Beyond Trauma

FEATURING:
Dr. Ray Scurfield
Vietnam Veteran, Katrina Survivor
War and Natural Disaster Trauma Expert
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.
COMBAT STRESS

We value opinions of our readers.
Please feel free to contact us with any comments, suggestions or inquiries.
Email: editor@stress.org

Editor In Chief: Daniel L. Kirsch, PhD, DAAPM, FAIS

Editor: Kathy Platoni, PsyD, DAAPM, FAIS, COL (RET), US Army

Combat Stress is a quarterly magazine, published in February, May, August and November. Each issue contains news and advertising designed with service members, veterans and their families in mind. It appeals to all those interested in the myriad and complex interrelationships between combat 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.

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Chaired by Colonel Platoni, the role of this board is to develop initiatives and communications to serve the stress management needs of Service Members and veterans.

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AIS Fellow - Mississippi
Member – AIS Combat Stress Board


Scurfield has also written substantially about the impact of Hurricane Katrina, and helpful interventions to address post-Katrina mental health recovery. Scurfield has been recognized as a "Hero of Katrina" by the University of Southern Mississippi (2006), the 2006 Mississippi Social Worker of the Year by the Mississippi Chapter of the National Association of Social Workers, the 2006 and 2007 College of Health Distinguished Teaching Awards and 10 additional awards and recognitions during his tenure at Southern Miss. He most recently received the 2012 Mississippi Lifetime Achievement Award from the Mississippi chapter, National Association of Social Work, and the NASW National Lifetime Achievement Award. NASW PRESS RELEASE : Raymond Monsour Scurfield, DSW, ACSW - Lifetime Achievement Award: Dr. Scurfield is Professor Emeritus of Social Work at the University of Southern Mississippi. In his 45-year career, Scurfield has made extraordinary contributions to the profession and society. Dr. Scurfield has a distinguished reputation in posttraumatic stress disorder (PTSD) as a clinician, innovative therapy and program developer, educator, and researcher publishing on topics such as Vietnam War and other war-related trauma, post-disaster interventions, race-related trauma, and exposure and experientially-based therapy.

In his USM teaching career (1998 – 2011), he was awarded 15 teaching, scholarship and service awards. He was the Mississippi State NASW 2012 Social Work Lifetime Achievement Award winner “for his outstanding contributions to social work education, research and veterans services”, and the 2006 Social Worker of the Year for his post-Katrina efforts in helping faculty, staff and students. His MSW (1967) and Doctor of Social Work (1979) are from the University of Southern California.

Dr. Scurfield was an Army ROTC Distinguished Military Graduate, Dickinson College, and served four years active duty as a social work officer, to include a year in Vietnam on one of
the Army’s two psychiatric teams. Then, during Dr. Scurfield’s 25-year career with the U.S. Department of Veterans Affairs, he was a leader of regional and national PTSD programs in Los Angeles, Washington, D.C., and Tacoma, WA, as well as the initial Director of the VA’s National Center for PTSD in Honolulu. He co-led two return trips to peace-time Vietnam with combat veterans. He received numerous awards and recognitions, to include the VA’s prestigious national Olin E. Teague National VA Award recipient “… in recognition of your extraordinary contributions benefiting war-injured veterans. Your achievements in the study and treatment of PTSD have become landmarks in psychiatry.” [President Ronald Reagan. Nov. 21, 1988].

Dr. Scurfield’s 70 publications include several about Hurricane Katrina, and articles, book chapters and his Vietnam Trilogy of single-author books about war trauma, the most recent War Trauma. Lesson Unlearned From Vietnam to Iraq (2006). Most recently, he is co-editor with COL Kathy Platoni of two books on war trauma (Routledge Publishing): War Trauma & Its Wake. Expanding the Circle of Healing (2012) and Healing War Trauma. A Handbook of Creative Approaches (2013). He is also co-author of Marsella, AJ; Friedman, MHT; Gerrity, et; and Scurfield, RM (1996). Ethnocultural Aspects of Posttraumatic Stress Disorder. Issues, Clinical Applications and Research. He has made over 350 media appearances, conference and training presentations to include 60 Minutes (in which the program he founded and directed, the Post Traumatic Stress Treatment Program, Tacoma, WA, was featured as a model VA program), Nightline, New York Times, Washington Post, Boston Globe, Christian Science Monitor, National Public Radio and numerous NPR-affiliated stations nationwide. He is the lead author of a three-part video series on PTSD group therapy with veterans of three eras of war (WW II, Vietnam and Persian Gulf War), A Journey of Healing, produced by the VA National Center for PTSD in Honolulu (1997) and distributed nationally. Also, the return trip to Vietnam in 1988 that he co-led, the first such trip with a PTSD therapy group of Vietnam veterans, was filmed and produced as a PBS documentary video and released nationally in 1999, Two Decades and A Wake-Up. He is recognized nationally and internationally through his writings and presentations as an expert in the field of war-related post-traumatic stress and natural disaster mental health and he has been a consultant for several organizations, to include ArtReach, Project America and Not Alone.

It is a tremendous honor for Combat Stress to celebrate the life and works of Dr. Ray Scurfield, whose boundless kindness and generosity only adds to the infinite impact of the thousands whose lives he has touched.
A Lifetime of Awards (...so far)

The letter above is from President Ronald Reagan in 1998 recognizing Dr. Scurfield’s contributions and achievements in the field of Post Traumatic Stress by bestowing the Olin E. Teague Award.
Dr. Scurfield has a distinguished reputation in posttraumatic stress disorder (PTSD) as a clinician, innovative therapy and program developer, educator, and researcher publishing on topics such as the Vietnam War and other war-related trauma, post-disaster interventions, race-related trauma and exposure and experientially-based therapy. NASW National Office, December 22, 2012.

At Right: 2006 The University of Southern Mississippi extends an award in recognition and gratitude for Dr. Scurfield’s work in the aftermath of hurricane Katrina.

At Left: 2012 Social Work Lifetime Achievement Award, NASW, Washington, D.C.

Above: Scurfield with the three Vietnam veterans and VA psychologist Leslie Root that went back to Vietnam in 2000 on their Study Abroad to Vietnam course that he and Dr. Root co-led with Dr. Andy Weist, History Prof.

Left: This photo was taken in Xom Bong Hamlet, just outside of Nha Trang, 1968-69, during a MEDCAP that Scurfield had organized with 8th Field Hospital medical personnel. As the "administrative" officer for the MEDCAP, Scurfield was writing down immunizations and other treatments that various villagers had received.
What to Say and Do Differently: It’s Time to Tell the Whole Truth

We all, to include deployed members of the Armed Forces, their families and our country, are entitled to have the truth, the whole truth and nothing but the truth concerning combat stress reactions, the impact of other kinds of trauma, post-traumatic stress, and the full range of possible short- and longer-term impact of war and other trauma. Isn’t this a hallmark of a democracy, to have a fully informed citizenry and to not let others decide “what is best for us to know?”

And so, just what is the “truth” that trauma survivors, to include active duty members of our Armed Forces and their families, and our veterans, and our communities, have not only the right but also the need to know? A related issue is, considering the realities and limitations of what can be done in a war-zone with psychiatric casualties, what can and should be done differently to address mental health concerns in a war-zone.

To my knowledge, important elements of following facts are not shared by the military with Armed Forces personnel and their families, nor are they shared by our government to the American people, nor are they routinely shared with survivors of other types of trauma, such as natural disasters and sexual assault. And since these are facts, I would argue that it is ethically responsible to insure that all military personnel serving in any war-zone, their families, and our veterans and our communities receive this information: Following is what I consider to be abso-
lutely vital information to be provided directly to the active duty member or veteran; some of this is currently provided by military mental health providers yet other essential information herein in not communicated. The words would be changed appropriately if this information were being given to family members or to the community.

**Myths and Realities about Combat Stress Reactions, Other Trauma and PTSD**

**Myth:** Heroes & “normal” or healthy persons don’t continue to have problems after being exposed to a trauma. If they do, that means that they already had problems and were “pre-disposed” to having such problems anyhow. “The trauma was merely a trigger.”

**Reality:** Trauma is so catastrophic that it will evoke symptoms in almost everyone “regardless of one’s background or pre-morbid factors,” e.g., it is abnormal not to have strong reactions to a trauma. As Viktor Frankl, concentration camp survivor and founder of logotherapy stated: *An abnormal reaction to an abnormal situation is normal behavior.* Indeed, trauma always has a significant impact on all who experience it, although they do not necessarily develop PTSD.

As one Iraq war veteran stated: *My body’s here, but my mind is there* [in Iraq.]

As one Katrina survivor said: *I can’t get what happened during Katrina out of my mind; I still remember vividly how terrifying it was.*

**Myth:** Time heals all wounds.

**Reality:** Not necessarily. For example, long-term follow-up studies of WW II, Korean and Vietnam war-veterans indicate that psychiatric symptoms not only do not necessarily disappear over time, but in a significant sub-group the symptoms have become worse, *probably exacerbated by the aging process,* i.e., triggered by greater likelihood of exposure to deaths of significant others as one grows older, age-related losses of job, career, health, and increased realization of one’s mortality.

**Myth:** My trauma was not as bad as what others suffered, so I should not be feeling as badly as I do/ Or, I should feel guilty because I was spared what others suffered.

**Reality:** Comparing your trauma with those of others is a no-win proposition. Your trauma is your trauma, and what is its impact on you? If you continue to deny or minimize the very real impact of your trauma experience on you, you are lying to yourself. You must be willing to face the truth about how the trauma has impacted you--or it will always have a hold on you. And valid guilt does not come from feeling guilty over that which you had no responsibility for or control over. You can have empathy for others without having to put yourself down by denying the impact of your trauma.

**Myth:** I must have been bad or somehow deserved what happened to me.

**Reality:** Bad things can happen to good people and through no fault of your own.
However, many survivors tend to blame someone for their trauma: themselves, others, institutions---or God.

**Myth:** I can never trust myself or anyone else again. I didn’t respond during the trauma in a way that I feel good about, or my judgment was bad, and the environment is dangerous. So, I need to isolate and be constantly wary and careful of my surroundings.

**Reality:** Trust in yourself or trust in others is not an all-or-nothing proposition. Developing appropriate degrees of trust does involve risks, yet is essential for a fulfilling life. Is living a life of isolation and constant wariness what you want?

**Myth:** My trauma (Katrina or . . .) is the cause of all of my problems that I am having. Or: I’m behaving or feeling this way just because of Katrina.

**Reality:** No one was a “blank tablet” before suffering a trauma; we all were persons with strengths and weaknesses, positives and negatives. You may be having problems now that existed before Katrina, or that are worse in the aftermath of Katrina. If this is so, you must be truthful with yourself as the cause(s) of your current problems or you will put blame and responsibility where it does not belong and you will not address what truly needs addressed.

**Myth:** I did okay during the trauma and for awhile afterwards, so I shouldn’t be having all of these negative feelings and reactions now.

**Reality:** People seldom “break down” psychologically or have emotions that overwhelm and incapacitate them while in the midst of an emergency or trauma or in its immediate aftermath. Rather, most survivors suppress or “bury” painful feelings and thoughts and learn how to “detach” yourself from your own emotions in order to survive and not be overwhelmed. Thus, typically, there is a delay in the onset of problematic emotions and thoughts until sometime after the danger has passed---hours, days or weeks later; in a number of cases months, years or decades later. And so, just because you are feeling okay and in control of yourself at this time (or even in the first several weeks or months following deployment or following the ending of a natural disaster), does not necessarily mean that this will be the case months or years from now.

**Myth:** I must be crazy or weak to still keep remembering and still be bothered by the trauma after these many months (or years) have gone by.

**Reality:** Trauma is unforgettable (unless one has psychic amnesia). It is absolutely normal to not be able to totally eradicate the memories of trauma, and to be bothered to at least some degree by the trauma---for months, years or decades afterwards. Therefore, a trauma survivor will not be able to totally forget salient memories of trauma---although a number of trauma survivors resort to artificial means such as substance abuse, psychotropic medications, constant exposure to current danger, become a workaholic or otherwise preoccupy themselves as a temporary way to forget.
**Myth:** If I can just forget about the (traumatic) memories, I can move on with my life.

**Reality:** Since trauma is unforgettable, if you are a survivor of a trauma that happened awhile ago, you have become an expert at detachment, denial, minimization, avoidance. Because that is what you have been doing in an attempt to forget about the unforgettable traumatic experience. However, at some point the detachment/denial stops working so well. You may have become exhausted; or you have become so extreme with your detachment/denial that it starts causing other problems in your life---because you may have become too detached from your emotions and from people. And this then is an additional problem on top of the unresolved painful memories and problems from your original traumatic experience.

**Myth:** Most trauma survivors are highly motivated to eliminate or reduce PTSD-related symptoms like isolation, numbing, & physical arousal/hyper-alertness to the environment.

**Reality:** A number of PTSD symptoms also are survival modes that were learned during or following the trauma; and many survivors are very reluctant, ambivalent or not interested in giving them up. They may: (1) feel that it is quite justified to stay removed and apart from others, because they are different and do not feel comfortable in many social situations; (2) believe that to let themselves feel emotions once again will only result in painful reliving of traumatic memories, and (3) believe it is wise not to trust and be wary of the environment, and so hyper-arousal is a necessary protection against a hostile world.

**Myth:** If I full remember and re-experience aspects of my original trauma (through talking about it, thinking about it, focusing on it), I will lose control and either become sucked back into the vortex of that memory and never be able to come back out again—or I will go crazy, or start crying and not be able to stop crying and not be able to stop, or become so enraged that I will hurt someone or myself.

**Reality:** Trauma survivors do not go crazy from remembering and talking about their trauma. But they may go ‘crazy” trying so desperately to deny the undeniable—that the trauma happened, that it hurt then and it hurts now, that it has not gone away and that it needs to be dealt with.

**Other Realities about War and Its Impact**

Combat, war and other traumatic experiences always have a significant impact on all who experience it, both shorter-term and longer-term.

You may well have either significant "positive” and/or “negative” outcomes or impact from your war or other traumatic experiences, both while deployed and following your return. This impact may be evident immediately, later or after a very long period of time has elapsed. However, having even many positive war experiences or positive survival experiences
from other trauma will not necessarily re-
solve or ameliorate the grief, hurt, fear
or loss that you suffered or witnessed.

Most vets feel that, overall, their military
experiences were more positive than
negative. For example, a study of Viet-
name vets showed that 56% felt that their
Vietnam War and military experiences
were an entirely or mostly positive effect
on their lives. However 33% felt that
Vietnam and the military had an equally
positive and negative impact; and 11%
felt that the impact of their Vietnam and
military experiences were entirely or
mostly negative. Major negatives from
the Vietnam experience included: loss of
civic pride, of faith in America; cynicism;
inability to make friends; and experi-
ences of grief at death and suffering.

To attempt to suppress or “bury” painful
memories, and to learn how to “detach”
yourself from your emotions while in the
war-zone or while in the midst of other
trauma is almost certainly helpful to be
able to continue to function during con-
tinued exposure to the trauma. These
strategies also will help you to be able to
make it through your deployment. On the
other hand, there is absolutely no evi-
dence that doing this will have any im-
pact on whether you will or will not sub-
sequently develop longer term mental
health problems.

People rarely break down psychologically
while in the midst of an emergency or
trauma, to include in a war-zone.
Rather, typically there is a delay until
later---after getting back to a more se-
ure area, or hours or days or weeks
later, or in a number of cases months,
years or decades after leaving the war-
zone. And so, just because you are feel-
ing okay and in control of yourself at this
time (or even in the first several weeks
or months following deployment or fol-
lowing the ending of a natural disaster,
etc.), does not necessarily mean that this
will be the case months or years from
now.

There is compelling evidence that the
more anyone is exposed to traumatic
stressors, such as war, the greater the
likelihood that you will eventually de-
velop post-traumatic stress or post-
traumatic stress disorder. And so, for
example, the longer you are deployed in
a war-zone and the more you are repeat-
edly redeployed back to the war zone,
the risk will be increasingly higher that
you will ultimately develop PTSD. This is
the risk of being willing to repeatedly put
yourself into harm’s way.

[This last-mentioned reality dictates that
the following additional information be
provided to acute psychiatric casualties
in the war-zone who are being treated
and being sent back to their duty stations
if they are to be duly warned about the
mental health risks they face.]

I want to be very frank with you about
what will happen by going back to duty.
There is the risk that by going back to
your duty station and once again being in
harm’s way, you may well suffer addi-
tional psychological or emotional difficul-
ties if you are exposed to yet more com-
batt stressors and trauma.

This is understandable, and you should
recognize if this is happening and not
think that you are going crazy or are a
“weak” person. However, you must pay
close attention: do what you have to do to protect yourself and survive during the remainder of your tour.

Be aware that you may well have suppressed or delayed emotional problems and issues related to exposure to combat that can surface months or years after leaving the war-zone. But as a veteran there is knowledgeable help available through the Department of Veterans Affairs and Vet Centers.

A Veteran’s Worst Wounds May Be the Ones You Can’t See.

- More military deaths by suicide than in combat in 2012
- Military suicides are at their highest rate in 10 years
- 8% to 20% of military personnel deployed in Iraq and Afghanistan experienced a traumatic brain injury
- 20% of national suicides are completed by veterans
- 300,000 veterans of the wars in Iraq and Afghanistan have been diagnosed with PTSD
- Traumatic brain injuries can increase suicidal thoughts and behavior

Recognizing mental illness is the first step toward recovery. Show returning soldiers that seeking help is a sign of strength. Learn more at psychiatry.org/mentalhealth

February 2015 Combat Stress
The American Institute of Stress
www.stress.org
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In a US Army Study, “The treatment subjects averaged about 43 extra minutes total time slept when compared to control subjects who reported an average 19 minutes less total time slept.”


Patient Self Reports: Alpha-Stim® vs. Drugs

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Decades after Charles Figley’s landmark Trauma and Its Wake was published, our understanding of trauma has grown and deepened, but we still face considerable challenges when treating trauma survivors. This is especially the case for professionals who work with veterans and active-duty military personnel. War Trauma and Its Wake, then, is a vital book. The editors—one a contributor to Trauma and Its Wake, the other an army reserve psychologist with four deployments who chairs our Combat Stress Board—have produced a book that addresses both the specific needs of particular warrior communities as well as wider issues such as battlemind, guilt, suicide, and much, much more. Published by Routledge, Taylor and Francis.

Order now on Amazon.com

Healing War Trauma details a broad range of exciting approaches for healing from the trauma of war. The techniques described in each chapter are designed to complement and supplement cognitive-behavioral treatment protocols—and, ultimately, to help clinicians transcend the limits of those protocols. For those veterans who do not respond productively to—or who have simply little interest in—office-based, regimented, and symptom-focused treatments, the innovative approaches laid out in Healing War Trauma will inspire and inform both clinicians and veterans as they chart new paths to healing. Chapter 12 is on Cranial Electrotherapy Stimulation (CES) with Alpha-Stim: Mild Electrical Triage of the Brain with War Veterans by Dr. Daniel L. Kirsch.

Order now on Amazon.com
This is a listing and description of 500+ resources for Service Members, veterans and their families.

The list is compiled and maintained by Dr. Ray Monsour Scurfield, Professor Emeritus of Social Work, University of Southern Mississippi. Dr. Scurfield is also in private practice with Advanced Psychotherapy located in Gulfport, MS.
War Trauma Resources
Updated October 2013

Click to Download PDF

This is a listing and description of 500+ resources for Service Members, veterans and their families.
GET INSIDE OUR HEAD

It’s Not Our Credentials That Make AIS So Impressive, It’s the Fellows That Go with Them.

The American Institute of Stress is a non-profit organization established in 1978 at the request of Dr. Hans Selye (the Founder of the Stress Concept) to serve as a clearinghouse for information on all stress related subjects. AIS Founding Fellows include:

Paul Rosch  Linus Pauling  Alvin Toffler  Bob Hope  Michael DeBakey  Herbert Benson  Charles Spielberger

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There are numerous lessons about war and its impact that have been learned and unlearned over the decades. Most of the following lessons were learned during and/or following the Vietnam War. However, soon after war ends, our nation manifests a collective amnesia about the impact of war—and lessons learned are “forgotten” in the ensuing years (Scurfield, 2006a).

Subsequently, a number (but definitely not all) have been “rediscovered” in the later years of the wars in Iraq and Afghanistan. For example, the government should have fully realized the extent to which the resources of the Department of Veterans Affairs needed to be augmented long before the psychiatric casualties began overwhelming the available assets. Instead, the VA will continue to have to play “catch-up” for years, maybe decades, in order to have resources and services in place sufficient to meet the needs of OEF/OIF veterans – while still trying to adequately meet the health and mental health needs of veterans of the Vietnam era (who continue to
comprise a substantial majority of veterans being served today), in addition to the few remaining veterans of the Korean War who have often been overlooked and forgotten.

This recurring collective amnesia about the extent of the impact of war is also reflected, time and again, by the unfortunate fact that initial euphoria and adulation paid by our country to our Armed Forces inevitably dissipate -- and many troops will move on to become very proud and/or perhaps very invisible, lonely and isolated Veterans of One.

“Our government sends us to war, the military uses us in war, and society forgets us after war.” (Scurfield, 2006a, 186).

Unique to combat veterans: our country sends us into harms way and sanctions us to be perpetrators to kill and maim when necessary, and to be killed and maimed, and to put our comrades at risk for the same, and to put civilians in the country in which we are waging war, at the same risk. Unfortunately, core PTSD mental health assessment and treatment interventions almost never significantly address a related core issue of veterans—their relationship with their country, their government, and their communities (Scurfield, 2006a). And when the nation is experienced or perceived by our veterans as having forgotten them, their sacrifices and the sacrifices of their families, this oftentimes is experienced as a profound betrayal (Scurfield, 2006a, 2007a). And so, one of the worst experiences that is most hurtful to veterans: to “be forgotten” or put at the bottom of the nation’s priority list when providing resources.

The greatest casualty of war, in addition to those killed and those physically and psychologically wounded, is to be forgotten. Sadly, universality underlies this issue.

OTHER SALIENT LESSONS LEARNED AND UNLEARNED ABOUT WAR

Front-line combat forces have always been the cannon fodder during war. From “Ulysses”, the movie: "War is young men dying and old men talking. It’s always been that way.”

There is the widely held and mistaken belief that warriors in battle are fighting primarily for their country. Not necessarily. For many combatants, they are fighting primarily for their comrades-in-arms and for their own survival. In the heat of war and battle, nothing matters more—and for a number of combatants, the welfare of their buddies is paramount, even more so than their own welfare. Hence, dynamics and issues within small-unit relationships are infused within the trauma of war and must be addressed in the process of healing.

Western countries continue to justify “conventional” warfare as being much more defensible than an enemy’s guerilla warfare or terrorist acts (Scurfield, 2002; Scurfield et al, 2003). Anyone considered a vilified terrorist in the eyes of one side, is almost always seen as a heroic resistance fighter by the other side, fighting against overwhelming technological superiority of massive and sophisticated amounts of weaponry. Facing such an overwhelming force, of
course the other side will resort to guerilla and/or terrorist acts. For every enemy killed through guerilla warfare, at least two new ones are created (Galloway, 2006). This means that a guerrilla or insurgent war cannot be entirely or even primarily won through killing the enemy; rather, it is the active and passive support of the civilian populace for the guerilla or insurgent forces and/or their being unwilling to be active against those forces that is essential to winning. In this vein—it took until several years after war had begun in Afghanistan and Iraq that key military leaders recognized this lesson from at least a far back as the Vietnam War and that “shock and awe” alone was never going to actually win such a war -- or any war for that matter.

Occupying troops in any foreign land initially may be welcomed as liberators, but the longer they remain, they inevitably will become despised as foreign occupiers. This is not a new phenomenon in Iraq or Afghanistan. It has almost always been this way---throughout history. Perhaps one of the rare exceptions is that I have been told that the U.S. military presence that has continued after the Korean War up until the present still is accepted as necessary and appropriate by a majority of the Korean people and government – although there is very vocal opposition as well.

The extent of the killing and maiming that occurs to the civilian populace in the country in which the U.S. is fighting almost never has any meaningful impact on war policy or on funding decisions. This devaluation of the loss of life among civilians in the country in which we are fighting is utilized to mask the intolerable realities of the full human costs of war (Scurfield, 2002). For example, estimates of the number of Vietnamese killed during the Vietnam War range from 2.4 to more than 3 million—and some 300,000 are still unaccounted for. Was it worth it? (Scurfield, 2006b). And now that ISIS (the Islamic State of Iraq and Syria) is overtaking Iraq after a protracted war that cost thousands more in lives and limbs, the issues are no different in the embittering aftermath of weighing the cost benefit ratio.

For conceptual clarity and organization, additional salient lessons learned and unlearned are grouped into the following categories:

- The Impact of War on Combatants
- Denial and The Minimization of the Impact of War
- Politics, Bureaucracy and the Labeling of Combatants Impacted by War as “Psychiatrically Disorder”
- Families of Service Members and Veterans

**Lessons Learned and Unlearned About The Impact of War on Combatants.**

Various studies of veterans from Vietnam onward reveal that 15 percent to more than 30 percent of war veterans suffer PTSD and/or other major psychiatric problems sometime during and/or following their return
from deployment. This appears to be the human cost of war on Americans—regardless of the war (i.e., Hoge et al, 2006; Kulka et al, 1990; Seal, et al, 2007; Solomon & Mikulincer, 2006).

Numerous studies dating from WW II onward, clearly document a direct linear relationship between the amount of exposure to combat stressors and the likelihood of eventually developing PTSD and/or other mental health problems (i.e., Kulka, 1990; Cozza, 2003). Thus, military personnel whose tours of duty in the war-zone are extended or who are sent back for two or more additional tours in the war-zone are at high risk to eventually develop PTSD, as are troops wounded in a war zone. However, our military personnel and their families are rarely, if ever, told this truth (Scurfield, 2006a). This linear relationship between exposure and mental health problems was confirmed by the third Army mental health survey of Iraq War veterans (Wood, 2006): Soldiers serving repeat deployments reported higher levels of acute stress than those on their first deployment. (See also Seal et al, 2007, who clearly demonstrated that younger age and length of deployment are significant risk factors). A cursory view of returning veterans might yield an estimate for PTSD diagnoses of more than 60 percent for multiple deployers.

For a substantial number of war veterans, the negative impact of war trauma exists for decades: Trauma is literally unforgettable, and so it is useless and counterproductive to encourage or attempt to focus on “helping the veteran to forget” the trauma (see Platoni (2006) for first-person account of Iraq War Zone trauma).

Many PTSD symptoms actually are...
also functional ways to survive in a war-zone, and *many vets do not want to let them go*, as these behaviors may be perceived as conducive to post-war survival back home (Murphy et al., 2006; Scurfield, 2006a), i.e.: detaching from one’s emotions; denying or minimizing the horror of war and what one is seeing and experiencing; hyper-vigilance and exaggerated startle responses.

The profound memories, both the positives and the negatives that are the legacy of war, are ingrained into the veterans’ psyche (Scurfield, 2006a). Scurfield (2004) has described this as a “combat cocktail” in which both remarkable “highs” and devastating lows are inextricably enmeshed together. Thus, many veterans are resistant to relinquish negative memories and their impact because they cannot separate such out from the remarkable positives of the war and military experience—the adrenaline rush, the thrills, the sense of power, the comradeship bonded in war and that frequently span entire lifetimes.

Medical evacuees from a war-zone face a host of stressful and traumatic experiences from the moment they are wounded or injured in the war-zone until long after they are returned stateside (Scurfield, 2006a; Scurfield & Tice, 1992). Most of these experiences are not discussed or adequately addressed—a conspiracy of silence about additional traumas and stressors that many of the wounded experience.

Such trauma and stressors include: directly after being wounded and while still in harm’s way at the immediate scene; through the various stages of the “medevac” process and eventual arrival at a military hospital stateside (this entire process is like a “second deployment” in terms of the trauma experienced), and both the Service Member’s and family members’ reactions initially and later, to include nonsensitive remarks from others back home, i.e., “It’s a shame that you had to lose your legs for nothing.”

What is reinforced and conditioned by military training *and* by military mental health practices in a war-zone include: conditioning about dehumanizing the enemy; teaching and reinforcing denial/suppression/numbing of one’s emotions; denial of the reality of what is actually occurring; “soldiering on” to focus on the mission above all else; and finally, sanctioning the discharging of one’s anger through violence onto the enemy.

However, the military spends *only a fraction* of the time and effort to help military personnel return from war and “unlearn” and “decondition themselves” from being a war-zone combatant (Platoni, 2007). This minimal attention to *deconditioning from being a combatant to being a civilian* has potentially very negative impacts after returning from deployment, in that ingrained combat survival behaviors too often are the *source of significant problems* when trying to readjust to civilian life (Scurfield, 2006a; Scurfield, Platoni & Rabb, 2012).
Singularly traumatic events for combatants include: (a) being wounded; (b) witnessing comrades-in-arms being maimed or killed; (c) feeling somehow responsible for the deaths or maiming of fellow and sister comrades-in-arms; and (d) being involved in the “unnecessary” or “mistaken” killing and maiming of civilians, especially women, children and the elderly (Scurfield, 2006a).

Key issues experienced by a number of Armed Forces personnel have too little -- if any -- attention paid to them in military or civilian mental health assessments or interventions: (a) racism towards the enemy, towards the civilian population and between Americans (Scurfield & Mackey, 2001; Loo et al, 2001; Scurfield, 2006b; (b) sexism and gender-based trauma (i.e., military sexual trauma) by some of our Troops against our own Troops; (c) homophobia (Scurfield, 2006b,c) and (d) command-perpetrated abuse.

For a number of troops, exposure to one or two singularly traumatic experiences, regardless of how long deployed, can be deeply impactful for years or decades to come. Indeed, even when veterans are exposed to innumerable tragic events in the war zone, almost always there are a small number of catastrophic experiences that stand out above all the rest. And it is uncovering and fully addressing those one or two singularly traumatic events that oftentimes become the key to healing from unresolved war-related issues (Scurfield, 2007b).

In longer-term studies of aging veterans of WW II, Korea and Vietnam, a substantial minority of veterans has been found whose PTSD symptoms not only persist over decades but are exacerbated and worsen over time (i.e., Archibald & Tuddenham, 1965; Solomon & Mokulincer, 2006). This seems to be associated with such factors as: loss of employment and/or retirement; increasing health problems; and the increasing frequency of deaths among family and friends; issues that may arise or reappear related to the war, such as spiritual/religious concerns, that are triggered by the impending ending-of-life on this planet (Scurfield, 2006a).

Many military veterans inevitably accept an exaggerated degree of responsibility for every trauma involving them that occurred in the war-zone—versus when a democratic nation goes to war, should not every citizen of voting age bear a share of the responsibility for all that happens during the war? (Scurfield, 2006a; Platoni & Scurfield (2012b) for a detailed description of the “determining the percentages of responsibility” technique to address such issues).

Lessons Learned and Unlearned about Denial and Minimization of the Impact of War.

During any current war, governmental and military authorities inevitably issue highly optimistic reports that the mental health services for this war are unparalleled in our history and are doing a good job to minimize mental health casualties. Even when true, seldom is there mention that the
acute psychiatric casualty rate has absolutely no relationship whatsoever to longer-term psychiatric rates (Scurfield, 2004, 2006a, b). Indeed, the acute psychiatric rate that occurs while in the war-zone and within the first several months following return from deployment is always less than the longer-term rate (Solomon & Mikulincer, 2006; Scurfield, 2006b). Factors contributing to this include reluctance to self-report such by Service Members due to stigma, fear of negative impact on their military careers and the “suck-it-up, soldier-on” military culture that reinforces denial, suppression and minimization of the impact of trauma exposure. This lesson should give national policy makers great cause for concern that the Department of Veterans Affairs (the VA) requires significant funding and staffing to handle not only the needs of our veterans today, but the even greater needs that are almost sure to come tomorrow and the day after...

In spite of the dedicated military mental health providers in the war zone and their heroic efforts to mitigate and minimize the impact of the innumerable traumas that occur, there is no evidence that the military medical mission to “conserve the fighting strength” and the practice to medically evacuate psychiatric casualties out of a war-zone “only as a last resort” but instead to return them to duty as immediately as possible, have any relationship to positive longer-term mental health of the psychiatric casualty (Scurfield, 2004, 2006a).

Everything in the war-zone drives the decision to return a psychiatric casualty to combat and to help combatants to deny and minimize the impact of trauma that they are exposed to. This is understandable vis-a-vis the medical mission and the mission-focus within the military. However, what is not clearly communicated is that this does not necessarily mean that this will be in the best interests of the individual psychiatric casualty. For example, the practice of returning almost all psychiatric casualties to their duty stations as soon as possible, obviously results in their facing yet additional and recurring trauma and thus, becoming at even higher risk for developing PTSD (Scurfield, 2004, 2006a).

Institutional factors contribute to under-reporting of mental health problems and concerns. Politicians and DOD officials will do this to “hype” how well the current war is progressing. And officials of the government, DOD and VA, oftentimes appear more interested in attempting to minimize the truth about the full human impact of war by “blaming” the individual casualty for having war- and post-war related problems---rather than admitting the full extent to which war is the significant etiological factor (Scurfield, 2004, 2006a, 2006b).

War veterans and their families also contribute to the under-reporting of mental health concerns (Scurfield, 2006a, b): lack of trust to confide such to military mental health personnel; fear of stigma or other negative reactions from unit command and peers; fear of damage to one’s military career; and the natural tendency for
trauma survivors to deny to oneself one’s problems in an attempt to put them aside and move on with one’s life.

This denial can work for awhile; the military community is a tight-knit milieu that offers support, resources and camaraderie for both military personnel and their families that simply are not available after being discharged from active duty, particularly as this applies to Reserve and National Guard personnel. The military community reinforces the “suck-it-up, Soldier-on, deal-with-it” mentality to suppress any mental health issues and/or not admit them to anyone; family members and friends also want and typically tell the veteran to “just forget about the war and move ahead with your life. You shouldn’t be bothered by this after all these months (years)”

Lessons Learned and Unlearned About Politics, Bureaucracy and the Labeling of Combatants Impacted by War Trauma as “Psychiatrically Disordered”

Pro-war and pro-military advocates and politicians oftentimes are not pro-veteran adherents (Scurfield, 2004). This is because there always are extremely strong competing priority funding tensions between funding the existing war and extremely expensive technology/military weaponry versus funding programs and benefits for veterans---those who favor funding for expensive technology, weapons, etc., oftentimes are resistant to more funding for veterans’ benefits, health and social programs.

The Secretary, U.S. Department of Veterans Affairs (VA) is a political appointee by the President. Hence, he/she typically is more responsive to current administration policies (i.e., cutting the federal budget except for DOD funding) than being an ardent advocate for veterans’ health, mental health and benefits needs (Scurfield, 2004, 2006a).

Yes, there have been improvements in DOD-VA coordination and interactions. However, overall, there is a remarkable paucity of coordination and collaboration between the DOD and the VA, with a historic prevailing DOD attitude that those who do not perform well, can be discharged “for the VA to take care of.”

There is a remarkable angst created by having a veterans’ benefits system that in effect, financially rewards veterans for having psychiatric disorders, and that punishes them financially if they improve significantly. Indeed, the system in place literally requires that veterans be given psychiatric and/or medical diagnoses to be eligible to receive financial and priority medical services. Unfortunately, this may increase the likelihood of malingerers coming forward as well. This is an extremely powerful dynamic that inevitably inflates the numbers of veterans who are given and who maintain a PTSD diagnosis. Tragically, the pressures to obtain and to keep a PTSD diagnosis in order to qualify for and retain a service-connected disability rating, are enormous and can lead to (a) distorting treatment outcomes and (b) labeling many veterans with a
PTSD or other psychiatric diagnoses who may have a normal and expectable response to war trauma (Scurfield, 2006a).

There are serious problems with the validity and usages of a PTSD diagnosis in terms of being able to differentiate between a “normal” or “expectable” response to trauma versus a “disordered” response – and using a PTSD diagnosis to incorrectly label many veterans as “psychiatrically disordered” who are actually having what should be considered normal and expectable reactions to combat. In turn, veterans contribute to this dynamic—they want and feel that they deserve a disability rating -- but these can only be awarded if they are labeled with a psychiatric disorder.

Ironically, the military recognizes this dynamic much more than the VA does. Military mental health refers to “combat stress reactions” and not the psychiatric disorder of “PTSD” for the vast majority of psychiatric casualties in a war (Scurfield, 2004, 2006a). There also is the growing sentiment that the much less pejorative and arguably the more accurate word “injury” should replace “disorder” in the diagnosis, e.g., post traumatic stress injury or PTSI (www.posttraumaticstressinjury.org).

Politicians, military officials and current active duty personnel all tend to emphasize how different and unique the current war is in comparison to previous wars. This emphasis is used to invalidate an appreciation of the lessons learned from prior wars that are still applicable today and obscures the remarkably powerful universal aspects of all wars (Scurfield, 2006a).

“Politics” and political issues always are extremely important dynamics and stressors that deeply impact on combatants and veterans and hence, need to be an integral element and subject of mental health intervention. Is the country united or divided about the current war? If divided, what is the impact of debates and criticisms “pro-this-war” and “anti-this-war” on our troops and their families during the war and afterwards, Because there always is an impact.

And the troops themselves and veterans always have deeply held political convictions about the rightness or not of this current war. The ramifications on healing are enormous. If a combatant believes strongly in the merits and moral rightness of this war, that belief can help to sustain oneself through the horrors exposed to and committed. Conversely, if while deployed or sometime after deployment one is or becomes against this war or is extremely ambivalent about its rightness, this can be devastating to one’s own rationalizations about how the combatant feels about what had to be done to survive. Such issues must be addressed openly and honestly as a legitimate aspect of therapeutic interventions (Scurfield, 2006a, 2007b).

Lessons Learned and Unlearned About Families of Service Members and Veterans.

Our country, especially to include the VA, provides extremely minimal ser-
vices for the *partners and children* of veterans, e.g., VA work-load credit received is *extremely* minimal for services to family members. This practice completely ignores the fact that *PTSD inevitably is a family and marital relationship problem*, i.e., it is impossible for a veteran to have PTSD and for this not to have a significant negative impact on the partner and children. There is no excuse, other than worries about the financial/budget ramifications, to deny full services to family members who are impacted by their Service Member/veteran who is suffering from PTSD or any other service-connected condition. Ironically, many veterans’ organizations and veterans themselves also are concerned about an “expansion” of such services to family members because of the worry that such, *absent additional funding* for such expansion, will result in a reduction in services to veterans. The single exception is the existence of the Veterans’ Readjustment Counseling Centers (Vet Centers), which are community-based and not part and parcel of standard VA medical benefits, and which do provide services to family members and “significant others”.

There are over 20 important “do’s” and “don’ts” about how to interact with someone who has returned from deployment to a war-zone (Scurfield, 2006a; see also Lyons, 2007). Unfortunately, family members oftentimes learn these only through needless trial and error---or they are never learned. And yet these have been experienced following *all* wars. Family members have the right to be educated about such do’s and don’ts, and our government holds the responsibility to see that this is the case, *before* veterans return from deployment. For example: *never* tell a veteran that “you understand” what he/she went through during war—or afterwards; do *not* say, “Did you kill anybody?”; do *not* take it personally when your veteran does not want to talk about the war with you, or about what he/she is going through now—but that he will talk with fellow and sister Service Members and veterans. There is oftentimes a huge disconnect between those who have served in time of war and the civilian populace, which results in increasing degrees of separation and isolation for the former, while the latter oftentimes remains contentedly clueless and out of touch.
And Still More Lessons Learned and Unlearned

A current war *always* has a significant impact on many veterans of *previous* wars and hence on resources, i.e. media accounts of a current war not infrequently can tear asunder and exacerbate old psychological war wounds. Alternatively, there might be renewed pride and determination that our current Armed Forces will be treated fairly and with full respect and support.

Returning decades later to a land in which a veteran fought can provide powerful post-war healing opportunities not otherwise available (Scurfield et al, 2003, Scurfield, 2004, 2006b regarding healing trips to Vietnam).

For every negative legacy that a veteran brings home after the war, there is a countervailing and potential positive aspect---and vice-versa. For example: (1) “Nothing means nothing anymore” (Scurfield, 2006a: 194) versus -- “A clearer sense of priorities—what is *really* important now.” (2) “Disturbing loss of trust and loss of faith in our nation’s institutions” versus “Development of a very healthy questioning of the motivations and behaviors of those institutions” (Scurfield, 2006a: 195); and (3) “I must be *crazy* to still remember and be bothered by all that happened so many years ago” versus “It is a sign of *health* not to forget and remember what should be remembered about it. And if you and I don’t remember, who will?” (Scurfield, 2006a, 195).

A Whole Other World Out There.

There is one more unlearned lesson that underlies the rationale for a new book edited by the authors, *Healing War Trauma. A Handbook of Creative Approaches* (Scurfield & Platoni, 2013). And that is that “one size does not fit all” – *that there is no one clinical intervention or healing approach that is the end-all treatment equally appealing to and appropriate for all or even most Service Members and veterans.* “Exposure-based” approaches that are widely utilized by the VA are not appealing to – or tolerable for -- many veterans to enter in the first place, and there appears to be a significant drop-out rate from completing the full protocol. Furthermore, many veterans report clear symptom exacerbation through exposure therapies. Additionally, real life does not necessarily accommodate required treatment frequency guidelines.

There is a whole other world out there that says that there is much more to the damage that has been incurred by Service Members and veterans from their war experiences than their *DSM-5* defined PTSD symptoms. Furthermore, *Healing War Trauma* describes just some of the many avenues of interventions that tap into and stimulate the creative, expressive, movement/body/actions, existential, social and religious/spiritual dimensions of war survivors. Our Service Members, veterans and their families have earned the right to have the richest array of healing approaches available, and the right to be able to select approaches that appeal to them and that they are willing and able to participate in sufficiently to gain the peace and joy that they so richly deserve.
REFERENCES


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The American Institute of Stress
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www.stress.org

info@stress.org
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