



The Repetition & Avoidance Quarterly

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The Washington State Veterans PTSD Program

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WDVA Forges Higher Education Outreach

By Peter Schmidt, Psy.D.

It was back in January of '07 when Tom Schumacher and I were first asked to make a presentation about returning veterans to the Advising Counseling Council (ACC), (deans and directors of counseling and advising in the Washington State Community and Technical College System). As a result of this presentation we were asked to be part of a morning workshop hosted at Seattle Central Community College in May, where, along with Lisa and Steve Tice and a student veteran, JK Howell, we addressed veteran issues and had a panel discussion. Close to sixty counseling and human services professionals from community and technical college and four year institutions were in attendance. Clearly it was at this conference where it became quite evident there was a great deal of fervor and interest for working with this population. One can say the spark of these two events ignited a fire that has spread across the state.

As a result of the presentation at ACC I was asked to present at Pierce College, Puyallup, and Ft. Steilacoom in May. It was the fall of '07 where Tom officially initiated a higher education outreach effort. In January of '08 I was asked to present at Highline Community College, followed by another at Shoreline Community College in February. Including the aforementioned, I've had the privilege and honor of presenting at three universities, sixteen community and technical colleges, one VFW Post, and three conferences, totaling roughly 900 plus participants. Those in attendance are typically faculty, staff and administrators. On occasion I've also had the pleasure to co-facilitate with state contractors and VA personnel as well.

An informal network has been created with particular individuals at each campus and they are now sharing some of their best practices. Evergreen State College, for example, has created 14 Work Group Recommendations, a model to be used by any institution. Highline Community College hosted a welcome session for vets and their dependents during Fall quarter. Shoreline Community College purchased coins from their local VFW and presented one to each new veteran student as a form of welcome to the campus. Green River Community College hosted a "Vets Think Tank," where members of the campus community were

invited to brainstorm ways of best serving their veteran population. Wenatchee Valley has a house that is dedicated for vet use and Lake Washington Technical College has veterans dedicating their time to landscaping the campus, (vets unified on a common purpose and mission). Whatcom and Highline Community Colleges have created a Vet Support Team, comprised of key leadership across campus and whose purpose is to look at ways of best serving veterans. Edmonds Community College now has an active veterans club where the students most recently hosted a veterans' resource fair. The students contacted various vet-related agencies and put the program together. These students initiated a Freedom Run on Veterans Day. The Club Vet President solicited participants and records miles (walked, ran, cycled, 15 minutes with weights in the gym) and the total accumulates toward the goal of a mile for each GI who has fallen in the current war in Iraq and Afghanistan. These are, to list a few, attempted efforts to assist the veteran transition from combat to campus.

More concerted efforts will be necessary to serve the surge of veterans returning from military service and entering the academic environment. I have heard stories of faculty feeling helpless when a veteran shares his wartime trauma experiences in a speech or paper. Veteran students have shared how innocent peers ask "What's it like being in combat and killing someone?" leaving them aghast and speechless, feeling even more polarized in the environment. Washington State University and Whatcom College have already experienced veteran suicide. With unemployment being high and a spiraling economy, our higher education institutions will be the beacon of hope for those leaving active duty. These institutions will need to be ever more prepared to deal with the complex issues and dynamics of the warrior/student.

I welcome any ideas or comments you have to share about these higher education outreach efforts. Please feel free to contact me at pgschmidt7@gmail.com or 425-773-6292. ##

King County News

Welcome to the King County update in the *RAQ*. We hope to pass on some helpful information on King County services. There are numerous new services that have been assisted by the King County Veterans Levy. The King County Veterans programs have expanded to an additional office in Renton, and will send representatives to an office in Auburn one day a week. In the spirit of going to where veterans are and improve community services highlights the new services, which are funded through the Levy and King County Public Health. The projects are designed to increase outreach to Veterans and their families. Healthpoint (formerly King County Health Centers) and Valley Cities Counseling have come together to provide services and awareness through primary care and outreach to veterans.

The new staff that are providing the outreach and trauma services are Ava Norris-Carter and David Calvert. Ava is a social worker, and an Army veteran of active service and reserves. She is providing outreach services to active military, guard, reserves, and veterans. These outreach services are providing veterans with linkage to services and benefits, such as obtaining their DD 214 and assisting them with housing and vocational services. She provides the information and contacts to enable veterans to connect with providers of services. David is retired from the Washington Air National Guard and provides clinical counseling services. He works in conjunction with Ava to provide veterans and their families with needed clinical support. He provides trauma screens to outreach clients and provides extended clinical services. David comes to us with a background of working in school systems and Western State Hospital. Please contact Ava and David if your veteran clients have needs for additional services.

Contact information:

Scott Swaim – 253-250-4596

Ava Norris Carter – 253-235-0209

David Calvert – 253-235-0213

Healthpoint – 425-277-1311 and Website: <http://www.chckc.org/>
SS ##

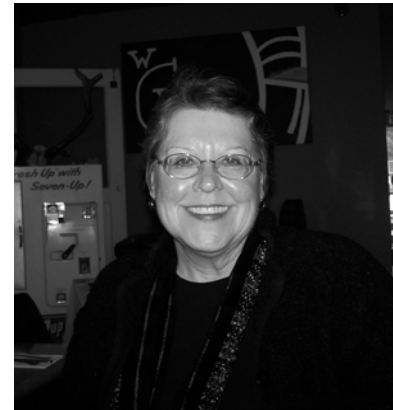
Budget Cuts Force *RAQ* Changes

The publisher of *The Repetition & Avoidance Quarterly* announced that this Volume 13, Number 1, edition of the *RAQ* will be the last to be printed in paper form, to meet cuts demanded by the State's budget constriction. The newsletter will continue electronically and will be available by Email or on the WDVA website (dva.wa.gov). The circulation department of the *RAQ* requests that those who are currently on the mailing list send in an email address to teresat@dva.wa.gov and the next edition will be sent to you electronically.

The *RAQ*'s editor wishes to assure the loyal readership that the newsletter's feisty spirit and pithy commentary will continue unchanged and encouraged readers' comments on the anticipated change. Those among the readership who do not have access to Email or Internet should contact: Tom Schumacher by telephone at 1-888-320-0512, others may wish to Email: tom@dva.wa.gov; or emmettearly@comcast.net. ##

Publisher note: We were tempted to rename the electronic version of the *RAQ*, to the *E-RAQ*, however good taste prevailed. TS

King County Veterans Program PTSD Meeting Introduces New Eastside Contractor



Terry S. O'Neill, Ph.D.

The King County Veterans Program PTSD Contractors met for their quarterly meeting led in Tom Schumacher's absence by Scott Swaim, MA. Scott introduced a new Eastside Contractor, Terry O'Neal, Ph.D. Dr. O'Neil received her Ph.D. from the University of Kansas and was an intern at the Puget Sound Health Care System Seattle hospital. She will be providing psychology services to veterans and their family members from her office in Bellevue.

Seattle PTSD Contractor Ron Lowell, MSW, presented in detail the assessment procedure used at the Addictions Treatment Program at the Seattle PSHCS (VA Hospital). Mr. Lowell illustrated the elaborate screening interview with personal anecdotes regarding the difficulty and personal health risks associated with contact with addicted veteran patients.

Scott Swaim informed the contractors (Tom Wear, Ph.D., Laurie Akers, MA, Dwight Randolph, MA, Diane Nakamura, Ph.D., Mike Phillips, Psy.D., Steve Riggins, MA and Karen Reep, MA.) of the outreach efforts that were being made to assess and treat the veterans of the current Wars on Terror, and led a discussion of treatment issues raised by attendees.

Emmett Early, Ph.D., expressed a desire to increase the news content in the WDVA-King County Veterans Program newsletter, the esteemed *Repetition & Avoidance Quarterly*. He asked for contributions of news about program changes and innovations. ##

WDVA Counselor Provides Consultation to Community Therapists

by Diane Nakamura, Ph.D.

So far this Fall I have held the first four of what I hope will be many consultation groups for mental health professionals working with veterans. These counselors come from a variety of disciplines, but what they all have in common is a desire to help clients who are veterans, active military or their family members to the best of their ability. Hmmmm . . . , a little like my own aim. Some members are volunteering time through the Soldiers Project Northwest while others are in private practice providing services for fees or through insurance. Some help because they want a better outcome for the men and women who have served our country in this war than in the past. Others help because of they understand through personal experience what the men and women in the military have experienced.

I had a few goals in starting this group. One goal was to stretch the dollars that the King County contract provides to assist veterans by increasing the quality of care veterans are receiving in the community. Being a big believer in receiving ongoing consultation, I thought it was time for me to share some of my knowledge in the field of trauma. After all, many great therapists have helped me along the way and I figured it was time for me to pass some of this along. In addition, I am certain I will learn much from the members of this consultation group and I will grow and improve in this process.

For example, one of our consult group members is G. Anthony "Tony" Barrick, Ph.D. He is a Licensed Mental Health Counselor and has a Ph.D. in Counseling Psychology from Ball State University. He was a supervisory psychologist with the U.S. Navy, a counseling psychologist with the U.S. Army, and an Alcohol and Drug Abuse Prevention Program specialist with the U.S. Army. When I asked him about what interested him in this consultation group he wrote, "*I am interested in the group because I have an affection for military families, coming from over 30 years of work as an active duty officer (nearly six years in the Air Force) and as a civilian working with the Air Force, Army, Navy and Marine Corps. Being in the consult group is a way of 'giving back' to them and a way of enhancing my current and future work with military families.*" With the wealth of Tony's experience added to the mix of this consult group, I am sure all of its members will benefit.

In addition to case consultation (discussed in ways that do not identify any clients, of course), the members suggested that we also spend time discussing topics related to treatment and assessment of trauma and PTSD, common military experiences, experiences common to veterans, etc. At our first meeting one member asked about assessment tools for PTSD and I discussed the *Trauma Symptom Inventory*, developed by John Briere, that I often use as an adjunct to good clinical interview. We also talked about consulting with VAMC clinicians when a client is being seen for some services there as well as working with one of the counselors in this consultation group. We briefly covered the differences between military mental health services and VA services as well as many general psychotherapy issues during our case consultations. In both meetings we discussed mild to moderate dissociative experiences.

I am looking forward to our next meeting, on the first Friday in December, and to future meetings as this group seems to be enthusiastic about providing quality services and growing together in this professional and meaningful interpersonal experience. There is still space for other mental health providers, so pass the word and contact me, Diane Nakamura, either by telephone at 253-852-4699 or via e-mail at Diane@DoctorDiane.com (not case sensitive) for more information. ##

Retired Army General Eric Shinseki Named Next DVA Secretary

On December 7, 2008, President Elect Barack Obama named retired army general Eric Shinseki to be his Secretary of the Department of Veterans Affairs. The significance of naming the Hawaii-born Japanese-American General as VA Secretary on the day of the Pearl Harbor Anniversary did not escape many veterans of military service.

General Shinseki was involved in combat in Vietnam War, serving two infantry combat tours with the 9th and 25th Infantry Divisions. He served as an artillery forward observer and was wounded severely, receiving two Purple Hearts.

General Shinseki received National notoriety during the Wars on Terror by testifying before Congress that the invasion of Iraq would require many more troops than was planned. He was forced into retirement for his testimony, which proved to be correct.

In naming his pick for DVA Secretary on Pearl Harbor Day, President-Elect Obama seems to be pointing to the spirit of reconciliation and encouraging a reconsideration of past prejudices, animosities, and beliefs. General Shinseki's task is to run an organization so huge that it has been thought of as a model for a national health care system. The Department directs not only the nations largest health care system, it is saddled with the responsibility to manage benefits, including disability, vocational training, the GI Bill education benefits and burials of military veterans. While the DVA does not concern itself with the health needs of veteran family members, it does have within its system the potential for expanding services to veterans who do not have service-connected disabilities, including those higher on the income spectrum than are now being served. Washington Senator Patty Murray, who is now senior in the Senate Veterans Affairs Committee, has declared that she would like to see the DVA health care system expand in such a fashion.

The concept of the veterans' health care system becoming a model for a national health care system has a more attractive appeal as the Veterans Affairs hospitals spawn clinics in rural areas and urban neighborhoods. The innovation of computerized health records, already shared between the DOD and DVA, presents an attractive idea. EE ##

Movie Review:

Milk—Fated Gay Politician Murdered

Reviewed by Emmett Early

Harvey Milk entered San Francisco politics at age 40 in the early 1970s, was finally successful in his 3rd campaign for a City Supervisor position when the city reorganized the system to have areas of the city elect their representatives. Milk finally won his seat because his district represented the liberal Castro and Haight-Ashbury Districts. This was the era just before the outbreak of the AIDS epidemic, the hay-day of the Gay Renaissance in San Francisco. *Milk* was directed by Northwest filmmaker Gus Van Sant. The film has all the trappings of a Hollywood film biography of a popular historical figure, and Van Sant adds a loving partisan view of the Gay movement of the time.

Sean Penn, who has himself adopted San Francisco as his own, plays Harvey Milk. Penn gives a brilliant performance. His body, his mannerisms, his voice, are Milk's. When at the end of the film the pictures of the real Milk are shown, the audience has difficulty telling the actor from the man he's playing.

Van Sant doesn't explore Milk's life before age 40. Other biographical details indicate that Harvey Milk was a veteran of the U.S. Navy during the Korean War (1951-1955) and achieved the rank of Lieutenant JG serving aboard a submarine rescue ship. He emigrated from New York, where he was a financial analyst, to start a camera shop in the Castro District. From his store, Milk entered community organizing and ran for office as an advocate of the gay community, but so long as the Supervisor positions were City-wide, he came close, but lost each time, until the election law was changed.

Milk is primarily a joyful film depicting a liberation of a community. Milk was one of a migration of gays from across the nation, allowing them to, as they say, come out of the closet. Harvey Milk evolves from political activism to politician, and when he finally wins the election, as one character notes, he becomes the first openly gay person in a significant political office. However, as a pioneering public figure, Milk stirred resentment and began receiving death threats. His killer was a less skillful City Supervisor Dan White (played by Josh Brolin), who was outshined by Milk and is depicted as decompensating into mental illness. It is White who finally shoots Milk and the City's mayor, George Moscone. White had resigned his Supervisor job after the California voters rejection of Proposition 6, which would have allowed discrimination against gays.

As Milk is transformed from a relatively shy businessman into a social activist and politician, he receives death threats in the mail. The film periodically segues to Milk dictating his story, to be released in the event he is assassinated. He has taken the threats seriously, but is swept up in the social movement. There is something that rings very true about a person's sense of fate when, like the combatant, he is caught up in an historical event.

Director Van Sant juxtaposes Harvey Milk's ascension as a gay public figure with Dan White's decline into irrelevance. Dan White's defense in court was labeled by journalists as "The Twinkie Defense," because he claimed to have become psychotic as the result of a junk food diet. The film has him also drunk at times and sinking into dysphoria. He is associated with tradition when we see him first as a father at the christening of his child at a Catholic Baptism. Milk, seeking political alliance, is the only politico among the witnesses. White is also a former fireman and cop. The multiple career moves suggest an instable figure trying to take root.

Milk also shows newsreel footage of Anita Bryant's movement to revive traditional values, directly attacking gays as depraved and ill. Milk contributed to the failure of Proposition 6 by engaging the State Senator who sponsored the referendum in Statewide debate.

Van Sant makes the point, as I suppose does Harvey Milk's story, that psychopathology is independent of sexual preference. The director has had a succession of popular films, along with a film about gay hustler with narcolepsy, *My Own Private Idaho*, filmed in Portland.

Milk does not mention Harvey Milk's Navy enlistment. Chief Petty Officer is a relatively high rank, suggesting an unblemished record for a single hitch. What we used to call Ego Strength describes a trait having to do with strength of identity, which clinicians have come to regard as an asset during times of prolonged stress. To serve an enlistment in military service during the era of the Korean War as a gay man without legal complications, is probably a good indication of stability of identity. The film also shows us Harvey Milk's rather unstable social love life, during which he seems to grow emotionally. One lover commits suicide and Milk states that *all* his lovers have succumbed to suicide. Yet Sean Penn's Milk seems to acquire a sense of peace that allows him to transcend the chaos. He seems to grow naturally into the suit and tie of his political office.

Filmgoers recall Josh Brolin's other recent roles, as George Bush in Oliver Stone's *W*, and as the Vietnam War veteran hunted hunter in the Coen Brothers' *No Country For Old Men*. He depicts the killer Dan White as a man with a troubled identity, who has reached his limit and succumbed to the stress. He too is caught up in the social upheaval that is focused in San Francisco, and on his way down, he took with him Supervisor Harvey Milk and Mayor George Moscone. He was convicted but released from prison on appeal, and then he committed suicide too. ##

Countertransference in Psychotherapy During Wartime

Countertransference is an awkward term that has little meaning outside the mental health field. It refers to the reactions of a therapist while treating a client. No therapist is immune to this phenomenon, and there is no way of avoiding the experience of countertransference. The term was originally coined by Sigmund Freud and was considered an integral part of psychoanalysis. The experience was especially strong when analyst and client met every day in the intense intimacy of a psychotherapeutic relationship. In fact, transference, the client's reaction to the therapist, was promoted as an integral part of the analytic treatment process.

The mental health professions have varying levels of training to prepare therapists. Much emphasis is given to the issue of self help, supervision, and consultation. The practice of psychotherapy by its nature can load a therapist with dark imagery of suffering and loss. Recently at a meeting, a therapist was describing the diagnostic intake for a substance abuse program. He observed that the clientele can be poor in self care and carriers of infection. He said that he had been contaminated on more than one occasion merely shaking hands with patients and described the MRSA infection on his hand. The process of countertransference has some analogous properties. Under ordinary circumstances in a clinical practice the therapist hears secrets and confidences that darken consciousness. Therapists treating war veterans and their family members are also burdened with the weight of hearing about the worst kinds of suffering and death. By the time the Vet Centers started, the Vietnam War had ended. Even then, the emotions that were shared had huge national implications that affected the therapists. Every therapist had lived through the era. The anger, feelings of betrayal, shame, guilt, and grief, expressed by the clients were loaded with feelings about the war policy itself, all of which threatened to contaminate the therapist with countertransference.

Therapists who treat the veterans of the Wars on Terror and their family members are burdened with feelings about war policies that are ongoing. Some clients may even be required to return for further deployments to the combat zone. The therapist cannot help but be influenced by emotions that in turn influence the conduct of therapy. This has been especially true during the recent period of political contest. The issue with countertransference is not so much concerned with the emotions that the therapist has, but how those emotions influence the process of treatment. If anger is expressed, or political opinions put for justifying or arguing against the war policy, the therapist must remain neutral, even though the therapist is supposed to be representing reality.

It is essential that the therapist not engage in delivering psychotherapy to war veterans in the time of war without having ongoing peer consultation or supervision. The therapist must have his or her emotions in proper perspective.

Bonding

The problem is especially relevant for the therapist treating clients caught up in historical events, such as those leading up to the ongoing Wars on Terror of today. When the planes crashed into the World Trade Center, the therapist and the client witnessed the same events through the same media. Both were caught in the spell of national catastrophe. The same connection of shared experience between therapist and client occurs when there is an emergency in the neighborhood, an earthquake or storm. Instead of the client relating his or her experiences in psychotherapy, the event is shared: the therapist and the patient both witnesses.

Now, with ongoing wars involving the U.S. with all its political, cultural, and social implications, the therapist finds the task of maintaining objectivity, to say the least, difficult. The therapist may disagree with the war, or may support it, but is *not* objective. The client expresses opinions the therapist shares. Is not the therapist supposed to reflect reality? It is as if the client had cancer and the therapist had cancer, too.

Sharing emotional experiences together fosters bonding and when bonding takes place, the therapist becomes subjectively involved with the client, like it or not. Therapists who have had extensive supervised training have practiced objectifying and viewing emotions with intellectual detachment, which can provide the opportunity for modeling the technique to the client.

Two ways of looking at countertransference are first looking at how one reacts emotionally to a client, and secondly by noting how that reaction results in behavior during the treatment hour. Briere and Scott in their 2006 *Principles of Trauma Therapy* used the term "counteractivation," which is not an improvement in language, (although they give excellent examples,) and in fact seems to subsume only part of what we understand to be countertransference. Does the client talk about things that disturb me? Do I have in my past traumas similar to my client's topic and does that cause me to avoid the topic, skirt the issue, make light of something that should be delved into for the client's benefit? Does the client's image cling to me like cigarette smoke so that I ponder the topic in the dark at night when I should be sleeping? Am I seeing too many clients with traumatic histories, such that my consciousness has darkened?

Countertransference and Shadow

Carl Jung admonished us to know our Shadow, making such knowledge essential to the process of psychotherapy: Shadow being that part of my mind with which I do not identify. If my client is talking about grief at the death of her aging mother, I must be aware of how I feel about her in relation to how I feel about the death of *my* mother.

Knowing one's shadow, in that Jungian sense, is like seeing into a cosmic black hole. Can't be done directly. One can only theorize by watching what is sucked in and the reaction one has to the implied content.

(Continued on page 11, see *Countertransference*.)

Social Support in the Course of Chronic PTSD

The early treatment of choice for Vietnam War veterans with PTSD was group psychotherapy or "RAP" support groups. Anecdotal reports among veterans were consistent that they found significant support among their veteran peers, while experiencing various levels of alienation among the general community. Researchers at the Menlo Park, California, VA Hospital examined the function of perceived social support among veterans who had required inpatient treatment for PTSD. Charlene Laffaye, Steven Cavella, Kent Drescher, and Craig Rosen published their results in the *Journal of Traumatic Stress Studies* ["Relationships Among PTSD Symptoms, Social Support, and Support Source in Veterans with Chronic PTSD", 2008, 21(4), 394-401]. The authors were able to assess the social support networks of 128 veterans who completed a residential treatment program for PTSD. They assessed the veterans for PTSD severity, as well as details concerning their perceived support from family members, veteran and non-veteran friends upon discharge from the treatment program and in a 6-month follow-up. The authors sought to understand the positive and negative factors in the role of social support in relation to the severity of PTSD.

Laffaye, et al, found that their veteran subjects "reported having more veteran peers than nonveteran friends in their social network. Participants reported they were in regular contact with and received instrumental assistance ("help with practical things") from roughly equal numbers of family members and veteran peers. However, they reported having significantly more veteran peers than family members and more family members than nonveteran friends who they could or did turn to for emotional support" (p. 396). The participants in the research also report experiencing the least amount of interpersonal stress from their veteran peers (p. 397). A further elaboration of their findings indicates that the more PTSD symptoms that the veteran reported predicted a greater erosion in perceived level of interpersonal resources at follow-up from non-veteran friends (p. 398).

Laffaye, et al, disconfirmed their hypothesis that PTSD symptoms at first measure predicted their second evaluation of social support and stressors. The authors summed up their results. "The study findings indicate that veteran peers are an important and highly valued component of veteran PTSD patients' social networks. Veterans were the largest (most numerous) component of participants' social network. Although participants reported receiving instrumental assistance from roughly equal numbers of veterans and relatives, veteran peers were their most common source of emotional support" (p. 399). Their veteran peers were rated as being both supportive and least stressful. Elaborating on their findings, the authors note that PTSD symptoms significantly predicted "erosion of perceived interpersonal resources from non-veteran friends..." (p. 399).

Laffaye, et al, did not find that social factors would influence symptom course. The authors, however, point to a significant limitation in their study, which evaluates the social support system of veterans with PTSD that has been chronic for 30 years over a period of only 6 months. They observe that veterans in their study "have experienced the effects of many years of social disruption, including multiple divorces, conflicts with relatives, and disrupted friendships: thus, the social damage may have already been done" (p. 400). Laffaye, et al, even opine that "it appears that among veterans the benefits of social support are reduced once PTSD becomes chronic" (p. 400).

Comment

Sometimes research in psychology produces confirmation of the obvious. Clinicians have observed for years that the importance of peer relationships among veterans is sometimes more valuable than family, and certainly valued above non-veteran relationships. Such research is always welcomed, since sometimes the obvious can be disconfirmed when rigorously tested. But was the testing rigorous enough? Laffaye, et al, initially contacted 354 "eligible participants", of which 188 participated in the survey (53%), and only 128 completed the 6-month follow-up, which was 36% of the original sample. Not to suggest that this is an unreasonably small sampling, but who were among the 64% of the uncooperative veterans with chronic PTSD? Conjecture, purely conjecture, suggests that these uncooperative veterans had even less social support than the participants in the Laffaye, et al, study.

It begs the point, however, that when PTSD becomes chronic, the path of social destruction is predictable. Veteran peers become significant perhaps because of identification, bonding, that allows veterans to empathize with each other. What irks the current coterie of mental health providers and outreach workers is that the growing number of the veterans of the Wars on Terror avoid treatment, perhaps wishing and hoping that the symptoms will dissipate with time. What we see, unfortunately, is the evidence that the symptoms harden and become fixed in habit over time.

The authors caution their readers to not generalize their results beyond this sampling of Vietnam War veterans with chronic PTSD. Other carriers of PTSD may not apply when it comes to issues of social support, although there is an intuitive sense that persons who are victims of similar traumas may be more empathic to their fellow survivors than others.

What rings very clear is the long term consequences of engaging in war when there are other options available. Those who participate in combat are likely to have the course of their lives altered irrevocably, as a path that deviates from its source. EE ##

Raymond Chandler's Writings Linked to PTSD Hyperarousal

A study of the works of the late detective fiction writer Raymond Chandler placed his wartime exposure to combat in perspective with his creative writing. Tom Hinley's 1997 biography of Chandler follows the American author through his public school education in England prior to World War I. Chandler was living in California during the war and moved to Canada to enlist in the Canadian army in 1917. He was sent to France and served in the trenches with the Canadian Expeditionary Force for one year. He was wounded in an artillery barrage and was hospitalized with a concussion. Chandler never wrote in detail about his wartime experiences, but an indication of the amount of combat he was engaged in is measured by the fact that his Canadian infantry unit was disbanded after he was injured due to "depletion." Chandler, who had not abused alcohol before his military service, began what would become a lifetime pattern of binge drinking.

Raymond Chandler's most successful writing concerns hard-boiled detective Phillip Marlowe. The author began writing for pulp detective magazines after he left his job as an accountant with a California oil company due to alcohol abuse. His novels were received with critical acclaim in England and the U.S. Part of the author's appeal is his gifted attention to detail, and his biographer gives us a sense of PTSD pathology in his writing: "Though it was serving him well in his writing, this permanent scrutiny of his surroundings was not always an advantage for Chandler as a person. It was a heightened form of self consciousness that made it very hard for him to relax or accept anything at face value. It was a purgatory; the inability to switch off unless comatose with drink..." (p. 94, *Raymond Chandler: A Biography*).

Chandler began writing for cinema in 1944 when he was hired to co-write a screenplay of the noir classic *Double Indemnity*. He was the exclusive writer the next year of the original screenplay of *The Blue Dahlia*. The character of Buzz, played by William Bendix, comes close to the mark of Chandler's own history. Buzz is hypersensitive to noise. He is rough-talking and opinionated. He has a plate in his head from a concussion, and although Chandler didn't have a plate, he shared with Buzz a propensity to drink alcohol, "double bourbon with a bourbon chaser," with the occasional blackout, memory loss, and confusion. Buzz was a crewmember in a Navy Liberator that was piloted by Alan Ladd's character, Johnny. Chandler originally wrote Buzz as the murderer of Johnny's wife in a blackout and has him set about trying to discover the murderer, which was a clever plot idea that was censored by the wartime Production Code that required any plot concerning the Navy to be previewed and approved by the Navy. The Navy didn't want a wounded war veteran depicted as a violent alcoholic.

There are plenty of corpses in Chandler's fiction. Phillip Marlowe describes them in detail, searches the corpses for ID, and then leaves them for others to find and remove. EE ##

Local VA Study Shows Prazosin Reduces "Distressed Awakenings"

Charles E. Thompson and his colleagues at the Seattle Puget Sound Health Care System reported on their research results studying the efficacy of the medication prazosin in the treatment of veterans with posttraumatic stress disorder. They published their results in the *Journal of Traumatic Stress* [2008, 21 (4), 417-420]. The authors make a distinction between distressed awakenings from nightmares and what they refer to as "nonnightmare distressed awakenings." They note that these awakenings may be due to increased central nervous system adrenergic activity during sleep. Prazosin, they observe, is the only clinically available antagonist that crosses the blood brain barrier and specifically blocks central nervous system responses to adrenergic stimulation.

Thompson, et al, describe the evaluations of 22 veteran patients who were considered for treatment of PTSD. The patients' sleep disturbances were specifically quantified and prazosin treatment was begun. Patients were evaluated every other week for an approximate average of 3.5 visits. The authors reported that "all three sleep symptom parameters [trauma-related nightmares, sleep difficulty, and nonnightmare distressed awakenings] were significantly reduced following prazosin treatment.

Thompson, et al, caution the interpretation of their results and call for a placebo-controlled study to verify the promising findings. They suggest in their discussion of their findings that trauma-related nightmares and nonnightmare distressed awakenings "have common association with hyperarousal and startle and their similar reduction by prazosin suggest that increased brain responsiveness to norepinephrine at the postsynaptic alpha-1 adrenoceptor contributes to the pathophysiology of both symptoms" (p. 419).

The study of prazosin as a treatment for PTSD symptoms of hyperarousal was pioneered by researchers at the Seattle PSHCS. The authors note that the improved control over sleep disturbance buoys the patient's global sense of well-being and general ability to function, which in turn would enhance ability to constructively channel daytime hyperarousal. EE ##

RAQ Retort

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

emmetearly@comcast.net

tom@dva.wa.gov

Book Reviews:

Three by Primo Levi: *Survival in Auschwitz*, *The Reawakening*, *The Periodic Table*

Reviewed by Emmett Early

In New Orleans, at the 1990 ISTSS meeting after the death of Italian author Primo Levi, a session was held to discuss his work and life. He had died from a fall from the upper floor of his building. The discussion in the ISTSS session led to speculation that Levi had committed suicide. The 68-year-old author/chemist had been ill and about to enter the hospital. I remember Everett psychiatrist William Bunselmeyer standing up in the back of the room and wondering if Levi, as a survivor of Auschwitz, might have considered entering another institution as a posttraumatic threat to his integrity. (I paraphrase Dr. Bunselmeyer's statement.)

Primo Levi had just graduated with a degree in chemistry from the university in Turin when the Fascist government introduced racial laws designed to segregate Jews from other Italians and severely limiting their opportunities. Levi writes about this time in *The Periodic Table*, which is a collection of stories, some autobiographical, some fictional, each based on an element in the Periodic Table. He describes his difficulty finding a graduate student research position, and when he graduated, a job in his profession. Although the Italian Fascists were difficult for Levi, the introduction of German Nazis into Italy forced him to take refuge in the mountains with the Resistance. Levi was a small intellectual man who was unskilled in the use of arms, but he had the advantage of being robust and adventurous. Shortly after he sought refuge, the Fascist soldiers raided the camp and arrested him.

Levi picks up the narrative in the first book he wrote after his release, *Survival in Auschwitz*. He was transported to Auschwitz in 1944 and describes with harrowing detail his reduction to a state of debasement and starvation. His narrative, however, never becomes self-pitying or even particularly emotional. He has a scientific approach which gives him a dispassionate style, yet he never ignores the pathetic conditions that he and his fellow inmates had to endure.

The Italian prisoners were transported in a freight car without food or water to the concentration camp in Poland. The men were separated from the women and children. Then the work-able men were separated from those doomed for the gas chambers. Levi's description of the camp routine and the conditions is vivid, yet never difficult to read. He is matter-of-fact. He manages to give us some wonderful individual characters among his fellow inmates. He notes that the numbers tattooed on their arms denoted what group and even what nationality they were, giving them some valuable information in the polyglot community where misunderstanding could lead to beatings and even execution.

Levi's dispassionate description of conditions at the camp

is clear and vivid in detail, as if he were describing a chemistry experiment. Here, for example is his observation of inmates trying to sleep, stacked like cordwood in barracks: "We try in vain, when the nightmare itself or discomforts wake us, to extricate the various elements and drive them back, separately out of the field of our present attention, so as to defend our sleep from their intrusion: but as soon as we close our eyes, once again we feel our brain start up, beyond our control; it knocks and hums, incapable of rest, it fabricates phantasms and terrible symbols, and without rest projects and shapes their images, as a grey fog, on to the screen of our dreams" (pp. 62-3, *Survival*).

Being a skilled chemist may have saved Levi from death. The winter of 1944 was infamously cold in Europe and the death toll among those transported with the author was almost 100%. Levi learned to be clever and adapt to the bizarre conditions of the concentration camp, where survival was a daily contest. For instance, even though they were desperately hungry, it was prudent to time one's place in the soup line so that one benefited from getting the dredges at the bottom, where there was more substance to the meager soup.

Levi doubted that he could survive a second winter until he had the good fortune to be selected to work in the camp's chemistry lab. Even then, he avoided the final Nazi extermination march, as the Russians approached, because he was ill with scarlet fever and quarantined in the hospital. The patients in the camp hospital were abandoned, many died and Levi barely survived until the Russians arrived. Levi was near death and this gives credence to Dr. Bunselmeyer's hypothesis that Levi's later pending hospitalization awakened intolerable traumatic memories for the author.

Some of the richest posttraumatic observations come in *Reawakening*, which describes the author's odyssey from Auschwitz home to Turin, with a bizarre detour deep into the Russian steppes, where the former prisoners were gathered by nationality before the long transportation home by rail on a bomb-damaged railroad system. Levi writes of his ferocious hunger as a traumatic memory awakened by the presence of food and cooking cues: "our memory of the hunger of Auschwitz was still too recent, and had changed into a violent mental stimulus, which obliged us to fill our stomachs to the utmost and imperiously forbade us to renounce any opportunity of eating" (p. 148, *Reawakening*).

Levi's writings on his horrible prolonged near death experience are an invaluable contribution to our understanding of the psychological impact of trauma. His exploration of the trauma survivor's ambivalence toward memory is an example. He asserts that it is necessary to remember. In his noteworthy (Continued on page 9, see *Levi*.)

(Levi, continued from page 8.)

chapter in *Survival* (p. 87), “The Drowned and the Saved”, he writes: “In our days many men have lived in this cruel manner, crushed against the bottom, but each for a relatively short period; so that we can perhaps ask ourselves if it is necessary or good to retain any memory of this exceptional human state.

“To this question we feel that we have to reply in the affirmative. We are in fact convinced that no human experience is without meaning or unworthy of analysis, and that fundamental values, even if they are not positive, can be deduced from this particular world which we are describing.”

In *Periodic Table* (p. 153), Levi described the benefit to his recovery of writing about his traumatic life in Auschwitz: “Paradoxically, my baggage of atrocious memories became a wealth, a seed; it seemed to me that by writing, I was growing like a plant.”

In *Reawakening* (pp. 152-3), Levi describes with a piquant humor his numbed reaction to a concert put on by Russians at a holding camp on the Steppes. He writes: “If I still had my former sensitivity, I thought, this would be an extremely moving moment.”

We in the profession of healing usually only have access to the survivors of trauma. We don’t know how the others thought, except for the invaluable hidden treasures of diaries. We know that Bruno Bettelheim and Victor Frankl both used their scientific training to take a step back from the brutal experience and make mental notes. Primo Levi also used this kind of dispassionate observation, yet he manages to express the shame-filled impact of the traumatic degradation. In *Survival* (p. 121), he writes: “As we have been condemned to this life of ours, reduced to our condition, we must be tainted by some mysterious, grave sin.... They know us as thieves and untrustworthy, muddly ragged and starving, and mistaking the effect for the cause, they judge us worthy of our abasement.”

What kept him struggling to survive during such a horrible time? Levi observed, “I am not even alive enough to know how to kill myself” (*Survival*, p. 144). Later, after returning finally to Italy on a train full of starving, desperate survivors, in which the passengers would leap from freight cars at stops and towns in Russia and Poland, raiding the local wells for water and picking up every edible item in the vicinity that wasn’t guarded, he continued to struggle at home to earn a living (an ironic term for him), in a war-devastated economy. He had been hardy in his youth. He worked as a chemist, finally gaining regular employment and status in a paint company. He wrote books that gradually gained him international respect. Yet when he grew ill enough to require hospitalization, to in a sense have his freedom taken away, Primo Levi had a fatal accident at age 68, falling down the stairwell from the upper floor of the same apartment building where he had lived as a child. His legacy is profound and incredibly rich. He teaches us that it is necessary to remember and find a way to grow that allows us to work with the symptoms of trauma, and, in Levi’s chemical jargon, transform the base material into creative spirit. ##

Travis Twiggs’ PTSD & Death Reviewed In Detail

In the last edition of the *RAQ* (12-4, page 8) we reported on an AP story about SSgt Travis Twiggs of the U.S. Marines who died by his own hand after shooting his brother when surrounded by police. We mistakenly referred to his nickname as “T-Bo”. A *New Yorker* article by William Finnegan, writing in the 9/29/2008 *New Yorker* (“The Last Tour: A decorated marine’s war within,” pp. 64-71), reports more detail surrounding SSgt Twiggs’ death.

Travis Twiggs grew up in Louisiana. His nickname from childhood was *Tebeaux*, which in Cajun means “handsome little man.” He served four deployments in Iraq and one in Afghanistan. He was assigned to the War Fighting Laboratory at Quantico, which tested new weapons, when he wrote about his PTSD for the *Marine Corps Times*. He was hospitalized on two occasions at Bethesda Naval Hospital and was finally assigned to the Wounded Warrior Regiment when he went AWOL and began his last journey with his older brother, Will.

Finnegan’s article gives no mention of the possibility that the Twiggs brothers were smuggling, which was suggested by their being chased by police from the Mexican border. The author interviews Twiggs’ family members and fellow marines. Twiggs was married and had two small children. His father, mother, and wife describe his reaction to treatment efforts, complaining that he seemed to get worse with the medications, and of course he was drinking alcohol heavily. In one interview, Twiggs’ wife’s landlady makes a telling comment: “He always seemed a little over the top in terms of physical energy—he’d work out in the basement at 3 A.M. for a couple of hours before he went to work—but I just put that down to being a marine” (p. 65).

Another insight comes from Twiggs’ wife, Kellee: “He told Kellee that he couldn’t stand to look in the mirror. He was racked with guilt, in particular over the deaths of two young lance corporals in his platoon. The only thing that really helped, he wrote, was returning to Iraq” (p. 67). The author indicates that Twiggs’ guilt was related to posttraumatic rumination about not having acted on a feeling about the marines’ vulnerability as targets for the enemy, but deferred to his commanding officer.

Will Twiggs, Travis’ older brother, had been having difficulties with employment and relationships. They were apparently on a road trip drinking binge. Regarding his alienation and final suicide, Kellee is quoted as saying, “But he really left us a long time ago. He tried to come back. But he couldn’t. That was not my husband out there” (p. 71). She contended that her husband should have been placed in a VA PTSD ward where he could have received cognitive therapy. “I think guilt is what killed him, what made him let go, made him disconnect, from us, from everything. He thought he’d let us down, let the families down, let the boys down who died, let the command down” (p. 70). EE ##

Emotional Intelligence and PTSD Avoidance

The PTSD symptom of avoidance, we know, manifests in several ways. DSM-IV recognizes and requires actually 3 avoidance symptoms. One of these multiple manifestations of a PTSD avoidance symptom is isolation: “feeling of detachment or estrangement from others.” For some this symptom proceeds naturally from the peri-traumatic reaction of psychic or emotional numbing. The combatant after a period of time ceases to react emotionally, or reacts with a muted response to loss, pain, and threats to safety. If Emotional Intelligence is defined as an ability to accurately read and act on emotional cues, then that kind of intelligence is reduced when psychic numbing sets in.

John Mayer, Peter Salovey, and David Caruso, reviewed the concept of Emotional Intelligence (EI) in the *American Psychologist* [2008, 63(6), 503-517]. They defined it as “the ability to engage in sophisticated information processing about one’s own and others’ emotions and the ability to use this information as a guide to thinking and behavior. That is, individuals high in EI pay attention to, use, understand, and manage emotions, and these skills serve adaptive functions that potentially benefit themselves and others” (p. 503).

PTSD avoidance by definition seeks to avoid stimuli that cue the PTSD symptoms of hyperarousal and repetition (traumatic memory). The stress experienced in intimate social relationships, such as family, daily relationships at work and community activities, probably increases as Emotional Intelligence declines. The veteran who avoids social intimacy over time becomes less skilled, so that soon even the trivial talk at the cash register in the market becomes something to avoid.

The veteran with PTSD can find himself or herself socially and emotionally isolated, and yet be in the middle of a group. The veteran doesn’t have to become geographically isolated. He or she can be living and working in the center of a city, like Travis Bickle in *Taxi Driver*, and be unable to effectively affiliate with other, may function within some predictable social milieu, as in a club where social behavior is clearly defined, may cloak themselves with intoxicating substances, mimicking spontaneity after ingesting disinhibitors.

Paranoia can also provide a cloak of avoidance. Humphrey Bogart played a war veteran who was a successful screenwriter in Nicholas Ray’s film, *In a Lonely Place*, who managed to alienate all who were potentially close to him with compulsive irascibility. Paranoia we know can be a trait that grows abundant in the greenhouse atmosphere of social isolation. Pretty soon the veteran is reading the minds of the neighbors and planning preemptive strikes like an overzealous government. According to the above definition of EI, psychological projection obfuscates intelligent reading of social and emotional cues. Paranoia alienates the veteran until he adopts an outlaw status shielded by anger and cynicism. The condition is exploited gleefully by filmmakers, exemplified by the successful Rambo series (*First Blood*, & etc.) and many biker-vet movies made during the 1970s.

It follows that effective psychotherapy ought to improve a PTSD veteran’s Emotional Intelligence, assuming that the therapy involves the fostering of a healing relationship. This process is aided by a primate’s instinctive inclination to affiliate. Primo Levi describes this amidst the horrors of Auschwitz when he came upon a fellow Italian citizen. The veteran may rationalize coming to see the therapist because of the need to keep his service-connected disability status validated, or present some other rationale, (somebody else insists), but the wish to affiliate may assist the process of healing.

The return of empathy to the veteran’s repertoire is a harbinger of progress in the psychotherapy of PTSD. Grief, anxiety, and guilt are likely to be the first dragons encountered, and there can be no convenient institutional time limit on how long it takes to slay them. One of the sad, wistful examples of the return of empathy in a veteran with PTSD can be seen when the veteran allows himself to love his grandchildren—but sad when the love has skipped a generation swallowed by alienation.

Mayer, Salovey, and Caruso view Emotional Intelligence as operating at the “intersection between emotions and intelligence—specifically limited to the set of abilities involved in reasoning about emotions and using emotions to enhance reasoning” (p. 514). Veterans with PTSD avoidance symptoms have difficulties with several of the authors’ “Four Branch Model of Emotional Intelligence” (p. 507). The branches consist of 1. “Managing emotions so as to attain specific goals.” 2. “Understanding emotions, emotional language, and the signals conveyed by emotions.” 3. “Using emotions to facilitate thinking.” 4. “Perceiving emotions accurately in oneself and others.” It is branch 3 that gives the PTSD veteran the most trouble when emotions are driven by associations to traumatic memory or charged with hyperarousal. Our concept of what is rational or irrational relies largely on whether the emotion is appropriate for the moment. What Henry Krystal termed “over-reactive affect” describes the reaction in which emotion is *not* used to facilitate reasoning.

The veteran with PTSD flies low under the radar when the isolation of avoidance is performed *within* the family and *within* the group; that is, when the veteran is emotionally isolated by closing off feeling and detaching from what might be called the emotional consensus. My favorite analogy to this is when the veteran has hearing loss and is able to not participate in what is being said at the dinner table, while yet physically present and even, as the war veteran lord of the manor was in *Gosford Park*, host of the gathering.

It is difficult for anyone to develop an understanding of emotions and emotional language, when emotions are affected and interfered with by memories of psychological trauma. It is a source of alienation for veterans of combat that the emotions that they have witnessed and experienced are not shared or perhaps even conceived of by others in their environment.

EE ##

(*Countertransference, Continued from page 5.*)

Positive Countertransference

The process of professional retirement brings out a most positive form of countertransference. As I announced my plan for retirement, my referrals stopped and the clients who remained with me were the ones benefiting the most, it seems, the ones with whom I had the best relationship. Countertransference is also affection.

A client's tangents may be charming, intellectually interesting, but they may also be like the bird that feigns distress to divert my attention. Race, gender, and ethnicity are commonly examined in seminars as factors that trigger countertransference. Cultural bias can also be triggering when the client's cultural values conflict with the values of the therapist: as when the outlaw biker meets the straight therapist, or when the client's righteously expressed politics conflict with the therapist's beliefs. Such views may be expressed innocuously in time of peace, but with the nation involved in controversial war, and when the therapist also treats traumatized veterans, countertransference may loom large.

Feeling as Countertransference

I was taught to monitor countertransference as if it were a gauge: how I felt during the hour was relevant data. Feeling helpless, ineffective, afraid, angry, titillated, disgusted, doubtful, impressed, bored, etc., were feelings that should be conscious in the therapist if present. If the client has stood me up for previous appointment and I cannot charge him because he is impoverished, and if it happens again, even if it is an obvious treatment issue—the client is disorganized and I am stymied—what I am feeling may be what the client is feeling, and I may want to articulate the feeling for his benefit, or I may decide to keep monitoring and file away the information. The difficulty comes when the feeling or emotion is noxious to me and I act not in the client's best interest, but in my own interests. I have to be circumspect about what I say. Is what I have the impulse to express to my client useful therapeutically, or merely self-serving?

Psychotherapists are admonished in training to consult with supervisors or colleagues on a regular basis, and as needed when the therapist senses countertransference is involved. It would be foolish for a psychotherapist, especially one treating PTSD, to be without regular consultation. PTSD is a disorder that is ambiguous at times. In this period of the Wars on Terror, treating combat veterans can bring a whole new aspect of pressure on values. Therapists do not have to agree with their consultants, but it is crucial to air one's opinions and articulate values so that they are clear in the mind of the therapist. This is all part of what Jung meant by the term "know your Shadow."

Countertransference as Projection

Analytic theoreticians like Carl Jung conceived transference and countertransference as unconscious projections, and, as such, when activated, reduce the perception of individuality. In

many cases the client's transference can trigger the therapist's countertransference. As soon as the therapist views the client as a member of a class or category, such as low-back pain derelict, born-again Christian, alcoholic, etc., the therapist loses touch with the very qualities that mark the client as an individual and will lead to healing.

Unconscious projection occludes an accurate perception of reality. It clouds the therapist's vision as if he or she had cataracts and didn't know it. Countertransference occurs when the client, recounting traumatic events, impresses the therapist. Both leave the hour feeling that something has been accomplished. The client may feel a load lightened by sharing, whereas the therapist may feel that consciousness has darkened: widened, but darkened.

Much attention has been given in literature to the controversial issues of countertransference as sexual or prejudicial. Empathy, however, can be construed as the therapist feeling what the client feels. There are probably very few psychotherapists who have arrived at their station without having endured trauma or grief over loss. It is part of life. What therapist isn't triggered when a client experiences a major loss, car accident, or family tragedy? What if the therapist has experienced similar, even greater loss? Is the emotion triggered empathy, or is it an intrusive emotion that is unwelcome?

It was a generally accepted axiom for those doing therapy during the post-Vietnam era that therapists who were Vietnam War veterans had a special challenge to stay objective. Many of us have observed the high levels of stress caused when therapists with posttraumatic stress disorder were treating veterans with PTSD. The price they paid was built into the PTSD symptoms: re-experiencing, hyperarousal, and avoidance, none of which were welcome or even helpful. The therapist who already had PTSD sleep disturbance had to endure the imagery triggered by the day's psychotherapy group, and so up for work the next day with dark eyes.

Doing mental health work, (with the exception of Dr. Phil,) is not done with a goal of getting rich. People who enter mental health work do so with a motivation that is integral to their character. The principle issue in terms of countertransference is to separate that motivation from everyday clinical practice. The therapist cannot let his or her reaction to a client be triggered by bias, prejudice, or avoidance. The Wars on Terror promise to continue for the foreseeable future. Veterans of the war, those civilians who have been affected by previous wars, who have a desire to help for reasons rooted in their character, all need to objectify, with the help of other professionals, where they stand when the images of psychological trauma are discussed.

EE ##

**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
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 Adrian Magnuson-White, MA, Shelton... 360-462-3320
 Keith Meyer, M.S., LMHC, Olympia... 360 250 0781
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 Dwight Randolph, M.A., LMHC... 253 903 7386
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 Darlene Tewault, M.A., LMHC Centralia... 360 330 2832
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 Washington State U. Psychology Clinic... 509 335 3587

Dan Comsia, M.A., King County... 253 840 0116
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 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
 Laurie Akers, M.A., LMHC, Everett... 425-388-0281

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:

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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 System (VA Hosp.) 206 762 1010
Tacoma Vet Center 253 565 7038	Spokane Vet Center 509 444 8387	Gulf War Helpline 800 849 8387
Bellingham Vet Center 360 733 9226	Spokane VA PTSD Program 509 434 7013	VA Suicide Hotline: 800 273 8255
Seattle VA Deployment Clinic 206 764 2636	Everett Vet Center 425 502 0617	

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