM category that it is precisely the coming together of those symptoms that causes pathology that amounts to a disorder. What is unique is the *combination* that points the clinician in the direction of PTSD instead of other disorders.

The term "ex-GI" is suggestive of a period of readjustment, even from a peacetime military. Readjustment after a tour in a combat zone is certainly more demanding, even without enduring psychological trauma, and no doubt still more demanding when psychological trauma has been encountered. The allegation that clinicians "pull" returning veterans into treatment is cynical and profoundly limited in understanding of how a clinician works. Veterans who are referred to the WDVA counseling are referred for the reasons that they present: "wife threatening to leave," "boss sent me," "another DUI," "They say I aggressed against my neighbor."

There are few clients of the WDVA program who are seen by only one professional. The veteran community is a small one and physicians, psychiatrists, and counselors in a variety of services may have input. Are they collectively living this conspiracy to "pull" the veteran into disability and overload the system, or are the wars we fight producing instability in a very stressful society? And what about the suicides?

The introduction of PTSD into the mental health nomenclature has stimulated a large amount of research, much of it the product of clinical settings, but there is also a body of epidemiological and clinical research that addresses PTSD as a variable without the prospect of secondary gain. Even the professional experts referred to by Mr. Dobbs agree that PTSD exists—at least most of them do. The outcry here seems to be in the numbers of war veterans who receive the diagnosis and treatment. To compare current war veterans to the veterans of past wars is a mistake, given the advances in medicine and technology.

When a veteran files a claim for PTSD, the DVA requires a variety of evidence and demands that the veteran be confronted by at least two examiners who are not the treating clinician. An adjudication officer then reviews the evidence, including the existence of documented military trauma as paperwork in a file. But perhaps Mr. Dobbs is taking a political stance in his article decrying the exaggeration of psychological trauma caused by our nation's wars. There is a rather stalwart call in his writing about letting the normal process of readjustment take its course. We, the clinicians, however have to hear about the coarse reality of what so-called normal readjustment takes, which usually is a process that establishes the many items in criterion C of 309.81: the symptoms of avoidance. How long, we would ask Mr. Dobbs, should we wait while "normal readjustment" plays havoc with the veteran's life? Do we "pull" the veteran into PTSD treatment merely because the social worker in the hospital emergency room has interviewed a veteran who had driven into a tree avoiding an imaginary IED—or do we wait for it to happen again?

It is the couch of a demagogue who would contend that a war veteran's condition of PTSD is only valid if he or she does not file a claim, but it is certainly right and expected that the institution establish that there is objective evidence to support the claim. Before our current crop of war veterans, the veterans of World War II and Korea were not inclined to seek disability for psychological trauma. They instead lived out what Mr. Dobbs would contend was normal adjustment after the war. Denial of the government that combat caused psychological trauma is wonderfully illustrated in the Army revision of John Huston's 1945 documentary *Let There Be Light*. The Army shelved Huston's version, which he filmed in a New Jersey hospital with real patients just back from overseas, and real professional staff. The Army, substituting actors for patients and staff, (all Caucasian), revised the content to show that the problems of the veterans were caused by poor parenting and expected flaws in the population, and not by the events of combat. Mr. Dobbs seems to be doing a 21st Century version of the revision, contending that malingering veterans and complicit clinicians, together with an overloaded and incompetent VA, are conspiring to create an inflated rate of PTSD that is not caused by the impact of the wars on terror on its combatants.

Yet, when in research PTSD is examined as a variable it is typically found to be implicated in poorer health outcomes. The contract that the recruit signs when he or she enters the military is that the government will care for the disabilities caused by military duty.

Mr. Dobbs failed to consider what the cohort effect means in terms of the introduction of the PTSD in DSM-III. It takes a generation to grow up with something to make it seem acceptable. The Vietnam War veterans were slow to assimilate the meaning of the diagnosis. The veterans of the Wars on Terror grew up with the PTSD diagnosis in their heritage. It is as much a part of their culture as cell phones and email. EE ##

Pseudo-PTSD: Malingering and Exaggeration Overlooked by Researchers and Clinicians

As the revision of the Diagnostic Manual approaches and DSM-IV becomes DSM-V, critics of PTSD are making their voices heard. Gerald Rosen of the University of Washington and Steven Taylor of the University of British Columbia recently published a polemical critique of the disorder in the *Journal of Anxiety Disorders* [2007, 21, 201-210]. The authors examined the subjective nature of PTSD as it has been defined, and argue that both researchers and clinicians have ignored the need to consider malingering and exaggeration when claims for compensation are involved. They define malingering, according to the DSM as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs” (p. 201). Rosen and Taylor then question whether the task of detecting such distortion is feasible (p. 202).

In amassing their review references, the authors consider the evidence for questioning the very existence of PTSD and at least the acceptance of symptoms as reported by patients. They raise the most fundamental issue at the core of the diagnosis, which is the assumption of a causal relationship between Criterion A, the psychologically traumatic event, and Criteria B, C, and D, the symptoms. They cite the movement behind launching of the diagnostic criteria and the subsequent claims of veterans emerging from the war in Vietnam. They imply that there was a bias in the process that was “particularly beneficial for Vietnam veterans and other groups who might have disability claims” (p. 202). And although they join the camp of Richard McNally and others in contending that the statistics of veterans with PTSD are inflated, the authors are guilty of a bias themselves in failing to consider the references to research that corroborate the epidemiological data that is independent of incentive to malingering, and yet corresponds closely with the expected range associated with PTSD.

Among their many criticisms of PTSD, they note that there is nothing in the diagnostic criteria that is unique to the disorder, and thus it overlaps many other disorders, e.g., mood disorders, panic, etc. (p. 206). They end up concluding that there is a “possibility that PTSD is itself a pseudo-diagnosis” (p. 206).

Rosen and Taylor lay bare a fundamental issue that polarizes researchers and clinicians and presents a thorny problem for those concerned with the care of veterans returning from combat. The critics are contending on the one hand that there must be objective evidence that a psychologically traumatic event occurred, and that the veteran is not lying or exaggerating his or her report of symptoms, while at the same time the clinician is tasked with providing an empathic healing relationship. The authors express concern that the failure of researchers to consider malingering inflates and distorts data, even though they acknowledge that the diagnosis itself has benefited the

field by stimulating research. Rosen and Taylor acknowledge in the end that “there is no single or preferred measure to detect malingering among PTSD patients or claimants,” and that “all instruments have their limitations” (p. 204).

Rosen and Taylor expose their own biased point of view when in their discussion they write: “Unfortunately, the utility of the PTSD construct is undermined to the extent that pseudo presentations of the disorder are prevalent and go undetected” (p. 207). They then proceed to assert that estimates of malingering the disorder are as high as 50%.

As DSM-V approaches with yet another revision of PTSD reflecting the accumulation of research, the diagnosis itself becomes fluid and the clinician is caught with the charge of treating a disorder that is largely subject to the veteran’s self report. Military records are not complete and often unavailable, at best providing evidence of direct trauma because of physical wounds or documents placing veteran in the combat. But the military documentation of traumatic events are more often subject to the whim of the morning report clerks. Some soldiers are thrust into traumatic situations outside their normal duties, for instance, clerks who end up assisting in field hospitals, or cooks who find themselves in a convoy ambush. It is upon the clinician to take the veteran at his or her word and proceed to render care. Yet, more often than not, the very process of treatment leads to the filing of a claim and the clinician is asked or may even volunteer to provide a letter of support. There has been debate among WDVA contractors that the provider of treatment ought not to be the clinician writing the letter of support. Even without the issue of the disability claim, the clinician is burdened with the onus of treating the veteran’s symptoms as real, acknowledging that symptoms cannot be separated, indeed are expressed through, the veteran’s personality and unique history, and that memory of psychological traumas, by definition, cannot be expressed objectively by the survivor.

Rosen and Taylor’s review adopts a cynical tone of forensic experts who are defending institutions against claims for disability compensation. For them PTSD, by its definition in the DSMs, provides a wellspring of ambiguity that serves to foster doubt in the eyes of claims adjudicators and juries. The implication of their position is that the PTSD claims of veterans are inflated by as much as 50%, and, in the end, the disorder may not exist at all. Yet in a recent *Journal of the American Medical Association* (8/05/2009) researchers at the San Francisco VAMC found PTSD to be associated with increased risk for heart disease in a sample of 300,000 WOT veterans. Given that there are not foolproof objective measures of malingering PTSD and that it is the clinician’s first task to establish a therapeutic relationship and help the veterans cope the various challenges of readjustment to civilian life, taking the skeptical stance of the forensic investigator would hinder the purpose of counseling. EE ##

PTSD Found to be a Risk Factor for Suicide Among VA Patients

DVA researchers confront the role of PTSD as a risk factor for suicide with three successive statements backed by evidence to lead off their article: "OIF/OEF veterans diagnosed with mental disorders commit suicide at a higher rate than persons in the general population", "PTSD predicts completed suicides", PTSD is "the most frequently diagnosed mental disorder among OIF/OEF veterans seeking Veterans Affairs (VA) health care" (p. 303) [Jakupcak, et al., Posttraumatic Stress Disorder as a Risk Factor for Suicidal Ideation in Iraq and Afghanistan War Veterans, *Journal of Traumatic Stress*, 2009, 22(4), 303-306]. The researchers studied 407 VA patients referred for mental health services. Their stated hypothesis was "after accounting for other risk factors, veterans who screened positive for PTSD would be more likely to report suicidal ideation compared to veterans who did not screen positive for PTSD. Further we predicted that veterans with PTSD who screened positive for mental disorders comorbid with PTSD would be more likely to endorse suicidal ideation than did veterans with PTSD only, and that those endorsing multiple comorbidities would be at greatest risk" (p. 304).

In describing the participants in the research, Jakupcak, et al, present an important caveat: "Sixty percent (60.1%) indicated they were applying for service-connected disability and 10.9% indicated they were currently service connected for PTSD" (p. 304). They also noted that 12 veterans had reported a suicide attempt within the previous 4 months. Researchers found that "Controlling for age, MDD, alcohol abuse, and drug abuse, veterans with PTSD were over four times more likely to endorse suicidal ideation than those without PTSD" (p. 305). They also found that veterans diagnosed with PTSD and two or more comorbid disorders were 5.7 times more likely to endorse suicidal ideation than veterans with PTSD only" (p. 305). The authors note that the "strong link between suicidal ideation and actual suicide attempts established in prior research...suggests that PTSD in OIF/OEF veterans may place them at risk for overt suicidal behaviors" (p. 306).

A cynic would observe that when over 60% of the sample were applying for PTSD disability, the research should address the issue of malingering. However, veterans who apply for VA mental health care with PTSD symptoms are very likely to also apply for a PTSD disability. OIF/OEF veterans are really the first cohort of combat veterans who grew up with PTSD accepted as a diagnostic reality. Cohort effects such as this make an established disorder not only more acceptable, but likely to be addressed by health and service organization representatives. This cohort was also exposed to digital communication and information devices and thus more likely to have learned and been warned about PTSD and its symptoms. This fact adequately explains why the researchers should find that "PTSD is the most common mental disorder among OIF/OEF veterans..." (p.306).

The warning that suicidal ideation in the presence of PTSD presents a risk for suicide, and that suicide must be assessed along with PTSD, overshadows the issue of malingering in veterans mental health care. EE ##

Resilience and Posttraumatic Growth Inversely Related

Israeli researchers studied two groups of Israelis in an effort to examine the relationship between resilience and posttraumatic growth among citizens exposed to traumatic events. [Levine, et al, Examining the Relationship Between Resilience and Posttraumatic Growth, *Journal of Traumatic Stress*, 2009 22(4), 2282-286.] One group the researchers examined was 2908 adolescents from 11 schools with "varied levels of terror exposure" who were administered diagnostic measures. The second group researched consisted of Israeli civilians and military personnel "approximately one year after the second Lebanon War in 2006" in which the subjects were involved. Both groups that were studied produced results that were similar, that "the least posttraumatic growth was associated with the most resilience..." (p. 284).

The authors define resilience as referring to "a broad cluster of personal characteristics that facilitate the ability to manage despite trauma. These characteristics include hardiness, optimism, self-enhancement, repressive coping, positive affect, and a sense of coherence". Posttraumatic growth "represents a change for the better following adversity". Levine, et al, explain their results by stating that "accordingly, posttraumatic growth only occurs if trauma has been upsetting enough to drive the survivor to (positive) meaning-making of the negative event. Resilience may make a person less likely to perceive threat to self or world views. Thus, the most resilient people are more able to mitigate the impact of the event..., resilient people are less likely to engage in the meaning-making behaviors" and are "unlikely to struggle with the implications of trauma" (p. 285).

The authors qualify their findings by noting that "the absence of PTSD need not mean resilience". Mood and anxiety disorders are also frequently found to be sequelae of a traumatic experience. They conclude, "Generally, high resilience (conceptualized as resistance) leaves little scope for posttraumatic growth. Clinically, this suggests that showing little distress and little growth following adversity may be a healthy sign of resilience rather than signifying pathological coping" (p. 285).

Levine, et al, discuss the question of whether posttraumatic growth and resilience in the face of trauma call upon different personality characteristics. They observe that "resilience people are less likely to engage in meaning-making behaviors," (p. 285) which may be an asset that facilitates avoiding trauma sequelae. One theory describes the development of PTSD after trauma as resulting from introspection, post-trauma adrenalin-assisted self assessment in the face of additional information and reflection. Resilient people may avoid PTSD by *not* engaging in meaning-making. EE ##

Delayed-Onset PTSD Examined in DVA Primary Care Clinic Sample & Found Rare

Christopher Frueh and researchers at the Charleston, SC, VAMC examined the frequency of delayed-onset PTSD in a sample of veterans who were treated in 4 VA primary care clinics. Their goal was to determine the prevalence of delayed onset in veterans who had current, lifetime or sub-threshold PTSD. They conducted telephone interviews of 747 veterans who were clinic patients using standard structured assessment measures. They published their results in the *British Journal of Psychiatry* [2009, 194, 515-520].

Frueh, et al, refined the concept of delayed onset PTSD: "There is a notable lack of clarity regarding the conceptual definition of 'delayed onset.' Merely because a disorder is recognized years after the aetiological event is not evidence that onset of the disorder was 'delayed.' It has been noted that PTSD diagnosed more than 6 months after a traumatic event may indicate delayed treatment or seeking of disability benefits, delayed onset of any symptoms of PTSD..., or delayed onset of the full disorder such that a change in one or two symptoms alters PTSD diagnostic status.... Another issue is the actual time interval from traumatic exposure to onset, with 'delayed onset' counting as any PTSD onset that occurs from 7 months to 50 or more years post-trauma. Thus, there is definitional and conceptual ambiguity in DSM-IV that affects our understanding of delayed-onset PTSD" (p. 516). The authors define delayed onset for their purposes as "when the respondent first started having endorsed PTSD symptoms, expressed in terms of the number of months after the index traumatic event that symptoms started" (p. 517).

Frueh, et al, found "a small percentage of veterans with identified current PTSD (8.3%, 7/84), sub-threshold PTSD (6.9%, 2/29), and lifetime PTSD only 5.4%, 2/37) met criteria for delayed onset PTSD" (p. 517). They conclude from their findings that "delayed-onset PTSD occurs, but is rare in this large, representative sample of veterans" (p. 517). Later the authors qualify their statement by noting that the sample they examined as representative of "veterans from Veterans Affairs primary care clinics" (p. 518). They conclude by applying their results to a general population of veterans by stating: "In combination, these data indicate that PTSD symptom onset by 6 or more years after trauma exposure among veterans either does not occur or is exceedingly rare. One implication if these findings are replicated is that the dramatic recent increase in the number of US Vietnam veterans seeking Veterans Affairs disability payments for PTSD cannot be explained as a result of a growing number of new cases of 'delayed-onset' PTSD. Thus, these data have implications for one aspect of the current discussion regarding Veterans Affairs PTSD disability administrative trends and policies" (p. 518).

Frueh, et al, identified 150 veterans in their sample of 747 outpatients who had PTSD symptoms at some time since military service. They conclude that those who claim delayed onset are found to be rare. It is true from this reviewer's clinical experience that true delayed onset of PTSD symptoms are rare. It seems upon reflection that most veterans had some symptoms manifesting quite soon after leaving the combat zone. Those symptoms may have been manageable or subsided after time and then years later grew troublesome again. Onset of symptoms for an older veteran is more often a condition of symptoms developing beyond the veteran's tolerance (or the tolerance of his or her family or associates). This makes one wonder if Frueh, et al, do not have themselves a red herring.

Cohort Effects

The authors discuss the differences in the experience of PTSD symptoms in various generations of war veterans. "The finding that PTSD is more common in younger veterans suggests a possible cohort effect, which raises the question of whether there will be higher rates of delayed onset in future generations of military veterans. A previous finding from this sample was that veterans >65 years of age report lower PTSD and better mental health than those <65. Other studies have also found evidence of cohort effects, with lower rates of PTSD among Second World War veterans relative to studies of Vietnam veterans. Several possible explanations may account for this finding. First, people may become more psychologically healthy as they age (e.g. a maturational ageing process), Second, older veterans may be less likely to acknowledge psychiatric symptoms that exist (e.g. a sociocultural cohort effect related to 'self-reliance' or perceptions regarding stigma for mental illness). Third, veterans with psychiatric problems may be less likely to survive to advanced age (e.g. a mortality effect). Last, younger veterans may be more sensitive to and more likely to report psychiatric symptoms based on changing social expectations (e.g. evolving interpretations and perceptions of psychiatric illnesses or a social learning effect)" (p. 518).

The confusion in Frueh, et al, about what their sample represents is important. One would assume that a sample of VA Primary Health Clinic patients consists entirely of veterans who are treated by the VAMC, making them a highly selective group, implying perhaps that they are more aware of illness than a general population of military veterans, thus leaving us to wonder what a sample of the general population of veterans would report. Perhaps representatives of a general population of veterans would be less aware of the symptoms discussed in the telephone interviews, perhaps even those who deny that symptoms of PTSD exist. Delayed onset PTSD is rarely found, especially among older veterans, but startling when it happens. EE ##

Story of Iraq War Veteran's Suicide Questions Treatment Ethics

The Seattle *Times* published the story of a Washington State University student, a veteran of the war in Iraq, who was scheduled to be redeployed, and who committed suicide. ["Soldiers' Emotional Battle Scars Put Doctors in Dilemma: Should Military Know?" by Hal Bernton, 7/20/2009, pp A1, A8.] Tim Juneman was a member of the Washington National Guard, who, the article declared, "survived a year of tough fighting that left him with a twin diagnoses of post-traumatic stress disorder (PTSD) and traumatic brain injury." The issue that the article raises is that Mr. Juneman had declared that he was suicidal and "a VA psychiatrist hospitalized Juneman but never notified the National Guard unit of his patient's distress over redeployment."

The article does not second guess the VA psychiatrist's decision, but rather questions the general ethics of not notifying the National Guard unit on the assumption that his deployment would have been cancelled. Mr. Bernton states: "VA officials say they must comply with privacy rules and are not required to share a veteran's health status with the Defense Department."

The general rule puts light on 2 issues related to the ethics of conducting psychotherapy with war veterans during a time of war. Questions arise immediately:

1. What does the therapist do when the war veteran client has diagnosed PTSD and *chooses* to return for another deployment? Are symptoms motivating the decision and thus raise the likelihood that another deployment to combat will worsen the condition? Many therapists have the philosophy that it is better for a client to arrive at his or her own decision, rather than be directed by the therapist. The therapist works along with the client to make decisions about, for instance, whether to leave a bad relationship, stop gambling, etc. The therapist may have a pretty good idea what the right choice would be, but cannot in the end make the decision for the client. But life and death is at stake when the decision has to do with returning to combat. Even if the therapist believes that the client is motivated by a pathological compulsion that could cause at best a worsening of the PTSD, the therapist is yet bound by confidentiality because death or self harm is not imminent—only a possibility.

Therapists who see many veterans as clients, whether they are activity duty, National Guard, or reserve, encounter the situation in which the veteran, whose symptoms have to do, at least in part, with previous military experience, is aware of an impending redeployment. The veteran's symptoms would not necessarily impair his or her function as a combatant, (PTSD symptoms often dissipate when the veteran returns to combat,) but conversely, the veteran's symptoms might be worsened after another experience in a combat zone. Most of us, I think, would advise the veteran that we believe he or she ought to consider in making the decision the possibility that symptoms could worsen. But then duty, self sacrifice, peer perceptions, camaraderie, all serve to influence the decision. We heard it from other war veterans who spoke of unfinished business,

obligation, revenge. What impact does a therapist's talking about the future have when all the influences weigh on the present?

2. What does the therapist do if the client facing redeployment is suicidal and does not want to inform the appropriate military authorities for various reasons? The client feels he or she would be shamed in the eyes of peers, or parents, or significant friends. The therapist knows that struggles with pride and self esteem can be projected into the eyes of others. Many clients, particularly if they have been involved in prior treatment, are aware of the conditions for involuntary commitment regarding suicidality and will not say the words in front of a county mental health professional that would compromise their freedom.

In the case of the *Times* article, the VA therapist had the veteran voluntarily hospitalized, but his National Guard unit was not notified. However, if the veteran has it within self control to say the right thing, he or she will soon be released from the hospital. PTSD is largely subjective and self control that is observed on a hospital psychiatric ward can suppress symptoms such that the veteran will seem safe for discharge. Then the question returns to the issue of the relationship that the veteran has with the outpatient therapist in the community.

The Spokane *Spokesman Review* reporter Kevin Graman reported on 8/11/2009 that between July 2007 and July 2008 "at least 22 veterans in the Spokane VA service area killed themselves...." The article stated for context that the Spokane VAMC provides care for 215,000 veterans from Wanatchee, Washington, to Kalispell, Montana.

Mr. Graman reported on 8/13/2009 in the *Spokesman Review* that psychiatrists at the Spokane VAMC were carrying a caseload of 850 patients per doctor. He noted that the Department of Veterans Affairs standard is 500 patients per doctor and also noted that the Spokane VAMC is in the process of hiring more psychiatrists. While such huge caseloads are certainly challenging, the fact emphasizes the need for effective follow-up with referrals to mental health professionals in the community close to where the veteran resides. Effective follow-up is more than a name and a phone number. It requires repeated communication with the veteran to ensure that contact is made and community treatment is working. Reality is that Washington State Department of Veterans Affairs war trauma program is the local resource in addition to VA fee-for-service to community professionals. Of course, WDVA doesn't cover Idaho or Montana. Effective referral of a client with war-related PTSD requires that a mental health professional who is experienced in the treatment of PTSD establish a therapeutic relationship with the veteran in the community, which is no small accomplishment.

The *Times* article reporting the suicide of Mr. Juneman ends with the spokesman for the National Guard who is
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quoted as saying: "It breaks our heart to lose somebody the way we lost that soldier,... Had we had any indication that he was struggling with those kinds of things, we would have done everything we could have to get him help."

I recall one of my first clients before I was licensed, while working under supervision at a community mental health clinic. My client was a depressed woman, about 50 years of age, who was addicted to codeine. The psychiatrist who had been treating her before I arrived elected to place her on a supervised urinalysis program to attempt to control the addiction. She committed suicide, overdosing on the medicine he had prescribed. I think she felt humiliated by the intrusive intervention. Technically I suppose the psychiatrist did the right thing, but I have always wondered what more kind and less rule-bound approach might have allowed her to keep her integrity afloat. Protocol for me then as a novice therapist under supervision was to defer to the professional with experience. I tell myself that I would not have made the same decision, but there it is...she is dead and I completed my licensing requirements.

Troops who are about to be deployed know what they are doing when they fill out health screening checklists. They know what answers would elicit an intervention. They would not answer the questions as we, their therapists, would have them answer. The transition from military and combat to civilian life becomes a unique journey. The referral to a mental health professional may be like the helping fairytale animal whom the hero comes across along the way and whose significance is not appreciated by the hero at the time. But later, when the life is at stake, the animal becomes the provider of just the right kind of help. The important element of this analogy is that the referral is repeated in various ways, by letter, by email, by telephone, so that the message reaches the veteran at various stages of his or her receptivity. When a VAMC psychiatrist has such a large caseload, when various military units stand down from their deployments introducing veterans fresh from combat back into the community, a systematic and persistent referral system is expensive, but probably necessary. The therapeutic relationship that proceeds from follow-up is a good hedge against despair. 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 be read by all the important people. Email the editor or WDVA.

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Collateral Damage

A terrorist organization that sets off bombs and roadside IEDs or conducts sweeping attacks on so-called soft targets, has as part of its strategy to kill members of the civilian population. Conventional military response, ideally, attacks terrorist targets and attempts to pinpoint where the terrorist is and strike only the combatant, not the civilian. World War II changed the way modern military evaluated what a military target was. In long past wars it was routine to sack cities, rape and enslave the civilians and pay off the troops with the pillage. More modern wars were less destructive of civilian population, at least allowing civilians to flee before destroying the city. In the Vietnam War there was a gruesome jest among troops that the village was destroyed in order to save it from communism. Slaughtering civilians inhibits winning the trust of the population.

Recent wars have employed firing missiles from pilotless drone aircraft controlled from afar. As far as I know a tactic begun by the Israelis against terrorist targets. A single missile is certainly more precise than a bomb. It destroys a house or a car or a bunker in a training camp, killing and wounding everyone there indiscriminately. One recent drone attack in Pakistan killed a leading terrorist attending a funeral. Vietnam War veterans reported witnessing the effects of collateral damage, walking through an area that had been subjected to artillery or air strikes. Explosions and the shrapnel killed the soldiers and everyone nearby.

The weight of killing from modern war is enormous. Nazi Germany instituted systematic slaughter of civilians and were the first in modern warfare to target a city (Guernica) for destruction from the air in an effort to dishearten the population. The British showed that the bombed population was not only not disheartened, but hardened in their resolve for fighting. It seems that 21st Century terrorists have encountered adverse public reaction to mass killings and it has been reported from Afghanistan that there has been negative public reaction to civilian casualties created from attacks on terrorists. Fighting what is now called an asymmetrical war without civilian casualties is nearly impossible if the terrorists use the population as cover and whose cause is furthered by public outrage at civilian destruction.

There may be some reaction in the U.S. population to the amassing of civilian casualties. We aren't given great detail when, for instance, a missile fired from a drone explodes amid a family gathering. We might hear about it later when a reporter interviews survivors. A nation that has tolerated carpet bombing, fire bombing, and the nuclear destruction of cities because it seemed a necessary part of total war seems to not be very concerned about pinpoint missile strikes from drone aircraft against an otherwise unreachable target.

An extended family lives in my neighborhood with teenagers, trucks, and cars coming and going. If I were living on the Afghanistan-Pakistan border I might be concerned lest one of my neighbors might be a terrorist leader and attract a missile strike that might just miss. Collateral could be me. EE ##

Movie Review:

The Hurt Locker: A Film About Fate in the Iraq War

Reviewed by Emmett Early

The Hurt Locker is probably the best of the films so far that have to do with the Wars on Terror. It concerns a bomb demolition squad in Iraq and virtually the entire film is composed of harrowing action. In the beginning the squad leader is killed trying to disarm a bomb that is remotely detonated by cell phone. He is replaced by Staff Sergeant William James (Jeremy Renner), who we quickly learn is reckless with regard to his own safety and very good at what he does. He has been similarly involved during other deployments and mentions Afghanistan as his most recent. He has pockmarks on his body that someone identifies as shrapnel scars. His only comment about the scars is to claim that his mother dropped him as a baby. He admits that he expects to die doing his job.

Sergeant James' method of going about his work exasperates others in his squad, particularly his second in command, Sergeant Sanborn, played by Anthony Mackie, because his actions place them in increased danger. Much of the squad's work is viewed by the local Iraqis, ominously peeking out of doorways and down from balconies and windows. The on-lookers pose a constant potential for danger and occasionally someone gets shot. Sergeant James' squad is forced to stand guard as backup while their leader dons his protective suit. The ritual is like the armoring of a medieval knight and at the same time it seems like a spacesuit in which the wearer must work with tools in an alien environment.

The Hurt Locker is directed by Kathryn Bigelow, who made her reputation directing action films like *Point Break* and *Blue Steel*. The film was written by Mark Boal, who last gave us the quality war veteran film *In the Valley of Elah*. The plot mainly concerns the squad and its principals, but diverts to action subplots as James takes off impetuously into the city at night (filmed in Jordan) to locate the family of a boy whom he befriended and who was killed and body rigged with explosives. There is another subplot in which the squad, while detonating explosives in the desert, come across a group of armed civilians with headscarves hiding their faces. They turn out to be contractors of some kind, apparently mercenaries, for they have two hooded prisoners they were transporting before their Humvee broke down. One of the agents is played by Ralph Fiennes and when he exposes his face and speaks to the squad who have him at gunpoint, there is a moment when it could be T.E. Lawrence in *Lawrence of Arabia*. Fiennes did in fact play Lawrence in a biographical picture. This scene deals with an ambush by snipers and is the only scene of prolonged combat, which proves to be as gripping as the city bomb sites.

Renner's Sergeant James does not have heroic movie star stature. He has a round face and a lumpy body and when he and his squad mate fall into a drunken male contest for dominance to see who can hit the other in the stomach the hardest, he shows himself to be physically tough. He is portrayed as someone who has been repeatedly traumatized and considers himself to be fated to die doing his job. In the very brief domestic scene when he is between deployments, James is shown

to be estranged from his wife and child.

The enemy is often ambiguous and hard to identify. When we see the enemy it is an anonymous profile, a sinister figure with scarf obscuring the face, a dark face peering from a distant balcony. Bigelow never lets us grow familiar with anyone but the bomb squad members. The pathetic, tense scene that occurs when a suicide bomber tries to surrender presents the only enemy figure with personality, and he is, sadly, helplessly, locked up in his work.

There is a mental health officer who visits Sergeant James and when James challenges the officer to see combat, the officer rides along with the squad. He proves to be a feckless innocent who seems to have only some mental health provider social skills that are not useful when delivered in a combat zone.

Sergeant James is not a war lover. He keeps returning to combat because he no longer fits doing anything else. He is not fearless, rather he is resigned to dying on the job. He is inured to the hardship and suffering around him, although he has cracks in his armor. When the boy who was selling DVDs is killed and his body rigged with explosives, James is anguished with grief and for a while puts his life in jeopardy in an ill-conceived one-man hunt. There is a touching moment during the desert battle with the snipers, when he manages to get a fluid package containing a straw and generously offers it first to Sanborn, who is concentrating on spotting his kill, and, unaware of the scarcity of water, drinks it up.

Some veterans of combat are afflicted with a terrible sense of unfinished business when they leave the combat zone fully believing that they would die there. These are veterans who have participated in multiple situations that were potentially traumatic, and although they may not qualify for the DSM-IV309.81, they are influenced by the belief that they will die soon and should have died in the combat zone. They might not file a VA claim for PTSD disability because they don't see themselves as having a future. Guilt is in the memory of the dead—the soldiers, innocents, and enemy who died. Once having surrendered to the idea of death, the veterans fail to live fully in a peaceful environment, although recklessness and impulsivity may cause their lives to fill with demanding challenges. They make troublesome, if colorful, civilians, and they don't take very good care of their health.

The Hurt Locker never makes an overt political statement, such as was made in *In the Valley of Elah*. We see callused battle hardened soldiers and officers. We see the destruction. In one scene, when James is searching for the killers of the boy, he is misdirected to an apartment where he confronts the residents with a drawn pistol. The man greets him with courtesy and offers his hospitality. The woman, however, howls with rage when she is confronted in her own kitchen and attacks James with kitchenware driving him away. That, in a symbolic way, captures the problem of fighting the Wars on Terror. The U.S. may have its way and prevail over the terrorists, but many indigenous lives are lost and homes and livelihoods destroyed in the process, not to mention the lives of our combatants. The film's title, a piece of current GI jargon, refers to the storage of pain. ##

Book Review:***Rain Gods*, by James Lee Burke. A war veteran crime novel.**

Reviewed by Emmett Early

If my count is right, *Rain Gods* is the 30th novel by James Lee Burke, most of them police crime novels. He has written 17 novels about a Vietnam War veteran, Dave Robicheaux, who appears in various law enforcement roles in Louisiana, most of them in the Cajun region of New Iberia. A few of the novels make sojourns into Mississippi and Montana. Dave is an alcoholic who most of the time attends AA meetings. He has a friend, a sometimes police partner, who is an unreformed violent alcoholic, and who is also a Vietnam War veteran. All the novels involve criminals who are violent and amoral, and many of them are war veterans as well.

Mr. Burke's most recent novel, *Rain Gods*, departs, but not far, from his previous characters. The protagonist in *Rain Gods* is Hackberry Holland, a sheriff in southwest Texas on the Mexican border. Hackberry is a Marine Corps veteran of the Korean War and a surviving POW. The story takes place in contemporary time, so although he is only described as old, the sheriff must be in his 70s. James Lee Burke was born in 1936, which makes him too young for Korea in 1950 and too old for the draft during the Vietnam War era. No mention is made in biographies that he ever served in the military. Hackberry Holland appears to be another age peer doing a hard job, with whom Burke has empathy.

Rain Gods contains many plot parallels to Cormac McCarthy's recent novel, *No Country For Old Men*. The plot involves heroin smuggling gone awry, with a mass slaughter of Asian women being smuggled across the border with the drug ingested in small balloons. It involved the old war veteran Texas sheriff and a young war veteran, Pete Flores, an Iraq army veteran in this case, as the innocent caught up by witnessing the crime. Pete is an alcoholic ne're-do-well who returns to an AA meeting. It is at the AA meeting that the criminals catch up with him. Pete has a girlfriend, Vicki, who plays guitar (Carter Family tunes) and waitresses for a living. She departs from the *No Country* parallels, in that she is a tough, scrappy woman who is a daughter of a policeman. She has a line about her war veteran boyfriend that, I think, summarizes one channel that war veteran dramas take. When the criminal assassin, known as the Preacher, captures her, she is undaunted and says: "Pete was burned in his tank. But the real damage to him happened when he came back home and met you and the other criminals you work with." (p.313).

Burke's war veteran cops are a crusty group of men who struggle to manage memories of combat and compulsion to drink alcohol. They are men whose lives lead them into further tragedy, often domestic. Hackberry Holland is a widow and one theme in *Rain Gods* plays off his old age. He was once an ACLU lawyer and married to a Cesar Chavez labor activist. The fact that the killer of the Asian women used a World War II era Browning Automatic Tommy Gun proves

to be unnerving. It, together with the ugly task of digging into the mass grave with a shovel, takes him back to the traumas of Korea. Interestingly, the sheriff did not have to dig into the mass grave and unearth of buried bodies. He did so compulsively.

The sheriff makes a very nice statement about the humanity that is indicated by a psychological trauma. "I had dreams about Korea for a long time," he said. "Once in while I still go back there. It's the way we're made. If certain things we do or witness don't leave a stone bruise on the soul, there's something wrong with our humanity." (p. 231).

There appears to be a formula that becomes predictable in the James Lee Burke novels. What attracted me to them initially, and keeps me reading them, is the local color that he provides. In the Louisiana Dave Robicheaux novels he describes the Cajun foods, the swamps and canals, the seedy side of New Orleans, and the Cajun music. In *Rain Gods*, Burke captures the same desert landscapes that Cormac MacCarthy depicted in *No Country*, except that Burke's language is far more sensual. MacCarthy's prose is spare, as if he were conserving his words like precious water. Burke describes the clothes that the residents of Southwest Texas wear. He dotes on horses in the pasture and the changes in the desert weather. The criminals are psychopaths who have active delusional psychoses in some cases, which make them frightening and unpredictable.

Burke usually manages to give his war veteran protagonists a love interest. His women characters are typically smart, earthy, and social humanitarians. It seems that they are placed in jeopardy in each novel because of the occupation of their men. The lawmen protagonists cope by retiring to a place of pastoral beauty, a sanctuary that is in almost every novel infiltrated and violated the criminals they are pursuing.

Psychotherapists who work with war veterans over time manage to see the two spectrums of clients that Burke features. The veterans who become cops and find that their work keeps them in a situation in which they are vulnerable to revisiting memories and are rendered worldly wise by their wartime experiences and military training. At the other pole of the spectrum are the veterans who stumble. In *Rain Gods* it seems that Pete can never get attached to a job long enough to be successful. Sheriff Holland fights to keep him safe from the criminals, and puts his job on the line to protect Pete from being jailed by federal law enforcers.

Hackberry sustained a back injury while a POW, and the injury gives him trouble throughout *Rain Gods*, and in keeping with the romantic take on the war veteran, he refuses to apply for a VA disability. He is not one of those trauma survivors we read about who are resilient and do not experience sequelae, but one of the stoic ones who manage their symptoms and suffer in private. ##

The Cohort Effect for Combat Veterans

When researchers discuss cohort effects, they usually refer to the influences that are common among a specific age group, that are more descriptive of that group than any other group. It is an important variable whenever one attempts to compare the veterans of different wars. When looking at the modern wars of the 20th Century, the veterans of those wars were quite different in their post-war adjustment challenges. It is useful to think of how veterans are similar across wars, and indeed, what may be universal or constant for veterans across all wars. In psychotherapy there was a question that seemed to come up repeatedly when discussing readjustment: what is normal for a combat veteran?

There are events that occur following wars that are unique for that period and mark the people passing through. After World War I, the remarkable events were felt by the whole nation, and actually by the war veterans of all the combatant nations: the Influenza Epidemic, known as the Spanish Flu, which killed millions of people world wide and left medics and nurses who treated them with at high risk for life-long lung disorders. Two interesting personalities, neither involved in WWI combat, were aviator Amila Earhart, who contracted the flu as a volunteer assisting convalescing veterans, and Dashiell Hammett, who drove an ambulance for the army during the war, but Stateside.

Another big influence upon the WWI veterans was the onset of the Great Depression, which devastated the world's economies. Although the war ended in 1918, and the collapse of the stock market didn't hit until 1929, the WWI veterans got the worst of it because they had just begun their working careers. That period led to the Veterans March on Washington, the so-called Bonus Army, asking for the meager bonuses that were promised but never authorized.

The movies of the post WWI era, like *I am a Fugitive from a Chain Gang* and *Heroes for Sale*, reflect the dark prospects for success.

Filmmaker Jean Renoir served in the French army in the cavalry, was wounded severely in the leg, recouped for several years and returned to the war as an aviator, with the dangerous job of flying air observers. He wrote in one memoir [*Renoir on Renoir*] a sentiment that seems related to that war, that affected his filmmaking career: "There is a force that I give in to in my films and that I believe in a great deal, and that's fate. I really believe that you can't go against the current, that we're caught in a kind of river that pushes us, carries us, and that men are not mean or good or traitors or not traitors. They are simply playthings of destiny..." (p. 205). He was writing about his great film, *Rules of the Game*, which is about society on the brink of World War II.

Interestingly, the Great Depression also affected the combatants of WWII, because they grew up and came of age during the period of low expectations and financial hardship. Like their predecessors, they were swept up in a universal draft and a world war that seems sometimes never to have ended. Pundit Garry Wills recently commented that the United States

government has been on a war-footing since with the advent of the Cold War of the Nuclear Age and the Wars on Terror that followed. The veterans of WWII returned to an economy that boomed with expectations of prosperity. One of the great innovations for that era was the introduction of the GI Bill granting low interest housing loans and educational grants that were unprecedented. Sociologist Suzanne Mettler ably documented the effect the GI Bill had on the WWII cohort in *Soldiers to Citizens*. She asserts that the success of the education grants turned WWII veterans into patriotic citizens. However, other variables are also in play: the unwanted Korean War of 1950-52, the introduction of television with the Army-McCarthy hearings in the Senate and the equally sensational hearings of the House Un-American Activities Committee. The threat of nuclear war was a real force in keeping the nation's veterans in a watchful, guarded state. Movies about veterans of that era depict the ex-GIs returning to a dark society that was riddled with injustice (*Key Largo*, *Blue Dahlia*, *Bad Day at Black Rock*), on the one hand, and economic pressure to succeed (*Man in a Gray Flannel Suit*.)

Veterans of the Korean War were largely absorbed in the post-WWII current. They fought the first of the wars which reached no clear conclusion and the first to face the reality of fighting on the brink of nuclear war. One major influence on the veterans of the Korean War was that it was unwanted by almost everyone, fought in a far off land with battlefield consequences that for the most part did not affect the citizens of the U.S.

What the veterans of WWII and the Korean War did face were cultural changes on a major scale at home. At the same time that post-war paranoia was prominent, cultural change began to escalate. Television was introduced and developed. Street drugs crept out of peripheral consciousness and into the middle class. For all the conservatism and patriotism of the WWII and Korean War veterans, cultural changes were sweeping their offspring. It seems that as unified as the veterans may have been, their offspring were polarized, perhaps expressing the undeclared sentiments of their parents. The first hint of this cultural change began with the counter-cultural, non-conformist Beatniks of the late 1950s, which seemed to assimilate the use of street drugs as a cultural expression. The status quo in America was disrupted by the Civil Rights Movement, the Hippies and the anti-war protests of the 1960s. It seems as these forces of upheaval were greeted by the war veterans who had hunkered down in reactionary political and cultural conservatism. They could do nothing to stop or change the current flow that Jean Renoir described.

The war in Vietnam lasted much longer than previous wars and was met with divisions of public sentiment. The draft was still in effect, but it was a highly selective system that allowed those who had no desire to serve with a means to avoid military service. The combatants in Vietnam were subject to the same influences as those at home, but were also taxed with fighting an implacable enemy that had time on its side.

(Continued on page 11, see *Cohort Effects*.)

Cohort Effects, Continued from page 10.

The personnel of the military were influenced by cultural changes in sexual mores: *Playboy Magazine* was a harbinger of change that began in the mid 1950s, and rock-n-roll swept the music world with its amplified guitars and passionate bands celebrating the psychedelic drugs. Addiction to alcohol has always been an issue for war veterans. In Vietnam, however, the war facilitated the exposure of combatants to opiates, speed, and marijuana on a large scale.

Vietnam War veterans were contaminated by the nation's need for a scapegoat to explain the adverse publicity that the war generated. Never before had journalists been permitted such access to the war zone. Journalists like Ernie Pyle and Robert Capa were able to document the spirit of the WWII veteran, but television journalism documented the contradictions and dark vicissitudes of the reality of combat in Vietnam. The United States as a nation literally had its shadow publicly exposed. Atrocities of prior wars were thought of as anomalous, if reported at all. The concept of total war excused the bombing of civilian populations. Casualty reports were laundered in consideration of what leaders thought was good for the public to know.

The warriors of the Vietnam War also carried their own music. The USO show made a few appearances, but the tape recorder and transistor radio were the media technological innovations, along with the compact camera that could be carried in a pocket. News traveled both ways, from the U.S. to the combatant, and from the combatant back. News of war and civil rights protests were influencing the Vietnam combatant, and reciprocally, the news the combatants were making quickly reached the American culture.

The Vietnam War veteran carried the contamination of the shadow in which Americans saw the brutality of combat in graphic depictions, and proceeded to blame the combatant. At the end of the war, a movement began among Vietnam War veterans and mental health professionals to recognize the emotional consequences of the traumas of combat. The selective nature of the draft gave emphasis to what must be an archetypal product of war, the economic advantage gained by those who do not fight the battles. Despite a lesser version of the GI education provisions, the civilian who avoided the draft by staying in college was in a post war position superior to the veteran. Another technological artifact of the Vietnam War was the selective nature of assignments and replacements generated by the 10+ year war. This resulted in an increased sense of post-war isolation of veterans who were strangers to each other. (State National Guard units that served in Vietnam were exceptions.) The iconic movie of the Vietnam War veteran, *First Blood*, created a war veteran character who is traveling alone and unjustly harassed by local law enforcement, and has to fight against almost overwhelming odds to survive. A later variation on the theme of the isolated war veteran is found in *Ulee's Gold*, in which the Vietnam War veteran is a hard-working, middle aged social loner who must contend with dark forces.

By the time the Wars on Terror began with the first Gulf War, followed by the wars in Iraq and Afghanistan, technological changes were accelerating to mark that particular cohort of veterans and make them unique. These veterans grew up accepting and utilizing the new communication technology in the same fashion that they accepted the now established diagnosis of PTSD. They carried cameras and cell phones into combat and the communication of combat actions was freer than ever before. Movies about the veterans of the Middle East wars capture the influence of the technological changes: *In the Valley of Elah*, *Stop-Loss*.

The veterans of the wars in the Middle East have grown accustomed to communicating on the Internet, via email and web pages devoted to veterans of their ilk. Whereas racial conflicts resulted in the integration of the armed services most notably during the Vietnam War, the racial integration was virtually complete by the first Gulf War. The military was not a product of the citizens' draft, but consisted of volunteer professionals. Those who served in combat may be considered largely products of lower economic classes, but the combat units were racially heterogeneous. The influence of gender was limited during the Vietnam War to nurses and doctors, by the era of the Wars on Terror, women were prominently serving in combat zones. Military personnel were frequently called back into combat after serving in previous combat deployments. National Guard and reserve units served in significant combat roles, taking leave from civilian employment. Regular army and marine personnel were especially vulnerable to multiple deployments lasting for months. These war veterans also became beneficiaries of a GI bill of education.

Cohort effects overlay on what we know to be universal or archetypal aspects of the war veteran. All war veterans of all ages have in common the impact of combat on their post-war lives and this is carried by memory. It is what made Odysseus weep at the songs of blind Demodocus relating the Trojan War. The cohort effects give the veterans of any particular war traits that are common for them that distinguish them from the veterans of prior wars. Because of the rapid development of communications media, the veterans of the Wars on Terror communicate with each other news concerning veterans. Just as PTSD finally reached the Vietnam War veterans in the mid-1980s, the veterans of the Wars on Terror are on the lookout for the symptoms.

We are still digesting the current cohort effects. The veterans of the Wars on Terror will probably not have the disastrous lung damage caused by poison gas, Spanish Flu, tobacco addictions, the contamination of Agent Orange, and the malaise of Gulf War Syndrome. The impact of the terrorist destruction of the Twin Towers gave legitimacy to the wars that had not been experienced since World War II. Mental Health practitioners will have to consider the current cohort of veterans without carrying the stereotypes garnered from the war veterans of previous wars. Some universals will apply, but the way they are manifested in the current veterans will be refracted through the prism of their unique cultural influences. EE ##

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 Wayne Ball, MSW, Chelan & Douglas... 509 667 8828
 Bridget Cantrell, Ph.D., Bellingham... 360 714 1525
 Compass Mental Health, Mount Vernon... 360 419 3606
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WDVA PTSD Program Director:

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 .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 or at www.dva.wa.gov "PTSD Program"

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
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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

WDVA offers Jail Diversion and Homeless Projects through the King County Veteran Program 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. Tom Schumacher ... 360 725 2226

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