



# The *Repetition & Avoidance* Quarterly

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## Suicide in the Military, Other Answers

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The suicide rate among military service members has seen a dramatic increase since 2001. Mastroianni and Scott (2011) in *Reframing Suicide in the Military* question the causes and explore Durkheim and Joiner's theories on suicide and how they apply to the current context of military-civilian life.

The authors acknowledge how there is common understanding that repetitive and stressful deployments, military hardships, PTSD, TBI, substance abuse, etc., can all be risk factors to suicide and despite raised awareness, training modules and screenings, suicide numbers continue to rise, particularly in the Army and Marine Corps (slight increases have occurred in the Navy and Air Force).

Contrary to popular belief, while ground services have experienced the stress of repetitive and extended deployments, the "2009 Department of Defense Suicide Evaluation Report (DODSER) identifies only 7 percent of military suicides occurred among service members with multiple deployments" and "while 51 percent of military suicides had been deployed at some time to Iraq or Afghanistan, only 17 percent experienced combat." Another curious finding is senior noncommissioned officers typically experience repetitive deployments, and yet suicides occur among junior enlisted.

The Army released the Health Promotion, Risk Reduction, Suicide Prevention Report (2010), where it was found there were "lapses in garrison leadership supervision and control" and lowering of recruitment standards through increased use of waivers, admitting recruits who engage in high-risk behavior, which could be the reason for the Army's higher suicide rate. Yet, the 2009 DODSER identifies few service members who committed suicide that went AWOL (10%), received Article 15's (15%), experienced civilian legal problems (12%) and where less than a one-third (27%) experienced job-related difficulties.

Durkheim believed the health of a society is reflected in its incidence of suicide and that a society sustains itself through "regulation" (well defined norms and customs that govern interactions) and "integration" (immersed in the life of community where there are shared ideas of what is inappropriate and

appropriate). If regulation or integration is too high or low, then suicides and other social ills will occur.

Durkheim described varying types of suicides. "Fatalistic" will occur when there is too much societal regulation and stifling existence, as for example, living under slavery. Little societal regulation and breakdown in established rules will predict "anomic" suicides. An individual who operates outside of the collective bonds of the group, or poorly integrates, can result in "egotistic" suicide. "Altruistic" can occur when there is strict adherence, for example, to a custom; it is one's duty to kill one's self when no longer constructively able to contribute to society.

Joiner offered the potential for suicide exists when there is failed belongingness, when one perceives self as a burden and when there is habituation to self-injury. Failed belongingness and burden are akin to Durkheim's concept of integration, and habituation occurs when one has gradually overcome the desire for self preservation and lowered resistance to self injury through rehearsal or observed self-harmful actions.

The military changes and builds one's identity and espouses values, beliefs and norms that are quite contrary to civilian life and where upon separation rules begin to disintegrate, leaving the option of anomie. If one does want to remain in the military and not engage in combat the only other perceived option would be fatalistic.

In the absence of a deployed service member a family will become more independent and self-reliant, leaving the soldier to feel less needed and with a perception the family can survive just fine without her or him. Reintegration with family becomes an issue and can result in altruistic suicide.

Combat leadership is trained for deployment and the war zone and not accustomed to the care of soldiers in a garrison environment, as cited in the HS/RR/SP Report. Inconsistencies in leadership, values and norms can lead to anomic suicide and the authors cite examples of failed leadership such as Abu Ghraib (2003), the deception found during the investigation of Pat Tillman's death (2004), the murders of 24 Iraqi civilians by  
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(Suicide, Continued from page 1.)

## The Stigma of PTSD Treatment

several marines (2005), and hindered investigation by leadership, etc. Each of these incidents and others cited by the authors has a common theme of inept or poor leadership and how those in authority deceived, obstructed, and failed in their duties. Interviews conducted by Mental Health Advisory Teams with soldiers and marines revealed how a majority had received ethics training, and a third of marines and quarter of soldiers reported not receiving clear guidance from NCO's and officers about noncombatant mistreatment.

Close relationships are formed within units and these become disrupted when transferred or moved to other units and at the end of a deployment. The intensity of such relationships is seldom found in civilian life. Guard and Reserves return home with decreased opportunity to participate as intensely in military culture. The transition to civilian life, where unlike the rules and regulations of the military, can also leave one feeling less integrated and where, by comparison, there is little regulation.

The authors postulate how multiple and extended deployments and training modules on resilience, stress and preparation have done little to curb rising suicide rates. The emphasis must go deeper to explore issues such as regulation, integration, belongingness, burden, and habituation, and allow service members to meaningfully reflect upon and interpret military experience. Variance in leadership and little awareness of transition issues and their impact leaves the service member to question identity, role, values, and norms, within the context of the military and in relation to family.

The political, cultural and social differences between civilian and military can also lend understanding to the complex issue of suicide. Our military is controlled by civilians where leaders involve us in conflicts not wholeheartedly supported by the majority of citizens, where civilians have little understanding of the sacrifice and impact of military service on the individual and family, where the burden of military service rests on the shoulders of a few and where little honest, open and thoughtful dialogue transpires between civilians and military. To better understand and prevent suicide means to explore further what is meant by the saying, "An injury to one is an injury to all."###

**The annual Contractors' Conference for WDVA and the King County Veterans Program will be held at Campbell's Resort at Lake Chelan October 25-28, 2012.**

The Institute of Medicine advocated for annual screening of active duty military personnel for PTSD. The group also urged outcome studies to determine the effective treatment for the disorder. Kevin Freking of the Associated Press reported in the *Seattle Times* [7/14/2012, page A4], "The Institute of Medicine is an independent group of experts that advises the federal government on medical issues. Its recommendations often make their way into laws drafted by Congress and policies implemented by federal agencies."

Mr. Freking quoted the chairman of the Institute, Sandro Galea, who is chair of the epidemiology department at Columbia University, that the Department of Defense "has no information on the effectiveness of its programs to prevent PTSD." The Institute reported that "barely more than half of those diagnosed with PTSD actually get treatment, often because many soldiers worry it could jeopardize their careers." Regarding outcome studies, the Institute also noted that "there hasn't been as much premium placed on tracking than their has been on implementing treatment." The report added that the VA treated more than 438,000 veterans for PTSD in 2010.

An irony embedded in this issue is the factor of reporting of PTSD from active duty military on questionnaires administered upon the return from combat. It seems active duty personnel under-report symptoms for reasons of stigma and the impression that reporting PTSD symptoms impedes advancement. The untested question lies in the influence of repeated testing for PTSD. The role of professional therapists, who are under pressure to document their work and meet institutional needs to assess, administer intake and outcome measures that address psychopathology.

The word "psychopathology" implies sickness of the mind. Yet the therapist who works for an institution or treatment program must justify the process and provide data. Unfortunately, the veteran's first and last impressions of the therapist's treatment may be the intake and outcome questionnaires. What role does the treating profession play in sustaining the stigma of PTSD? The therapist probably isn't biased and takes PTSD symptoms matter-of-factly, and is oriented toward helping the client or patient with the presenting complaint. Chances are that the veteran who engages in counseling in the community will be helped in a benign relationship. The distress expressed by the Institute of Medicine is that not only is no one really tracking the outcome of treatment for veterans, there appears to be a great number of veterans with PTS symptoms who have not sought treatment, and who won't because of perceived stigma, so that possibly the very quest to provide good treatment impedes utilization. EE ##

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## Optimism Predicts Resilience to Trauma Pathology

Navy researchers at the Robert E. Mitchell Center for Prisoner of War Studies in Florida examined the 37-year record of repatriated prisoners of the Vietnam War in search of variables that predicted resilience, which they defined as “exhibiting intact psychological functioning despite exposure to trauma” (p. 330). The traumas in question occurred during their imprisonment and included prolonged captivity, malnourishment, and physical and psychological torture. Repatriated prisoners were examined regularly for a 37-year period following their release. Of the 662 military service personnel who survived captivity there had been 121 deaths, and of the 440 living former prisoners of war, researchers had a complete set of data on 224.

Francine Segovia and colleagues reported their findings in the *Journal of Traumatic Stress* [Optimism Predicts Resilience in Repatriated Prisoners of War: A 37-year Longitudinal Study, 2012, 25(3), 330-336]. They paraphrase Martin Seligman to define optimism “as an explanatory style pertaining to how one explains life events. Optimists view bad events as temporary, local, and external; pessimists view bad events as permanent, pervasive, and personal (‘it’s going to last forever,’ ‘it’s all my fault,’ ‘it’s going to ruin me’)” (p. 331). The authors explained, “to be defined as resilient, a participant must have never received any psychiatric diagnosis over the 37-year follow-up period.” Of the 224 former POWs examined, 131 were deemed resilient, and 93 nonresilient.

Segovia, et al., found that “the most optimistic were 5 times more likely to be resilient than the least optimistic” (p. 333). They also found that officers were 5 times more resilient than “enlisted individuals.” In their discussion, they observe “The results indicate that among this group, it was not merely the type of trauma that occurred which explained how one fared afterward, but in addition, what type of person who experienced the trauma. The variable that had the strongest association with resilience was an explanatory personality style, optimism-pessimism” (p. 334).

Segovia, et al., make note that “of the six variables associated with resilience, optimism, the variable accounting for the most variance explained, is the only variable that could be altered through training or intervention. This is especially important and relevant for those with a high likelihood of trauma exposure. Optimism is driven by patterns of thought, and such patterns can be learned” (p. 334). The authors add, following Seligman: “Helping pessimists become optimists entails changing their way of thinking involving a variety of domains: (a) personalization (thoughts are changed from ‘it’s all my fault’ to less personalized ones), (b) permanence (thoughts are changed from ‘it’s going to last forever’ to ‘this event is specific to this area of my life’). Replacing the former thoughts may allow an individual to better cope and use strategies effective for coping with emotional distress” (p. 334).

Segovia, et al., note that they also found “that lower scores on the MMPI Pd scale, officer status, and older age at time of capture significantly predicted resilience” (p. 335). They endorsed the significance of the U.S. Army’s program to strengthen resilience in soldiers through their “Comprehensive Soldier Fitness Training,” which they said was a resilience program based on optimism for coping with emotional distress (p. 335).

In discussing the limitations of their study, Segovia, et al., point out that their sample of former prisoners of war consisted mainly of aviation personnel, suggesting that the older among them were officer pilots. They do not discuss the nature of the enlisted personnel who survived captivity and were repatriated. It was my perception, over the years of treating Vietnam War veterans for PTSD, that many non-officers who were captured in the combat zone were killed rather than processed as prisoners of war. The amount of extra training, particularly training in coping in the event of captivity, was likely a factor in proving that the officers were better prepared to cope with captivity than enlisted personnel. The evidence from a number of studies has shown that the older a person is when encountering traumatic conditions, the better the odds of surviving without posttraumatic symptoms. It is unlikely that the awarding of a commission by itself protects one from psychopathology, although it may provide a more protective climate upon repatriation. They note that there may be variables that intervene after repatriation that may influence later onset of psychopathology. Are officer pilots given better treatment after their return in the sense that they have careers and job opportunities that are instrumental in good adjustment to life in post-captivity?

Segovia, et al., note that many of the measures in their study were based on self report. It is unclear how optimism influences the reporting of negative emotions, which is a large component of any psychopathology. If optimism biases the self report, then the data would be skewed to present the optimistic as more healthy.

The authors are optimistic in endorsing the Army’s Comprehensive Soldier Fitness Training which hopes to reduce the incidence of PTSD resulting from combat. If the variable of optimism-pessimism is learned early and is the result of life experiences, influencing changes in thinking when an adult may require influencing personality over a significant length of time. 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.**

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# Invisibly Wounded: A Personal Story of Traumatic Brain Injury

By Timm Lovitt

My personal experience with Traumatic Brain Injury (TBI) started in 2005 when I was deployed to Iraq for a year-long deployment. My unit was the 10th Mountain Division and our mission was to deny and prevent enemy operations within the Baghdad area. We deployed late that summer and managed to get in just a few familiarization patrols before the fighting season began in September. It was really only enough time to figure out where the main points of interest were—such as Iraqi police stations and hospitals—and what roads we would be using to get in and out of our assigned sector. We had to adapt to the situation very quickly and knew the enemy would be testing us from the start. At the time I was a young squad leader who prided himself on leading his troops from the front. This meant that I was the first one to put myself in the line of danger and would never ask any of my men to do something that I could not do myself. This put extra pressure on me, because as lead driver in a patrol of six trucks, if something went wrong, it would be my fault for missing it.

September 14, 2005, started out just like any other day we had experienced in Iraq. Granted at that point in time we had only left the wire a total of 14 times, but we had already been in an ambush and an improvised explosive-device (IED) blast. We naively felt prepared for the worst the enemy could bring. We headed out to our Humvees two hours before our patrol to conduct pre-combat inspections. Our lieutenant came back from the command post after receiving the daily intelligence brief and gathered us around to relay the information. Somehow we were able to collect enough intelligence to tell us that there was enemy in the area and to be expecting five suicide car bombs in our area of operation. The lieutenant told us to be on the lookout and to report anything out of the ordinary. Shortly before leaving the base we had heard over the radio that a suicide bomb had been detonated in a public market and another one on an Iraqi police checkpoint.

The patrol commander decided that we would change our patrol mission and respond to the Iraqi police checkpoint. Our estimated time to arrival was five minutes, there were numerous reported casualties, and they had requested assistance from the U.S. Army. As we arrived on the scene we quickly established a security perimeter around the checkpoint so that the Iraqi police could regroup. We knew that there was intelligence on at least three more car-bombs and had to give them time to help their wounded without worrying about another explosion. After I got the last Humvee into place, forming a tight security perimeter around the checkpoint, with all avenues of approach covered, I returned to my truck and noticed that the traffic was starting to build. The checkpoint happened to sit on one of the most heavily used roads in Baghdad and I knew that it would be hard to keep all the cars back at a safe distance; our best bet was to hurry up and move on. Thirty minutes passed and cars began to inch closer to our position. This was normal behavior for

people trying to get home after work. Cars were now about 30 feet from our truck, a very uncomfortable distance. My gunner strained to keep an eye out for all of the dangers. He moved his eyes from the left, and then back to the right. As he performed this small, but necessary task, a car slammed on the accelerator and rapidly approached our truck. The distance was too short for my gunner to stop the driver and the car detonated approximately 10 feet from my armored Humvee. The blast was so large that my Humvee, weighing in at over 6 tons, was thrown back and then slammed to the ground. Those of us in the truck were thrown around like a loosely packed box of marbles. I was thrown from my seat to the back of the truck, where I hit my head on the ammo cans that were tied down. The blast was so large that, for a brief period of only a couple of seconds, I yelled to the other men in my truck to see if they were okay. Laced with a plethora of profanities, they proceeded to tell me that they were alright. Dazed, but alright. Men from one of the other trucks came rushing over to our Humvee and had to pry away debris that was pinning our doors shut. Once the doors were cleared we exited the Humvee, did a quick assessment of whether the truck was operable or not (of course it wasn't), and proceeded to load up and move out. On the drive back to the base I tried to ease the tension. I joked with my men about the heat of the desert being warm enough without giant blasts going off near us. We all had a couple of cigarettes to ease our minds. What we didn't know was that the silence was because we all had been invisibly injured.

When we got back to base we proceeded to unload all of our gear from the damaged Humvee and move it to a spare truck we had just in case a situation like this had happened. My guys then took the truck to the motor-pool to be worked on, headed to the dining facility to eat, and then each and every single one of us we straight to sleep without ever seeing medical attention; for we knew that in less than twenty-four hours we would have to wake up and do it all over again. For the next week or so we all woke up and were sluggish. It was hard to gain bearings on where we were and instead of socializing like everyone else we decided to sleep and rest. All of us also experienced horrible headaches. Motrin became more than just infantry candy to us; it became a necessity for daily functioning. I can remember such debilitating headaches for the next three months after the blast, that I can hardly remember anything else during that period of time. However, I do remember four of us in that truck having much shorter fuses. We would snap at the slightest thing. We all equated it to the heat. Our platoon medic told us that we needed to drink more water and stay out of the sun. No mention about traumatic brain injury.

We eventually grew accustomed to the headaches. We performed our duties for the next 11 months and returned stateside at the end of our deployment in mid-2006. Approximately 90 days after returning from war I transitioned out of the army and decided to return home to Seattle. The headaches were still a common occurrence, but in addition to them I also noticed that I was constantly angry and frustrated and even had problems with my equilibrium after waking up. I tried to cope as best as I could. After all I was an infantryman and a lot of that suck-it-up attitude stuck with me; however, it began to take a toll when I started taking classes at the local community college. I had  
**(Continued on page 5, see *Invisibly Wounded*.)**

## Complex PTSD Debated for Inclusion in DSM-V— The Disorder Deemed Not Sufficiently Independent

A group, headed by Patricia Resick from the Boston-based National Center for Posttraumatic Stress Disorder published an “invited article” on complex PTSD in the June issue of the *Journal of Traumatic Stress Studies* [2012, 25(3), 241-251], which also featured articles by critics in response. Resick, et al., write: “Psychiatric diagnoses are theoretical constructs developed to help understand the co-occurrence of psychiatric symptoms and other psychopathological processes.... For instance, PTSD was codified in the late 1970s to help understand the psychopathological sequelae experienced by large numbers of Vietnam veterans, and developed further by early research on rape, domestic violence, and child abuse....” (p. 242). Resick, et al., describe the symptoms defining CPTSD to include “several defining criteria for PTSD (reexperiencing, avoidance, numbing, and hyperarousal), as well as disturbances in self-regulatory capacities that have been grouped into five categories: emotion regulation difficulties, disturbances in relational capacities, alterations in attention and consciousness (e.g., dissociation), adversely affected belief systems, and somatic distress or somatization....” (p. 243). However, Resick, et al. concluded that “the lack of consistency in symptom descriptions has created challenges in defining and measuring CPTSD” (p. 243).

Critics replying to the Resick, et al., article argue that the lack of a diagnostic category in the DSM impedes research. Several authors responding to the Resick, et al., article applaud the call for a trauma spectrum disorder: “Unless and until complex traumas are shown to have qualitatively different causal effects, the working hypothesis that complex posttraumatic symptomatology also falls on a continuum seems plausible.” “We suggest, however, that efforts to explore the structure and boundaries of these phenomena should consider that they may not constitute a discrete disorder at all, but instead the product of extremes on one or more underlying dimensions, perhaps the same dimension(s) underlying PTSD, BPD [borderline personality disorder] and other overlapping conditions” (p. 248).

Judith Herman, who is credited with first identifying complex PTSD, wrote perhaps the most candidly critical of the responses (pp. 256-7). Dr. Herman is currently with the Cambridge Hospital in Massachusetts. She argued that there should be recognition that the majority of trauma patients have been multiply traumatized, that there is clinical significance and utility in the CPTSD concept. She writes that the Resick, et al., review was “particularly selective, citing only those studies that would seem to indicate that existing exposure-based treatments are both sufficient and benign” (p. 256). Dr. Herman further argues that “the CPTSD concept is more parsimonious than the concept of multiple comorbidities. Although CPTSD shares some features with several other psychiatric disorders, it is not congruent with any one.” She states: “The alternative to one parsimonious diagnosis is multiple comorbid diagnoses and multiple overlapping treatment protocols. In practice, this leads to polypharmacy and inefficient, poorly tailored psychotherapy” (p. 257).

Dr. Herman also advocates for “recognition of CPTSD as a subtype of PTSD [which] might expand the dimensional concept of a posttraumatic spectrum. This might be a fruitful path toward the development of consensus (p. 257).” She, together with other critics, argued that the “recognition of CPTSD as a discrete entity, within a spectrum of posttraumatic disorders, would also be likely to expand research in exactly the domains” called for by Resick, et al. (p. 257).

The authors replied to their critics (p. 260): “A cornerstone rule of scientific measurement (and of scientific progress in general) is that reliability must precede validity; that is, we must be able to agree that some stable, replicable construct exists before we can show that the construct is what we believe to be.” They argue that the definition of CPTSD “remains an open question.”

I am reminded of the repeated experience in clinical practice encountering a case file of someone with a borderline personality disorder. It would have in the history a variety of diagnoses ranging in severity from schizophrenia to adjustment disorder. The rule, when I saw this, was to assume I was dealing with a “borderline.” This seems to be the case also with complex PTSD. It is awkward to define and slippery, like confronting the demi-god Proteus, who, when you catch him, changes shape. Whereas you thought you’d caught a god, you caught a fish. It may be when confronted by repeated traumas, one is forced to change shapes. It seems poetic that scientific examination results in a frustrating controversy about what it is we are confronting.

EE ##

### ***(Invisibly Wounded, continued from page 4.)***

problems remembering my class schedule, the assignments I needed to complete and the dates they were due, and I even had trouble retaining the information I had picked up through reading the assigned materials. Something was wrong. It wasn’t until I spoke with one of the guys, who was also injured in the same blast, when I began to learn about TBI. He told me that he experienced the same problems that I was describing to him and he decided to take advantage of the VA system. He underwent an evaluation and they told him that he had suffered a mild-TBI.

Since September 14, 2005, all four of us who were in the truck that day have been diagnosed with various degrees of TBI. None of us knew anything about this injury while we were in the army, nor were we given proper advice by medical personnel. My only hope is that in sharing my story others will think about themselves and consider whether or not they have been exposed to this signature wound of the wars in Afghanistan and Iraq. ##

## The Controversy of the Forensic vs. the Clinical Diagnosis of PTSD

An article by Seattle *Times* reporter Hal Bernton [8/01/2012] is headlined “Army changes PTSD evaluations—Forensic Methods led to loss of pensions—Soldiers retested after problems at Madigan.” The article quotes General Lloyd Austin, the Army’s vice chief of staff, as saying: “What we found is that the forensic methods are not the right ones for the United States Army disability evaluation system.... We learned...[Madigan] officials acted in accordance with the standard of practice for civilian disability evaluations. But we also learned that while the evaluation may be fair and appropriate, it’s simply not optimal for the unique cases that the Army diagnoses and reviews.”

Mr. Bernton’s article goes on to review the history of the controversy. The Madigan forensic team’s work triggered complaints from patients, some of whom were tagged as possible malingerers. These complaints drew scrutiny from an Army Medical Command ombudsman, as well as from Senator Patty Murray.

The *Times* reports that an army source said that thus far, of the 229 cases re-evaluated, “more than 50 percent of those patients ended up receiving PTSD diagnoses.”

At the heart of the matter is the difference between the processes of clinical diagnoses and forensic diagnoses. A forensic examiner is hired by the agency to identify any evidence of malingering, error, or fraud. A clinician has the task of being able to assess the patient’s condition in the presence of the patient who may have sought counseling or medical help, or been identified in some triage or survey. The forensic investigator has the goal of finding error or flaw in the workup. The clinician has the goal of helping the patient.

Forensic examiners in legal proceedings are often seen as conductors of tough evaluations, using aggressive, rapid fire questions in search of contradictions and fabrications. The VA Comp and Pension evaluation has usually been seen as an objective, quasi-legal procedure in which the examiner interviews the patient and reads the files of hopefully all the relevant clinical reports.

What is in contention is a diagnosis that is largely based on subjective reports of symptoms. If the patient shows evidence of having been involved in a traumatic event and reports the minimal number of symptoms, most clinicians will make an appropriate diagnosis. Some time later, when objective testing raises doubts, everyone involved, including the veteran, are now removed from the traumatic scene and the evidence is relegated to memory and items on a computer screen.

What seems to be absent in the forensic examiner is heart—the desire to help the patient. Indeed, the forensic examiner may find that very emotion to be the flaw in the clinician’s report. The clinician wants to help the patient, but the forensic examiner seeks to protect the agency, in this case, the federal government. Ultimately it is the absence of heart that removes the critical evidence in the clinical workup. Excise the heart and the empathy is removed.

The controversy reached a dramatic peak by the publication in the August 2012 issue of the *Journal of Traumatic Stress*. The *Journal* published a polemic from Richard McNally and Christopher Frueh: “Why We Should Worry About Malingering in the VA System: Comment on Jackson et al. (2011),” [pp. 454-456] referring to an article in the 2011 *Journal* reporting on a survey of methods and procedures used by DVA Comp and Pension examiners, which was reported in our Fall 2011 *RAQ* [16-1, p. 4, “Variations in VA C&P Exams”]. They summarized their position by stating “the increase in delayed compensation claims among aging veterans, the self-reported worsening of symptoms and functional impairment despite treatment, the widespread symptom overreporting on psychometric instruments..., the failure of otherwise efficacious trauma therapies to help veterans with chronic PTSD..., and their departure from mental health treatment after achieving maximum financial compensation are consistent with...[the] economic interpretation” [that there is financial incentive that drives VA compensation claims for PTSD] (p. 455). McNally and Frueh ended their article by advocating “that the DVA’s disability policies be evaluated for fundamental reform to create an effective, responsive, and flexible safety net for veterans and to eliminate the disincentives to make use of treatment services that could lead to recovery...” (p. 455).

The McNally and Frueh criticism drew a stern rebuke from a host of prominent DVA researchers: Brian Marx, et al, “The Reality of Malingered PTSD Among Veterans: Reply to McNally and Frueh (2012)”, (p. 457-460). Marx, et al, pointed out that “in fact, no prevalence estimate for malingered PTSD among veterans currently exists” (p. 457). They indirectly criticized the authors for “a priori suppositions about differential prevalence of malingering among various veteran groups,” and called for further research based on “unbiased inferences” (p. 459).

Marx, et al, point out that a survey found that “among men, combat had the highest prevalence of delayed onset PTSD (11.8%), relative to other types of traumatic events...” (p. 458). They noted also that other factors drive the veteran dropout rate in treatment, including the symptoms related to PTSD avoidance. They hypothesized that the effects of aging on neurological and mental state changes in social and occupation circumstances (e.g., leaving the workforce), changes in physical health status, and exposure to other stressors may all play a role in delayed-onset PTSD” (p. 458). They also cited reference that “research shows that PTSD service connection is unrelated to veterans’ clinical outcomes or dropout rates” (p. 458).

Marx, et al, advocated for research that is not biased with a search for malingering, that is instead objective and fair. They note that McNally and Frueh, like hypothetical forensic examiners, viewed research with a selective attitude toward finding the fraudulent claim, which limited the scope of their study.

EE ##

## *VA Puget Sound Introduces New Technology for Delivery of Mental Health Services*

By Sara Smucker Barnwell  
VA Puget Sound

The VA Puget Sound Health Care System Teletechnology Service is using technology to improve veterans' access to mental health care. This team offers a diversity of mental health services through videoconferencing, telephone, mobile applications and online. The team aims to deliver cutting-edge mental health services that integrates conveniently with veterans' usual VA health care.

Veterans residing in rural areas or those too medically ill to travel may have limited access to specialized mental health care services such as psychiatry, psychology, social work and others. Although mental health services could benefit the veteran, the time, cost and inconvenience associated with traveling to see a mental health care provider at VA medical center regularly may be prohibitive. The veteran may live too far away from any VA facility, or be too medically ill to travel to his or her closest VA facility. The closest VA facility may be a small primary care clinic that does not have extensive mental health services. As a result, the veteran may have to travel long and untenable distances to receive specialized mental health services. Other veterans may have concerns about stigma associated with seeking mental health services, especially in small communities with fewer provider options.

VA Puget Sound Health Care System's Teletechnology Service team aims to address these barriers to mental health care access. The team deploys innovative technologies to deliver specialized mental health care that is convenient for veterans. The team's psychiatrists, psychologists, nurses and social workers provide clinical services such as videoconferencing-based therapy and psychiatric medication management, telephone-based medication management and supportive therapy, and home-based mental health symptom monitoring. Typically, veterans receive care through these modalities for non-emergency situations. Through this technology, the veteran may meet with a mental health provider without traveling to a major medical center, saving travel time and costs. Veterans may receive this care at a participating local Community-Based Outpatient Clinic (CBOC), Veteran Center, or even the veteran's home. Future goals include expanding services to be delivered into a variety of community locations (e.g., community centers, college campuses, and others) to increase convenience of care access for veterans.

The Teletechnology Service team also aims to increase access to educational materials about mental health. Interactive online mental health education information and mobile applications offer easily accessible health care information available at the veteran's convenience. These services are available to veterans receiving VA care. ##

## *The Eagles Walk the Talk*

By Peter Schmidt, Psy.D  
Veterans Training Support Center

Many colleges and universities in Washington State tout being "veteran friendly" and have become Partners for Veteran Supportive Campuses through the Washington Department of Veterans Affairs. With diminishing financial resources, space being at a premium, and competing agendas and interests between departments and programs, enacting a veteran-related best practice can be difficult to do. Not so for the Eastern Washington University Eagles!

President Rodolfo Arévalo, along with university leadership and community supporters, recently "walked the talk" by opening a Veteran Resource Center (VRC). This huge 2,000 square-foot facility boasts a computer lab, kitchen area, lounge, workshop and conference space, and offices. Student veterans receive quality support and oversight from program director, M. David Millet, Lt. Colonel (Retired), and other personnel (certifying official, recruiter/advisor, graduate assistants, faculty liaisons and Heather Bahme, dedicated and committed WDVA, Vet-Corps Representative). Over 500 student veterans are enrolled at Eastern and the university expects an annual 10% increase of those seeking degrees and using GI educational benefits.

The reintegration to civilian life and transition between the cultures of military and higher education can be a formidable challenge and barrier for service members and veterans. One major promising best practice employed by a few higher education institutions to facilitate readjustment and recommended in *Serving Those Who Serve*, published by the American Council on Education, is to provide space where veterans can gather to study and support each other. Eastern understands the importance of providing a forum where veterans can come together and experience team, community and mentorship. One can view the dedication of the VRC, located in Showalter Hall at the following link: <http://www.flickr.com/photos/wuphoto/sets/72157630519578742/>

If you are an alumni of a higher education institution please feel free to pass along this best practice. It might be of interest to inquire how your alma mater is serving its population of student veterans and their family members. ##

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### **Large Enrollment Expected by Veterans Using the G.I. Bill**

This fall, a record 590,000 veterans are expected to enroll in university and two-year colleges, according to Rachel Siegel, writing in the *Seattle Times* (8/13/2012, p. A4). Tom Tarantino of the Iraq and Afghanistan Veterans of America said that he expects an increase in enrollments in each of the next five years. Ms Siegel writes that "since the [G.I.] bill took effect in August 2009, almost three-quarters of a million veterans and their dependents have used the program to pursue some form of higher education." EE ##

# A Veterans' Counselor Provides An Example of Telemental Health Therapy

By Matthew Dowling

Suppose for a moment you are a recent returning combat veteran and are beginning to realize that the ways you have been coping with your combat stress aren't working. You decide to listen to those who say you should go to the VA and get some help, however you live 100 miles away from the nearest VA. With the distance and maybe some ambivalence about engaging in treatment, would you do the drive?

Or let's say you are a veteran struggling with chronic pain and have been referred to a mental health specialist who can help you manage your chronic pain. Unfortunately you don't drive, your wife works, and she cannot drive you the 20 miles to the nearest VA clinic. How would you get to the VA for your care?

Or in another scenario, you are a veteran whose primary care provider prescribes medication for depression, which is not working well. The PCP wants to refer you to a psychiatrist for medication management, but the nearest VA is over 100 miles away. How would you feel about driving to the VA for a 20-minute appointment?

These are three common scenarios that rural veterans throughout the country face on a daily basis. Show me a rural veteran engaged in VA care and I'll show you a veteran with a lot of extra miles on his or her car. Recognizing the needs of our rural veterans VA leadership has set out to build a VA that can provide high quality care to our rural veterans where they live. One way the VA has been doing this is by providing Telemental Health.

Telemental Health is providing mental health treatment (therapy and medication management) for a wide range of mental health issues via video. The veteran and clinician are in different places and therapy is done over video (think Skype, but with full internet security and encryption). Telemental Health is not new to the VA and has been a mode of practice for many years. However, as technology expands and more and more veterans move to rural areas, the need for Telemental Health treatment is ever growing. In order to meet the challenges of an ever expanding rural population the VA is investing in infrastructure, software, and equipment, as well as developing national policies, procedures, and standards so that we may provide high quality care via Telemental Health technologies.

## Portland VA Medical Center's Rural Mental Health Team

In 2011 the Portland VA, under the leadership of Mark Ward, PhD, received a grant, which allowed them to create the Rural Mental Health Team. The Rural Mental Health Team is comprised of social workers, psychologists, nurses and psychiatrists who provide group and individual evidence-based psychotherapy, medication management and case management services to veterans throughout the state of Oregon. Under the leadership of Dr. Ward the Rural Mental Health team has treated hundreds of veterans at VA Community Based Outpatient Clinics (CBOC) throughout the state. One of the most significant statistics highlighting this program's success is that in 2012 three clinicians saved veterans over 132,000 miles of travel to receive compar-

able care. These veterans were able to stay in their local areas and receive highly effective care comparable to what they would have received at the main facility. Not only is this saving the VA tens of thousands of dollars in travel related expenses, more importantly it is saving veterans' time, resources, wear and tear on vehicles, as well as increasing veteran engagement in treatment.

Also, over the last 2 years, the Portland VA was given permission to create the first home-based Telemental Health program where veterans are provided mental health treatment in their home. With special procedures to ensure veterans' safety, a carefully selected subset of veterans are sent webcams to receive TMH treatment into their homes. Under the visionary leadership of Peter Shore, PsyD, we have had over 600 visits in the Home Based Telemental Health Program and have treated depression, anxiety disorders, chronic pain, and a host of other mental health issues.

I am a Licensed Independent Clinical Social Worker and have been a therapist since 2005. Most of my career has been with the VA and my focus over the last 6 years has been providing therapy for veterans with Post Traumatic Stress. Most of my work has been in the usual setting—an office. However, in 2009 I also began providing group and individual therapy via Telemental Health technologies.

In 2011 I moved to Bellingham, Washington, and was offered the unique opportunity to work for Portland's Rural Mental Health Team. I love the looks I get when I tell people I work from home in Bellingham...for the Portland VA...with veterans in rural Oregon. In my experience it's hard for folks to wrap their minds around how a therapist can provide treatment from his home with veterans living hundreds of miles away. However, one thing I can say is that it works really well.

When I first started this work I came from the perspective that something is better than nothing. My thinking then was since we weren't in the same room, it would be very difficult to fully engage in treatment. However, since I believed "something is better than nothing," I agreed to do Telemental Health. Since that time though, after doing hundreds of hours of group and individual treatment, I've come to the conclusion that the work I do via TMH is equally as effective as face to face.

Therapy is, at its core, about the relationship between therapist and client. I do my best work when I put theory to the side and focus on the relationship. Therefore, if a person I am working with believes that I am listening, working hard to understand him or her, and can sense my compassion and desire to help alleviate his or her suffering, then I have accomplished the most important part of my job. The question is: can this be conveyed via video, and in my experience it can. Anecdotally I believe this for 2 reasons: First, when I ask veterans how they feel about TMH, most report some discomfort at first, however, by the end of the first session, all those who reported discomfort state that they seemed **(Continued on page 9, see *Telemental Health.*)**

***(Telemental Health, Continued from page 8.)***

to forget we were on video; second, I have yet to have a veteran not return for follow up appointments. They keep coming back, which seems to be a pretty good indication of comfort.

I have been hired to provide Prolonged Exposure and Cognitive Processing Therapy for PTSD. Both treatment modalities have a trauma-processing component, which means veterans are sharing their most terrifying traumatic events. These are highly personal traumatic memories that must be treated with the utmost care and respect. When I first heard about providing these treatments via TMH my first thought was “they must be crazy.” I have been doing Prolonged Exposure since 2009 and, even though I find it to be one of the most effective treatments for PTSD, I also know that it is a very intense treatment. Therefore, the thought of doing it via video was highly questionable to me. However, like most experiences I have had with TMH, my fears were quickly put to rest.

In addition to a literature review I also contacted Dr. Peter Tuerk at the South Carolina VA, who is one of the pioneers for PTSD treatment via TMH. He has been providing Telemental Health services for years, and more importantly, has been successfully implementing Prolonged Exposure with rural veterans. In a few conversations with Dr. Tuerk I began to realize that my hesitation about providing trauma focused treatment was mostly unfounded. Dr. Tuerk was not only doing Prolonged Exposure, he was getting great results.

With this newfound confidence I began providing trauma focused therapies for PTSD, and have found these treatments to be as effective as with my face-to-face clients. For example my most recent veteran to complete Prolonged Exposure had a 29-point drop on the PTSD Checklist (PCL), which put him at sub-threshold for a diagnosis of PTSD. In another example, a veteran whose trauma occurred over 30 years ago has now come to grips with the fact that he did everything he could have done, and has now let go of 30 years of guilt and self-blame. And in another example, I started working with a veteran whose first words to me were “I really don’t like this video stuff.” It was evident that he was uncomfortable and annoyed with the technology, and I believed he was going to be my first veteran to decline TMH. However, 4 weeks later he is fully immersed in treatment and has agreed to start a course of Cognitive Processing Therapy to address Vietnam era trauma.

I do not share the aforementioned anecdotes to toot my own horn. In fact I firmly believe that the successes these veterans experienced in treatment has more to do with their hard work and courage than anything I could ever offer them. My point in sharing these anecdotes is to highlight that these veterans were successful in treatment while meeting via video.

My hope in writing this article was to give a glimpse into the work of a therapist providing therapy via TMH. When I first started this work I was a reluctant consumer of this modality. However, as I continue to have successful experiences with treatment I am becoming more and more convinced in the utility and effectiveness of TMH.

Finally, as technology improves and more and more people are on-line playing video games, video-conferencing with family from the combat theater, playing in virtual reality worlds, and, for good or bad, almost always “connected,” meeting via video will become less of an oddity and more of the norm. In my training as a social worker I was taught from day one to “start where the client is at,” and if my clients are on-line, comfortable with conversing via technology *and* living in rural areas I believe it is incumbent upon me to meet them there. **(For more information contact [mattdowl@gmail.com](mailto:mattdowl@gmail.com).) ##**

## *Aggression in Veterans Linked to Combat Exposure and Post-combat Traumatic Events*

A group of researchers connected to the Boston VA National Center for PTSD examined the connection between aggression in veterans and the variables of combat exposure along with pre- and post-combat exposure to traumatic events. Jenna Lenhardt, Jamie Howard, Casey Taft, Danny Kaloupek, and Terence Keane published their results in the August *Journal of Traumatic Stress* [25(4), 461-464]. The authors hypothesized “that pre- and post-military traumatic events and combat exposure all would be correlated with aggression, but that combat exposure would be a stronger correlate than civilian traumatic events” (p. 461).

Lenhardt, et al., sampled 1,328 veterans who had served in the Vietnam theater between 1964 and 1975 and “were primarily recruited from inpatient and outpatient programs in psychiatry, substance abuse, PTSD, and general mental health” (p. 462). They measured aggression with three items: verbal aggression, “threatened someone with a weapon, threatened someone with physical violence without a weapon, or was verbally aggressive,” and three items that measured physical aggression (“used a weapon against someone, had a physical fight with someone, destroyed property” (p. 462).

Lenhardt, et al., discussed their results: “Our findings were consistent with previous research showing that exposure to traumatic events is associated with aggression among male Vietnam veterans” (p. 463). Specifically, “pre-military traumatic events, postmilitary traumatic events, and combat exposure all showed significant correlations with aggression. Postmilitary traumatic events and combat exposure evidenced the strongest associations with aggression” (p. 463). The authors referred to social learning theory, which “suggests that people learn via repeated exposure that violence is an acceptable and effective strategy for achieving interpersonal goals in conflict situations” (p. 463). Contrary to what social learning theory predicts, the authors found that later life trauma exposures (i.e., combat exposure and postmilitary traumatic events), predicted aggression more strongly than early life events.

Lenhardt, et al., noted that a significant limitation of their study is that it was conducted with a sample of VA patients and may not generalize to the general population of military veterans. They noted, however, that “despite its limitations, this study underscores the importance of not only assisting veterans in coping with combat trauma, but also postmilitary traumatic events that may increase risk for psychological difficulties, particularly aggression. Results highlight the salience of attending to the psychological aftermath of exposure to traumatic events and emphasize the importance of treating service members as soon as possible when they return from military service before aggressive patterns develop” (p. 464).

Importantly, the authors noted that their research does not account for the context in which the aggression takes place. “Thus, it is possible that certain traumatic events (e.g., assault) and aggression are correlated because they co-occurred, highlighting a need for future research to better account for contextual factors surrounding aggression” (p. 464). EE ##

**Movie Review:**

## *The Lucky One*—A Romantic Study of Survival

Reviewed by Emmett Early

In *The Lucky One* Zac Efron plays Logan, a soldier in Iraq who we first see in combat. There is a huge blast where he is fighting and when the dust clears and the fighting stops, Logan finds a picture of lovely woman about his age lying in the rubble. The woman in the picture writes that the bearer will be safe from harm, but the soldier who lost the picture is among the soldiers killed in action. There follows another series of combat events which Logan survives, and pretty soon other members of his combat team become convinced that he is charmed so long as he carries the girl's picture.

Logan, when he is discharged from the army, sets out to find the girl in the picture and travels to the Louisiana bayou, shown in all its best qualities, and *The Lucky One* becomes a romance, filmed with sweetness by director Scott Hicks.

The woman in the picture, clad in white lacy blouse is Beth, played by Taylor Schilling. She runs a dog kennel boarding facility that is set in a beautiful bayou park. Coincidentally Logan renews a relationship with his own pet dog who accompanies him faithfully almost everywhere. When Logan finally finds Beth he becomes tongue-tied and cannot tell her about the picture. She assumes he is applying for a job as a helper in a dog kennel that she runs and hires him. Logan is an ideal dog kennel helper. Blythe Danner plays Ellie, Beth's mother, who liked Logan from the moment he arrived. Logan remains tongue-tied throughout the movie.

*The Lucky One* reminds me of *First Blood*, the 1976 action film that put Sylvester Stallone on the map as Johnny Rambo. There is a characteristic theme of the local cop who harasses the veteran, satisfying the film tradition of portraying the stress as a force outside the veteran, with which he or she must cope. *The Lucky One* has very little violence and not much action, but all of the romance and glossy panache that idealizes the war veteran. The characters never talk about the war or debate the politics, but the film focuses instead on Beth's ex-husband who is the local cop and still loves her, becoming jealous of the tight-lipped, doe-eyed veteran, who displays the stoic passivity of a saint.

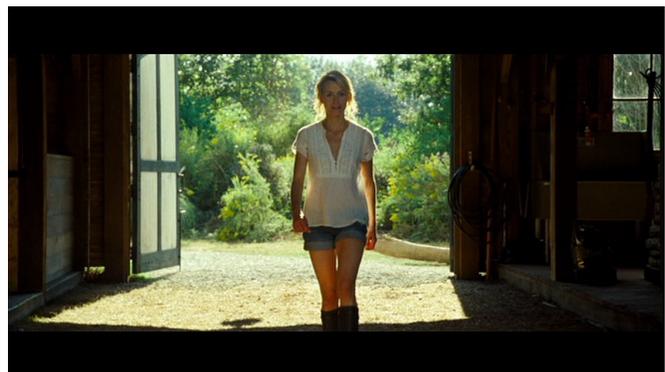
*The Lucky One* threatens violence but never really goes there, although there is an action sequence at the finale. Scott Hicks directed the 1999 war veteran film, *Snow Falling On Cedars*, a much better film that depicted veterans of World War Two on an island in the Straits of Juan de Fuca. *The Lucky One* is not to be confused with *The Lucky Ones*, a recent film about 3 Iraq War veterans, which was recently reviewed in the RAQ [15-4, p.9] The latter film was an entertaining road movie comedy about veterans traveling together across the U.S. It is remarkable because one of the veterans was a woman, who proved to be the most aggressive of the three. *The Lucky Ones* was a box-office failure and I predict that *The Lucky One* will never get a theater showing. It was released for rental in August.



**Logan, played by Zac Efron, picks up a picture that had been laying in the rubble following a combat operation. The picture belonged to one of the casualties and Logan keeps it for good luck.**

Films about war veterans can fit almost any genre: adventure, mystery, sports, workplace dramas, horror, comedy. I don't recall seeing a musical about a war veteran. Certainly the veteran's post war life can fit any drama about domestic life, including romance. The director of *The Lucky One*, Scott Hicks, apparently did not have a script that dealt with any of the issues that commonly complicate the lives of veterans returning from war. The screenplay by Will Fetters was adapted from a novel by Nicholas Sparks. Logan seems not to have an anxious moment and he has impressive control over feelings of anger—if he has feelings of anger. The veteran's inability to express his message is a metaphor, perhaps, of the difficulty all veterans have describing the experience of combat. ##

**Below is Beth, played by Taylor Shilling, who operates a dog kennel in a Louisiana Bayou, in Scott Hicks' new film, *The Lucky One*. The film was shot in St. Bernard, Louisi-**



**ana.**

**Book Review:**

## *The Road Back*, by Erich Maria Remarque

Reviewed by Emmett Early

Erich Maria Remarque is the internationally famous author of *All Quiet on the Western Front*. He was drafted from school together with his class and served in the German army as an infantryman for four years of combat during World War One. He, more than anyone, humanized the German soldier for the western world. His novel follows a young man very like the author, who was drafted out of school and served four years fighting in the trenches. Remarque's second novel was a sequel that picks up in the last hours of the war before the armistice and takes Ernst and his remaining classmates back to his home town to return to school. It is a remarkable work for those who are interested in the war veterans of today, because it gives us a feeling for what must be universal and normal for those who survive combat. Ernst remarks on his comrades' expressions: "the front line face. A fierce tension has frozen it—so extraordinary is the impression of our subconsciousness has imparted to us long before our senses are able to identify it" (*The Road Back*, p.11, A.W. When translation).

Gradually the soldiers, now veterans, separate and head off to different towns and neighborhoods. Ernst experiences the sentiment that is commonly felt by veterans about the others who fought together, and gives plaintive expression to the alienation of the war veteran when he is not with those he fought with. "We are so accustomed to shell holes and trenches that we are suddenly suspicious of this still, green landscape; as though its stillness were but a pretence to lure us into some secretly undermined region. And now there go our comrades, hastening out into it, heedless, alone, without rifles, without bombs! One would like to run after them, fetch them back, shout to them: 'Hey! where are you off to? What are you after, out there alone? You belong here with us. We must stick together.—How else can we live?'" And then he adds: "Queer mill wheel in the brain: too long a soldier—

"The November wind pipes over the empty barracks square. Yet more and more comrades go. Not long now and every man will be alone" (p. 51).

Ernst wasn't able to access a GI Bill, but in fact he was entitled to finish his schooling on the way to becoming a school teacher. But the obedient and respectful student who left school to enter the army was not the same man who returned. The school has to revise its criteria to accommodate the veterans as returning students, and even then the veterans don't quite fit. Ernst's comrade, the tough, outspoken Willy, expressed for the others, after the school master sets about to take them back and assign them to different sections. "'Don't you run away with the idea,' says Willy indignantly. 'that we're going to perch on forms, along with kids who never saw the war, and put up our hands nicely when ever we know anything. We're staying together'" (p. 127).

Ernst visits another veteran from his town, who expresses a common sense of alienation that veterans experience when they return home. "They come here to talk, my people and her [his wife's] people—and they don't understand me and I don't understand them. It's as if we weren't the same persons any more.' He props his head in his hands. 'You understand me, Ernst, and I you—but with these people, it's as if there were a stone wall between us'" (p. 135). This is every day war veteran alienation without the dramatic trappings of modern Hollywood action, aggression, and violence.

The most profound experience of alienation for Ernst comes with the encounter with his beloved mother and is perhaps the heart of Remarque's novel. His mother speaks: "'Ernst,' she says gently, 'I have been meaning to say this to you for some time: You have changed. You have become very restless.'"

Ernst responds to himself with poignancy: "Changed! I think bitterly, yet, I have changed!—What is it you know of me now, Mother? A mere memory, nothing but the memory of a quiet, eager youth of the days that are gone. You must never know, Mother, never know of these last years; never even wonder what they were like and much less what has become of me. A hundredth part would break your heart—you, who tremble and are shocked by the impact of a mere word, one word that has been enough to shatter your picture of me. 'Things will be better soon,' I say rather helplessly, and try to comfort myself with that." And as they part, his mother speaks softly, calling him "my good boy." Which Ernst says "It pierces me like a stab." What has come between the veteran and his mother is the war, the killing and dying, some by stab wounds.

It is this same memory of the carnage of combat that causes Ernst, when he becomes a teacher, to quit his job in the face of the innocent students. He cannot face them, and his father finds it incomprehensible that his son would leave a secure government job with retirement benefits in such a time of high unemployment. But Ernst experiences something that he attributes to his fellow veterans, right out of the future diagnostic manual, speaking to his father: "'Ach,' I say, laughing, 'where's the soldier will live to see sixty? There are things in our bones that will only show themselves later.—We'll all have packed up before then, don't you worry.' —With the best will in the world, I cannot believe I shall reach sixty. I have seen too many men die at twenty" (p. 261).

Remarque first published *The Road Back* in 1930. It was later banned in Hitler's Reich. Hollywood movie director and war veteran James Whale adapted the novel to a movie, but it was remade by the studio with another director before release to accommodate Hitler's Europe and is now out of print. ##

## 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  
 Dan Comsia, King, Pierce Counties.....253 284 9061  
 Paul Daley, Ph.D., Port Angeles.....360 452 4345  
 Duane Dolliver, M.S., LMHC, Yakima...509 966 7246  
 Jack Dutro, Ph.D. Aberdeen/Long Beach 360 537 9103  
 Sarah Getman, MS, LMHC, Longview....360 578 2450  
 Dorothy Hanson, M.A.,LMHC.....253 952 0550  
 Casper La Blanc, MA, Mason, Kitsap.....360 462 3320  
 Adrian Magnuson-Whyte, Ph.D. Shelton..360 462 3320  
 Keith Meyer, M.S., LMHC, Olympia... 360 250-0781  
 Brian Morgan, M.S., LMHC Omak.....509 826 0117  
 Peninsula CMHC Center, Clallam,  
 Jefferson Counties.....360 681 0585  
 Dennis Pollack, Ph.D., Spokane.....509 747 1456  
 Dwight Randolph, M.A., LMHC.....253 820 7386  
 Mary Ann Riggs, San Juan County.....360 468 4940  
 Jody Stewart, MA., LMHC, Kitsap County  
 Bremerton.....360 377 1000  
 Katie Stewart, MA, LMHC, Kitsap County  
 Silverdale.....360 620 3722  
 Darlene Tewault, M.A.,LMHC Centralia.360 330 2832  
 Roberto Valdez, Ph.D., Tricities.....509 543 7253  
 Stephen Younker, Ed.D., Yakima.....509 966 7246  
 Washington State U. Psychology Clinic...509 335 3587

### Special Programs

Veterans Training Support Center, Peter Schmidt,  
 Psy.D., LMHC, Project Director 425 773 6292

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

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. Services funded by Washington State or King County Human Services.

### Other Veterans’ Mental Health Services offered by the Federally funded VA or WDVA PTSD Program”

Seattle Vet Center 206 553 2706  
 Yakima Vet Center 509 457 2736  
 Tacoma Vet Center 253 565 7038  
 Spokane Vet Center 509 444 8387  
 Bellingham Vet Center 360 733 9226  
 Everett Vet Center 425 252 9701  
 Walla Walla Vet Center 509 525 5200  
 Federal Way Vet Center 253 838 3090

## King County Veterans Program Contract Therapists

Diane Adams (Nakamura) Ph.D., Renton...253 852 4699  
 Laurie Akers, MA, LMHC.....425 388 0281  
 Dan Comsia, M.A., M Div. LMHC.....253 840 0116  
 Diana Frey, Ph.D., Maple Valley.....425 443 6472  
 Dorothy Hanson, M.A.,LMHC Fed Way ..253 952 0550  
 Laureen Kaye, MA, LMHC, Duvall.....425 788 9920  
 Ron Lowell, MSW, LMHC, Seattle .....206 902 7210  
 Mike Phillips, Psy.D., Issaquah.....425 392 0277  
 Dwight Randolph, M.A.,LMHC Seattle...206 465 1051  
 Karin Reep, MA,LMFT, Duvall, Redmond.....  
 .....425 788 9921  
 Steve Riggins, M.Ed., LMHC Seattle.....206 898 1990  
 Terry O’Neil, Ph.D., Bellevue.....425 990 9840  
 Valley Cities Counseling, Renton  
 Christian Alexander, MS, LMHC.....253 250 4597  
 Veteran Referral Services,  
 Mabae Redmond.....206 335 3731

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 Veterans Program .....  
 206 296 7569.

### WDVA PTSD Program Director

Tom Schumacher 360 725 2226 Cell 360 791 1499

Training Resources in King County and Washington State: [www.veteranstrainingsupportcenter.org](http://www.veteranstrainingsupportcenter.org)

Gulf War Helpline.....1 800 849 8387  
 Puget Sound Health Care System  
 (VA Hospital).....206 762 1010  
 Seattle VA Deployment Clinic.....206 764 2636  
 Spokane VA PTSD Program .....509 444 8387

**24-Hour VA Crisis Hotline.....1 800 273 8255**