Suicide: 
Unseen and Uncounted

Are Suicides Contagious?

PTSD Report:
Politics, Genetics and Bad Drugs
The mission of AIS is to improve the health of the community and the world by setting the standard of excellence of stress management in education, research, clinical care and the workplace. Diverse and inclusive, The American Institute of Stress educates medical practitioners, scientists, health care professionals and the public; conducts research; and provides information, training and techniques to prevent human illness related to stress.

AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.
Chaired by COL Platoni, the role of this board is to develop initiatives and communications to serve the stress management needs of Service Members and veterans.

**Kathy Platoni, Psy.D, DAAPM**  
Clinical Psychologist  
COL/MS/US Army Reserve  
Army Reserve Psychology Consultant to the Chief, Medical Service Corp

**Stephen Barchet, MD, FACOG, CPE,FACP**  
Rear Admiral, MC, USN, Retired

**CPT. Alison Lighthall, RN, BSN, MSN**  
Editor of the AIS Combat Stress Newsletter

**COL Richard Petri, MD**  
Fort Bliss Physical Medicine and Integrative Health Services

**Daniel L. Kirsch, PhD, DAAPM**  
AIS President
We value opinions of our readers and our advertisers. Please feel free to contact us with any comments, suggestions or inquiries.

Email: editor@stress.org

Editor In Chief
Daniel L. Kirsch, Ph.D

Editor
Alison Lighthall, RN, BSN, MSM

Creative Director: Kellie Marksberry

Combat Stress is a quarterly newsletter with news and advertising designed for Service Members, veterans and those who know and love them. It appeals to all those interested in the myriad and complex interrelationships between stress and health because technical jargon is avoided and it is easy to understand. Combat Stress is archived online at stress.org. Information in this publication is carefully compiled to ensure accuracy.

Copyright © 2012 the American Institute of Stress (AIS). All rights reserved. All materials on AIS’ website and in AIS’ newsletters are the property of AIS and may not be copied, reproduced, sold, or distributed without permission. For permission, contact editor@stress.org. Liberal use of AIS fact sheets and news releases is allowable with attribution. Please use the following: "Reproduced from the American Institute of Stress website (or newsletter), © AIS (year)."
In this, our inaugural issue of the AIS Combat Stress Newsletter, you’ll find something you have not found elsewhere—the multifaceted experience of combat stress explored by a wide variety of people, expressed in simple language.

Our mission is to constantly broaden our understanding of combat stress in order to deepen this country’s compassion for our veterans, and through our greater compassion, find new ways of extending the circle of healing towards all veterans and their families.

You’ll also find this to be a no-BS zone. Here at AIS, we practice what could only be called “radical honesty.” We blend together relevant research and professional experience to reach what we hope will be an authentic understanding of things as they really are.

In addition to keeping you abreast of some of the latest research, we’ll also offer up opinions on a wide variety of issues. Sometimes we’ll express less alarm than others on a particular issue, and sometimes we’ll be expressing more. But regardless on what side of an issue we decide to stand, and regardless of its political correctness (or incorrectness), we’ll strive to give you something meaningful to think about.

This is our collective newsletter, where exchanging ideas and sharing information is our Prime Directive. Translated: we want to hear from you. We want to hear from veterans who have lived it and civilians who have treated it, professionals with degrees and people who graduated from the School of Hard Knocks.

So speak up and speak out. If you find a piece of research that you think hits the nail on the head, send it to us. We’ll summarize it and make sure everyone knows where to find the complete article.

Likewise, if you read something that is missing a key component in a study, send it with your comments and we’ll get that out there, too. We reserve the right to edit things that are submitted, but we won’t change the intent or core message.

More and more of our soldiers, marines, sailors, and airmen are showing signs of the physical and psychological injury commonly diagnosed as “post-traumatic stress disorder” (an issue discussed further in the next article.) Day after day, they are suffering in silence. Time is not a luxury we have here. We need to act today.

Education and discussion are excellent first steps. But tell us—thinking ahead, what do you envision the next steps to be?

Feel free to reach me by email at Alison@hand2handcontact.org or call me at my office, (413) 394-4101.
Here at the American Institute of Stress, we are focusing a lot of our time, energy and resources on combat stress. Why? Because we are dedicated to helping all those who served and continue to serve because they deserve it. And because someone needs to help without all the red tape our VA government healthcare system loves so much.

I have been working in so-called alternative or complementary or integrated medicine for decades. I don’t even really understand what all that means except that it refers to something that is therapeutic without drugs. Simply put, drugs can, in many cases, do more harm than good. I refer many to www.drugawareness.org to learn the truth about antidepressants. Immediately after the Aurora, Colorado Batman movie shooting I was interviewed by nine radio stations regarding what could have caused that man to do such a horrible thing. My first impression, based on studying all the other mall, church and school killing sprees is the likelihood of drugs. Prescription drugs. The same drugs being fed to our military Service Members like candy. They deserve better care than that. Hence our focus on combat stress and implied with that is the aftermath of that extreme stress, the POST-traumatic stress.

Is post traumatic stress a disorder? Well, I’d reluctantly say yes. But it does not affect everyone equally. Nor do flu germs. Those have to get through one’s immune system. We do have similar defenses in our psyche. One of the things I like about biological systems over, say, automobiles, is that we tend towards self healing. Or at least we have the capacity for doing that. When you get a cut, it doesn’t continue to crack through your whole body. It heals. And your mind wants to heal too. Just as cuts sometimes need someone to clean them and perhaps sew them up, so too does the mind need such help when it gets knocked out of kilter by too much stress.

So what can be done then, when post traumatic stress becomes a disorder? Well I believe one needs to go through the stages of healing. Try to avoid drugs as it masks and perhaps prolongs the pain. What works? There should be physiological help, perhaps such things as biofeedback devices like the emWave, or cranial electrical stimulation (CES), or even therapeutic breathing exercises. That must be combined with psychological help. Talk to someone. Preferably someone who was there and did that. Or a loved one, or a professional. Just talk it out.

It should never get so bad that it is hopeless. Suicide is not even the last resort. To see someone recover and become a useful member of a family, of society and for one’s self is a beautiful thing to behold. Our business here at the American Institute of Stress is to help save a few lives and to improve the quality of life for everyone. We certainly can’t do all that alone. We need everyone to join in the battle again. We’ll do our part as we Engage, Educate, and Empower people to help. What are we fighting for this time? The thing we first fought for as a new nation: life, liberty and the pursuit of happiness. Join us by making someone’s day a little brighter and then do it again tomorrow. Together we just might win this revolutionary war.
Since the onset of the Iraq and Afghanistan conflicts, there has been a progressive rise in the prevalence of PTSD in our troops. One study of almost 300,000 who served in those countries found that rates of the disorder increased from just 0.2 percent in 2002, to 22 percent in 2008, a greater than 1000 percent jump. There is no evidence that this is related to greater combat exposure but it does correlate with an increase in drug administration. Paxil and Zoloft, the only two approved drugs for treating PTSD, both carry black box warnings of increased risk of suicide. In addition, these and other serotonin reuptake inhibitors are barely more effective than placebos, so it is common to add Risperdal or other psychotropic drugs, as well as stimulants like Ritalin and Adderal, sleeping pills and narcotics, which can result in a lethal cocktail. We have discussed this at length in prior Newsletters, and three examples of such disasters that were reported in the February 12 2011 New York Times are described below:

**Gunnery Sergeant Christopher Bachus** had spent virtually his entire adult life in the Marine Corps, deploying to the Middle East in 1991, Iraq during the invasion of 2003 and Afghanistan in 2005. When he returned home, he suffered from anxiety, flashbacks of combat in Iraq, irritability and depression due to what doctors called "survivor's guilt". He was diagnosed as having PTSD and was started on drugs for depression, anxiety and clonopin, an antipsychotic. After a car accident, he assaulted the other driver and was admitted to the National Naval Medical Center in Bethesda for anger management therapy and training. On Jan. 29, 2008, he was found dead in his room and at least nine prescription drugs to reduce anxiety, improve sleep and reduce pain were found in his system. He was 26. His father said, "He survived over there. Coming home and dying in a hospital? It's a disgrace."

**Senior Airman Anthony Mena** was part of a military police unit that conducted combat patrols alongside Army units in downtown Baghdad. His duties included cleaning up the remains of suicide bombing victims and he was nearly killed by a bomb himself on one occasion. He returned from his second deployment to Iraq complaining of back pain, insomnia, anxiety and nightmares. Doctors diagnosed PTSD and prescribed powerful psychiatric drugs and narcotics. Despite this, his pain and depression deepened. In 2008, he told one doctor “I have almost given up hope. I should have died in Iraq.” Instead he died in his Albuquerque apartment, on July 21, 2009, five months after receiving a medical discharge. During those months, he rarely left home without a backpack filled with medications. A toxicologist found eight drugs in his blood, including three antidepressants, a sedative, a sleeping pill and two potent painkillers. The medical examiner concluded it was an accident. Anthony Mena was 23.

**Corporal Nicholas Endicott** joined the Marines in 2003 after working as a coal miner in West Virginia. He served two tours in Iraq and one in Afghanistan, where he was involved in heavy fighting and saw his comrades killed. On one mission, he was blown more than eight feet in the air by a roadside bomb. After returning from his third deployment, in 2007, Corporal Endicott told doctors that he was having nightmares and flashbacks, and was diagnosed as having PTSD. Although numerous medications were prescribed, he continued to suffer from severe anxiety, headaches and vivid nightmares. After a car accident, he assaulted the other driver and was admitted to the National Naval Medical Center in Bethesda for anger management therapy and training. On Jan. 29, 2008, he was found dead in his room and at least nine prescription drugs to reduce anxiety, improve sleep and reduce pain were found in his system. He was 26. His father said, "He survived over there. Coming home and dying in a hospital? It’s a disgrace."

**Gunnery Sergeant Christopher Bachus** had spent virtually his entire adult life in the Marine Corps, deploying to the Middle East in 1991, Iraq during the invasion of 2003 and Afghanistan in 2005. When he returned home, he suffered from anxiety, flashbacks of combat in Iraq, irritability and depression due to what doctors called "survivor's guilt". He was diagnosed as having PTSD and was started on drugs for depression, anxiety and clonopin, an antipsychotic. In 2006, after a period of improvement, his medications were discontinued, but he asked to be put on them again six months later. Although he was still anxious and depressed, he was deployed to Iraq again in early 2007, but was sent home in a few months when it was discovered that he was on psychiatric medications. Frustrated that he could not be in a front-line unit and ashamed to work behind a desk, he applied for a medical discharge, which proved to be a lengthy and stressful process that made things worse. In March 2008, a military doctor added opiates to his medical regimen to relieve back pain, and shortly thereafter, he called his wife in Ohio and told her "You know, babe, I am really tired, and I don’t think I’ll have any problems falling asleep tonight.” He was found dead in his on-base quarters in North Carolina a few days later. His wife later told investigators that he sounded delusional, but not suicidal. She was correct. An autopsy revealed two antidepressants, oxymorphone and oxycodone opiates, and an anti-anxiety medication in his system. **Nearly 30 bottles of pills were found at the scene, most of them recently prescribed.** According to the report, the delirium he experienced in his final days was “most likely due to the interaction of his medications.” Sergeant Bachus was 38 and had served in the military for seventeen years.
All of these three veterans died in their sleep, had five or more prescribed medications in their systems at autopsy and were classified as accidents, not suicides, since they had not taken more than prescribed dosages — just what their doctors had ordered. And for thousands more, these drugs make their quality of life much worse than the symptoms for which they were prescribed. One survey revealed that 12% of combat troops in Iraq and 17% of those in Afghanistan are taking antidepressants or sleeping pills to cope with stress. As emphasized in last June’s Newsletter, sleeping pills may be responsible for over 500,000 deaths/year and the incidence of suicide is 300 percent higher in seniors who take hypnotics.

Spending on stimulants jumped from $7.5 million in 2001 to $39 million in 2010, over a fivefold increase. The number of Ritalin and Adderall prescriptions for active-duty soldiers increased by nearly 1,000 percent in five years from 3,000 to 32,000. These drugs are usually prescribed for children and adolescents with ADHD (attention deficit hyperactivity disorder) because they increase focus and attention. Their main use in the military is to help fatigue and sleep deprived troops stay awake and alert, but they do much more than this. Because they increase the secretion of adrenaline-like chemicals, they also stimulate learning and memory formation. Similarly, a surge in these flight or fight hormones during stress also creates vivid and lasting memories. Some researchers believe that since PTSD represents a pathological type of learning known as fear conditioning, stimulants could increase the risk of developing this disorder. This is supported by a study in which subjects were given propranolol, a drug that blocks the effect of norepinephrine, or a placebo just before they heard one of two stories: an emotionally arousing one or a neutral one. When their memory of the stories was tested a week later, it was found that propranolol selectively impaired recall of the emotionally arousing story but not the neutral story. This shows that emotion raises norepinephrine, which enhances memory, since this did not happen when norepinephrine was blocked.

In PTSD, a shocking combat situation elicits a hard-wired flight or fight response with intense emotional arousal and a surge of norepinephrine that burns in the memory of the traumatic experience. It also promotes fear conditioning, a form of learning in which previously neutral stimuli such as sights, sounds and smells become linked with a trauma. Thus, for a soldier injured in a bomb blast, anything like the sound of an explosion or a burning odor is now a potent conditioned stimulus that can evoke the trauma and trigger PTSD symptoms like a flashback or startle reaction. Because norepinephrine enhances emotional memory, a soldier taking a stimulant medication that releases norepinephrine in the brain could be at higher risk of becoming fear-conditioned and developing PTSD from combat trauma. This sequence of events is supported by animal and human studies. Injecting minute amounts of norepinephrine into the amygdala, a region of the brain that encodes fear, significantly enhanced fear conditioning. In another study, college students were shown a picture paired with a small electric shock. Before viewing the pictures, subjects were randomly given yohimbine, a drug that releases norepinephrine in the brain, or a placebo. When students were tested 48 hours later, those who had received yohimbine had greater fear-associated learning. They also had a harder time “unlearning” the fear when presented with the picture in the absence of a shock, than students in the placebo group. This implies that soldiers with elevated norepinephrine levels due to stimulants are also at more risk of relapse when re-exposed to the initial stressor. And since the treatment of PTSD requires unlearning fear responses, troops taking stimulants would also be more resistant to treatment. Conversely, blocking the effects of norepinephrine with beta blockers can stop fear-conditioning and possibly even prevent PTSD. In one study, emergency room patients were randomly assigned to receive either the beta blocker propranolol or a placebo within six hours after experiencing a traumatic event. When tested one month later, those who had received the propranolol had significantly fewer PTSD like symptoms than the placebo group.

None of the above proves that drugs are contributing to the steady increase in PTSD and suicides, since there are other factors such as traumatic brain injury and childhood and adolescent influences that can also increase risk. However, it does suggest that drugs may be doing more harm than good in combat situations. The Army has already discouraged the off label use of Risperdal, and many feel that the possible link between stimulants and PTSD should be investigated as soon as possible.

Reference

As we were putting the finishing touches on this newsletter, the Defense Center of Excellence sent out a press release saying that the Army’s suicide rate doubled from June to July 2012. Incredibly, more U.S. soldiers killed themselves in July than were killed by the enemy in Afghanistan, bringing the Army's suicide rate for active duty troops to a record high of 26 in one month. Another 12 potential suicides occurred among Army Reserve and National Guard soldiers who were not on active duty.

In hard numbers, the total of 38 suicides in July surpassed the total of 32 soldiers killed in Afghanistan that month. We couldn’t let our first issue go out without addressing this very sad situation. (See reprint of Jacey Eckhart’s article on suicide as a contagion on page 12)

As we all know, these numbers are a fraction of the real story. For starters, these are just the suicides that have been verified as such. Some deaths were probably suicides but were without clear evidence such as motorcycle accidents, for instance.

Those still under investigation are also not included in July’s numbers, which means these numbers are likely to quietly climb as each case is closed and final conclusions have been made.

But there are some glaring omissions here that would, if counted, practically stop your heart. For instance, how many discharged veterans who are not enrolled in the VA system died by suicide? How many “accidental” deaths were actually carefully planned suicides, such as those motorcycle accidents?

And a statistic no one seems to be studying is suicide in military families: how many family members of Active Duty, Reserve, and Guard soldiers killed themselves? Is it greater than what we see in civilian families of similar make-up? Does parental deployment have any effect on the rate of suicide on military teens? We know deployment is a major contributor to the divorce rate; does it increase, decrease, or have no impact on the chance that a spouse will die by suicide?

No one knows. At least not yet.

The AIS Combat Stress Board calls upon our research colleagues at Walter Reed, Bethesda, military medical installations, and civilian universities to begin delving into this critical, but entirely ignored, area of study. If we are to heal as a nation, we must reach out to everyone who is suffering, but in order to do that, we must first know who is suffering, how they are suffering, and why exactly they are suffering. Only then can we know how to proceed.
Suicide Facts

- 8th leading cause of death in U.S.
- More women attempt suicide.
- More men complete suicide.
- Elderly and ages 15-24 are highest rates
- Most in whites, except for 25-44 age range (Black)
- A suicidal state is only temporary but can return.
- A trail of clues is usually left.
- Most often suicide is premeditated, not impulsive.

Soldiers Who Complete Suicide:

- Rarely seek help through the chain of command, Chaplaincy or Behavioral Health
- < 1/5 of all completed suicides have seen Behavioral Health
- Often don’t show “classic” warning signs of suicide in the unit.
- Frequently choose very lethal means and act privately, precluding rescue.
When so many good people are trying so hard to prevent suicide among our military members, why do the numbers continue to climb? One factor that we may be ignoring is the effect that all this media attention may have on the suicide rate. Especially in tight-knit communities like the military. Especially among members of the population who are under 24 years old.

Since 1974, it has been established that suicide imitation can be spread inadvertently by media. Sociologist David Phillips called it “The Werther Effect.” Other scientists refer to it as “media contagion.” Whatever you call it, certain details of news coverage of a suicide -- such as describing exactly how a person died and publishing tributes from family members -- have been shown to significantly increase the rate of suicide deaths.

The Center for Disease Control, the Substance Abuse and Mental Health Services Administration, and the U.S. Department of Health and Human Services all published guidelines to prevent that media contagion from happening.

Those guidelines are not being followed with military members. In a 2011 study, Amanda Edwards-Stewart and her colleagues reviewed 240 military and civilian newspaper reports of suicide from 15 different sources for compliance with the guidelines. Nearly all reviewed articles violated at least one guideline. The researchers found that military suicides were more likely to be reported in the news than those in the civilian population. Ineffective behavioral health treatment was more likely to be noted as a contributing factor to the suicide.

The authors noted: “Such emphasis can imply that seeking help for depression and suicide may lead to suicide instead of preventing it. This may be especially damaging to the military population, for whom stigma regarding behavioral health care prevents treatment-seeking.”
We can see examples of this kind of media contagion everywhere right now. The coverage is undeniably well meant. For example, the recent TIME magazine article about military suicide violated many of the CDC guidelines. The article had prominent placement on the cover of the magazine. There was some “glorification” of the two members of the military who were featured. There were complete descriptions exactly how both Service Members killed themselves and the grief experienced when each of them was found. The reporters described just how the Service Members sought help for behavioral health and exactly how the help failed. That is exactly the kind of coverage that has been shown to increase suicide imitation.

Yet the article was well-researched. Insightful. Respectful of the military families involved. It exposed the idea that suicide is not confined to the heavily deployed -- a third of the suicides occurred among those who had never deployed and 43 percent occurred among those who had deployed only once. It revealed that the Service Members knew exactly what to say to avoid further scrutiny. It revealed how one Service Member sought help from behavioral professionals six times. *Six times.*

We cannot afford to ignore the suicide rate in our community. We cannot pretend these deaths are not happening. We also have to be aware that certain kinds of attention exacerbate the problem. Which puts us smack in a classic military Catch 22, walking a line between the living and the dead, hoping we can do the right thing.
Studies reveal that 6% of boys and 15% of girls have PTSD symptoms, and that at least 40% of U.S. high school students reported having experienced one or more traumatic events. Half of this group subsequently develop PTSD. Some studies suggest that up to 100% of children who have seen a parent killed or endured sexual assault or severe abuse tend to develop PTSD, and over one-third of those exposed to community violence such as a shooting or stabbing now have the disorder.

Preschool children exposed to domestic violence and other traumatic events are also at increased risk for developing traumatic stress disorder. Researchers studied 120 children between ages 4-6 from low income families who had been exposed to domestic violence in the previous two years. Almost 40 percent experienced additional traumatic events such as sexual assaults by family members, physical attacks or life-threatening illnesses. This group subsequently developed more behavioral problems (aggression, depression, anxiety) and significantly higher rates of PTSD.

Even dogs that served alongside U.S. military personnel in Iraq and Afghanistan are now developing PTSD. In the past, many were euthanized after serving their tours of duty but now often go on to live with their handlers in the civilian world. As a *New York Times* article reported, "The four-legged, wet-nosed troops used to sniff out mines, track down enemy fighters and clear buildings are struggling with the mental strains of combat nearly as much as their human counterparts.

By some estimates, "more than 5 percent of the approximately 650 military dogs deployed by American combat forces are developing canine PTSD." According to the article, the care they get "can be as simple as taking a dog off patrol and giving it lots of exercise, playtime and gentle obedience training" or using the same medication prescribed for people who suffer from panic attacks. Domestic dogs can also apparently suffer from PTSD.

**References**

Springer D, Padgett D. Gender Differences in Young Adolescents' Exposure to Violence and Rates of PTSD Symptomatology. *American Journal of Orthopsychiatry* 2010; 70: 370-370


This year’s Crisis Intervention Team International Conference, held in Las Vegas August 19-24, offered more seminars on veterans’ issues than ever before. With a noticeable uptick in veteran-involved crisis calls to law enforcement and social service agencies across the country, the seminars were well attended by police and mental health professionals alike.

CIT is a system of collaboration between mental health and law enforcement, with the purpose of enhancing both consumer and officer safety. Originating in Memphis 25 years ago, it has moved from being exclusively a training program to, in its most sophisticated form, a multi-agency, multi-dimensional team approach that can handle everything from de-escalating someone in crisis to providing a family of ten permanent housing, food, and clothing.

The core of the CIT approach is a 40-hour training course for front line responders, such as law enforcement officers, dispatchers, EMTs, civilian outreach workers and professional counselors. It includes didactic lectures on everything from specific mental health diagnoses and psychotropic medications, to several hours of practicing interventions and discussion with family members of those with mental illness.

Seminars this year that focused on veteran issues covered topics such as understanding combat trauma, how to collaborate with the Army’s Warrior Transition Battalions (that oversee the care of the Army’s wounded warriors), and law enforcement encounters with veterans. But I found that even in seminars that were not specifically about veterans, the topic almost always came up as an area everyone needed to know more about.

Ironically, I’ve provided the veteran portion of the CIT training to law enforcement, corrections, and emergency responders many times, but until I attended this conference I honestly didn’t understand how it all fit together and how impressively comprehensive many CIT program are in communities such as Houston and Memphis.

I encourage all of you to find a way of receiving this free training. It’s usually sponsored by the local NAMI chapter, but sometimes the local police department will do it on its own. But if that doesn’t work for you, I strongly encourage you to put next year’s CIT International Conference on your calendar. It’ll be the week of Columbus Day 2013 in the beautiful Northeast (Hartford, CT), just in time for the fall colors. I’ll be there—you should be, too.
Unlike diabetes, cancer or a heart attack, Post Traumatic Stress Disorder (PTSD) is not a diagnosis that everyone is happy with since there is no way to confirm its existence, much less measure its severity. There are no blood tests, biopsies, x-rays or other imaging studies to indicate that any abnormality is present. A PTSD designation depends entirely on the patient's complaints, and as demonstrated in past Newsletters, it is relatively easy to fabricate these in order to obtain a medical discharge and tax-free disability compensation for life. The reason these benefits never expire even though PTSD patients often experience complete remissions, is that that the term "disorder" implies some condition that is permanent and can't be cured. Senior military officers as well as psychiatrists have now suggested replacing "disorder" with "injury", which does not carry the connotation of a lifelong stigma that often discourages people with mental health problems from seeking assistance.

This issue is coming to a head since the new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is scheduled to be published in March 2013. This is the bible of mental illnesses that is used by the courts, Armed Services, Veterans Administration, insurance companies and everyone else to determine the presence of a mental disorder, and in some cases to rate its severity for reimbursement purposes. A group of 12 psychiatrists will be holding public hearings to determine whether PTSI (Post Traumatic Stress Injury) should replace PTSD and there is even a website devoted to promoting this change. One of the most ardent proponents has been Gen. Peter Chiarelli, former Vice-Chief of Staff of the Army, who was concerned with the increasing rates of PTSD and suicides he encountered after two tours in Iraq and struggled to find ways to correct these.

As the four star general pointed out, "No 19-year-old kid wants to be told he's got a disorder", and he was the first to drop the word "disorder" by referring to the condition as simply PTS (Post Traumatic Stress). PTS was adopted by officials at the highest levels of the Pentagon, including Defense Secretary Leon E. Panetta, but was rejected by the medical community and especially pharmaceutical companies. This was likely because of concerns that insurers and government bureaucrats would not be willing to pay for a condition that wasn’t explicitly labeled a disease, disorder or injury. In addition, any change might raise questions about the causes of PTSD, the best way to treat the condition, barriers that prevent troops from getting help, and other issues that could have major financial implications for health insurers and federal disability claims. Huge amounts of money and reputations could be jeopardized and vested interests obviously want to maintain the status quo. While General Chiarelli retired last February many others are now also urging that PTSD be abandoned and replaced by PTSI, since injury suggests that the condition can be healed and is not necessarily permanent. There will surely be a lively debate about this proposed change, so stay tuned to see what happens.

Reference
www.posttraumaticstressinjury.org/
Stress is unavoidable, and comes in many shapes and sizes that makes being in a state of peaceful happiness seem like a very lofty goal. But happiness is easy to find once you are able to find ways to manage your stress and keep a healthy perspective when going through difficult times in life. You will always have stress, but stress does not always have you!

Click here to subscribe!

We’ve Gone Social!

Like us on Facebook
www.facebook.com/aistress

Follow us on Twitter
www.twitter.com/AIS_StressNews

Stay connected and get updates as they happen.