Meet Me Where I Am..

How the Battle Follows Us Home?

Bio: Michael J. Bruns

- TBI Case Manager-Brookhaven Hospital-Tulsa, OK
- Service Connected Disabled Veteran
- Served in the United States Army (Infantry), Army Reserve (Support), and Wisconsin National Guard (Artillery)
- VA Clinical Training program at the VA National Center for Post Traumatic Stress Disorder (PTSD) (Palo Alto, CA).
- Provider training in Traumatic Brain Injury (TBI), through the Defense and Veterans Brain Injury Center (DVBIC).
- MS Counseling-Mental Health-Missouri State University
- Disable Veterans Case Management-State of Missouri
- Certified Brain Injury Specialist (CBIS)
- Offender Workforce Development Specialist (NIC)

Learning Objectives

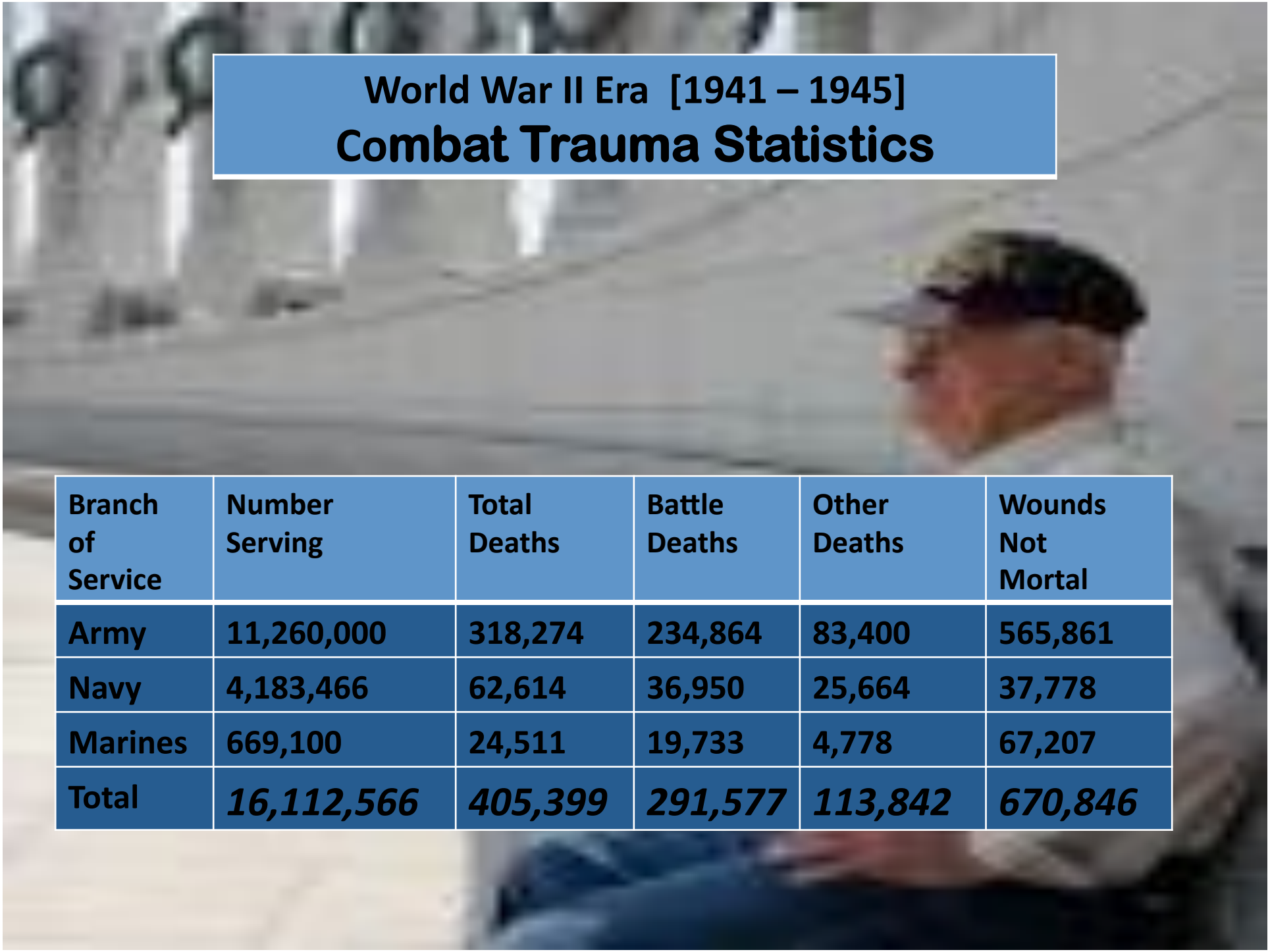
- 1. To learn the differing contributing factors to the sequelae of combat trauma with veterans of WWII, Korea, Vietnam, Persian Gulf War and OEF/OIF.
- 2. To understand the current and evolving needs of combat trauma veterans by war era over the course of their lifespan in regards to PTSD, Brain Injury and co-occurring diagnoses.
- 3. To consider how creating a continuum of care and integration of best practices between the community and veteran supported services is beneficial to the client, their families and the community.


Understanding Veterans from World War II to Present
REEL to REAL

Periods of War WWII to Present

Periods of War	Beginning Date	Ending Date
Gulf War Era	Aug. 2, 1990	Date yet to be prescribed
Vietnam Era	Feb. 28, 1961	May 7, 1975
Korean Conflict	June 27, 1950	Jan. 31, 1955
WWII	Dec. 7, 1941	Dec. 31, 1946
Peacetime	Any dates outside of specified periods of war	Any dates outside of specified periods of war

Conflict	#Serving Worldwide	Total Serving in Theater	Average Days of Combat	Current Living Veterans (As of May 2013)
WWII	16,112,566	*	40	1,711,000
Korea	5,720,000	1,789,000	*180	2,275,000
Vietnam	8,744,000	3,403,000	240	7,391,00
Persian Gulf War	2,225,000	694,550	**20	2,244,583
OEF/OIF			310+	



World War II Era [1941 – 1945]
Combat Trauma Statistics

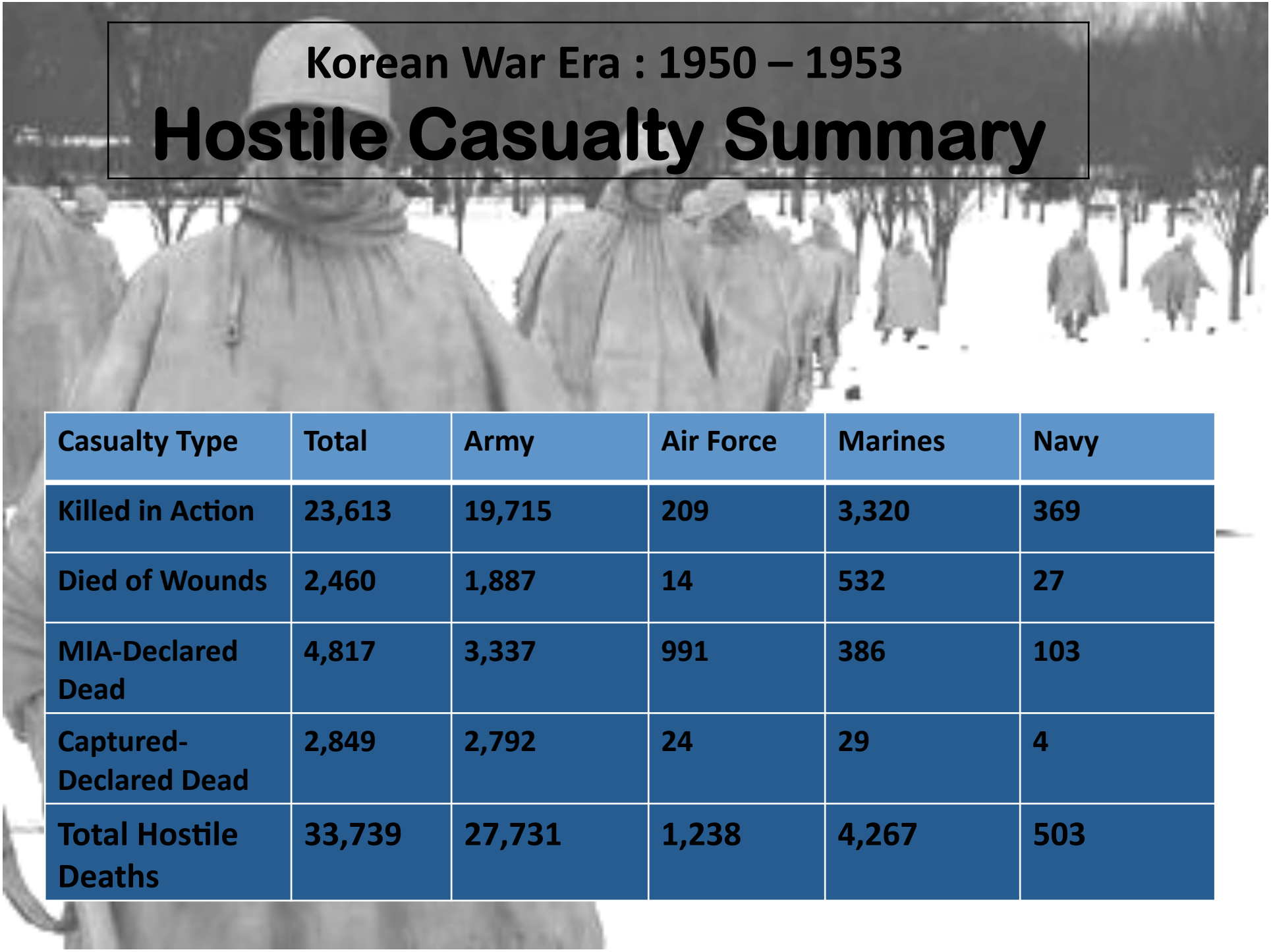
Branch of Service	Number Serving	Total Deaths	Battle Deaths	Other Deaths	Wounds Not Mortal
Army	11,260,000	318,274	234,864	83,400	565,861
Navy	4,183,466	62,614	36,950	25,664	37,778
Marines	669,100	24,511	19,733	4,778	67,207
Total	*16,112,566*	*405,399*	*291,577*	*113,842*	*670,846*


World War II Era : 1941 – 1945
Signature Trauma's
"Combat Fatigue": Anxiety Neurosis, Depressive Neurosis, Melancholia, Anti-social Personality and Schizophrenia.
[35 Years prior to PTSD as a Defined Dx]

World War II Era : 1941 – 1945

Contributing Factors to Combat Trauma

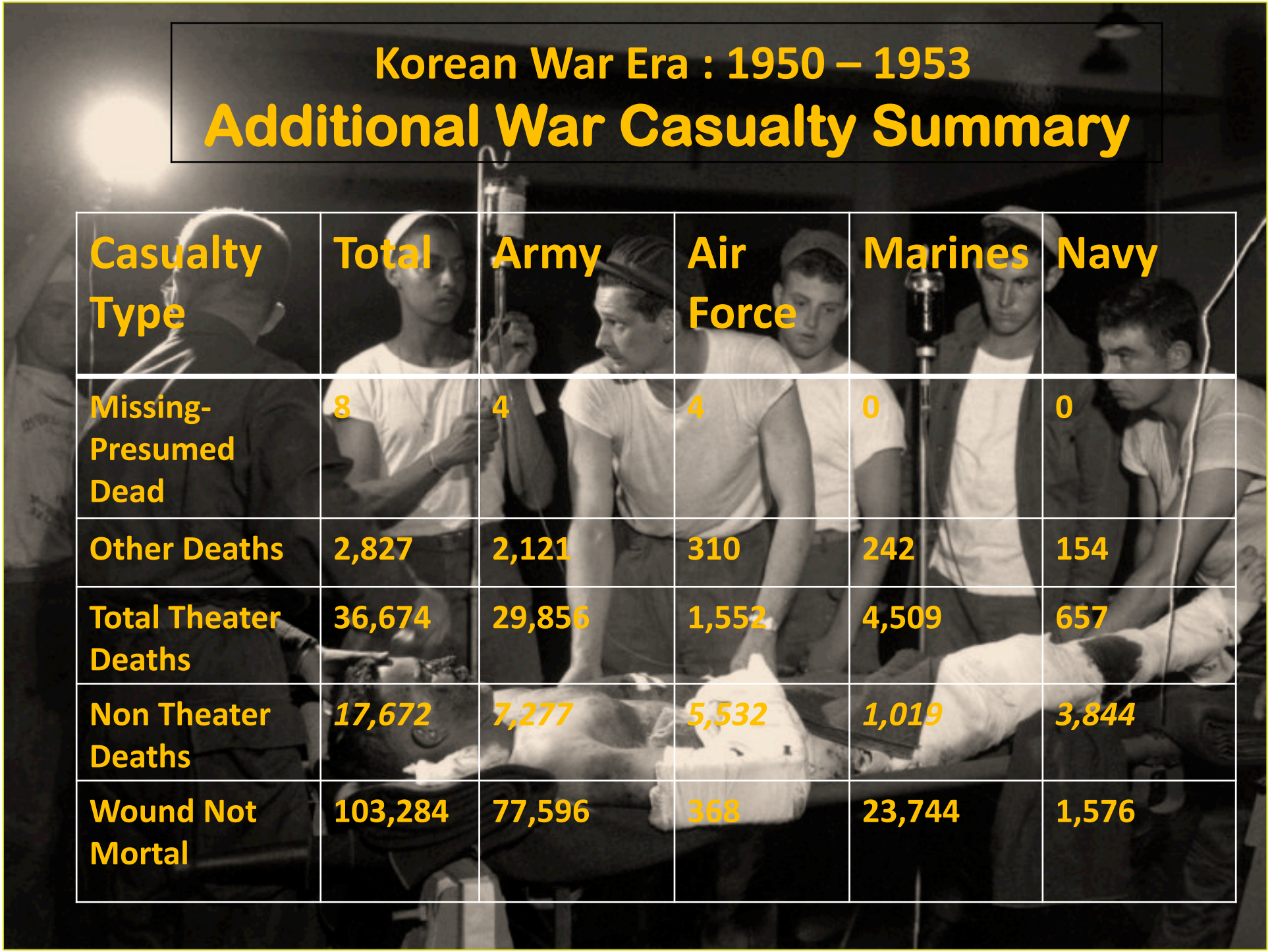
- Multiple Theaters: Africa, SE Asia, Europe, Middle East, Mediterranean
- Deadliest World Conflict in History (50 to 70 million deaths)
- Extreme Weather, Diverse POW Camps, Variety of Infectious Diseases, Battle Field Trauma, Concentration Camp Liberations
- Delayed Onset: Often Mid-Life or Later [Currently High Suicide Risk]



Korean War Era : 1950 – 1953

Hostile Casualty Summary

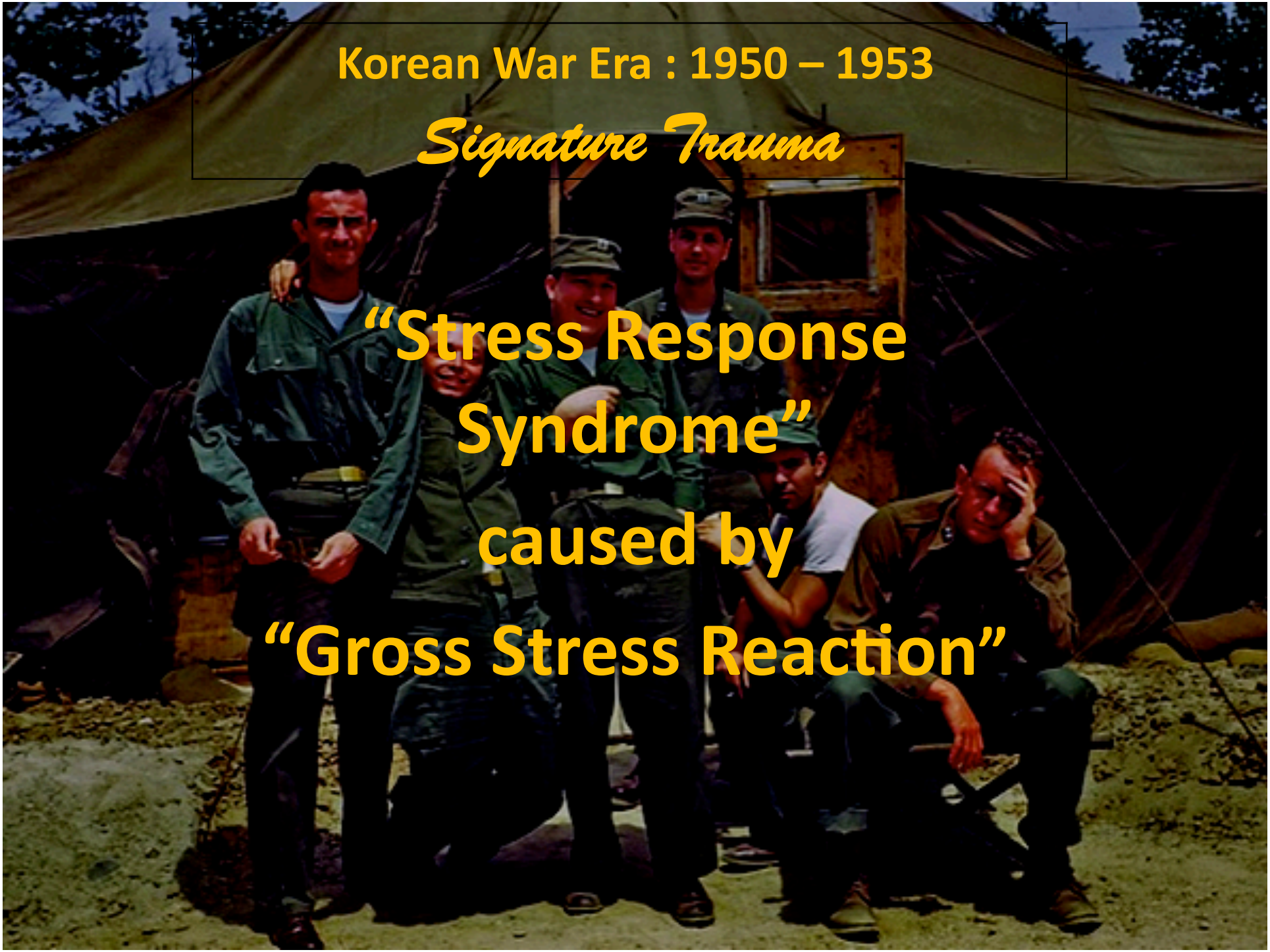
Casualty Type	Total	Army	Air Force	Marines	Navy
Killed in Action	23,613	19,715	209	3,320	369
Died of Wounds	2,460	1,887	14	532	27
MIA-Declared Dead	4,817	3,337	991	386	103
Captured-Declared Dead	2,849	2,792	24	29	4
Total Hostile Deaths	33,739	27,731	1,238	4,267	503



Korean War Era : 1950 – 1953

Additional War Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Missing-Presumed Dead	8	4	4	0	0
Other Deaths	2,827	2,121	310	242	154
Total Theater Deaths	36,674	29,856	1,552	4,509	657
Non Theater Deaths	*17,672*	*7,277*	*5,532*	*1,019*	*3,844*
Wound Not Mortal	103,284	77,596	368	23,744	1,576


Korean War Era : 1950 – 1953
Signature Trauma
“Stress Response Syndrome”
caused by
“Gross Stress Reaction”

Korean War Era : 1950 – 1953

Contributing Factors to Combat Trauma

Extreme Exposure to Cold

Long Term Sequelea to:

Frostbite

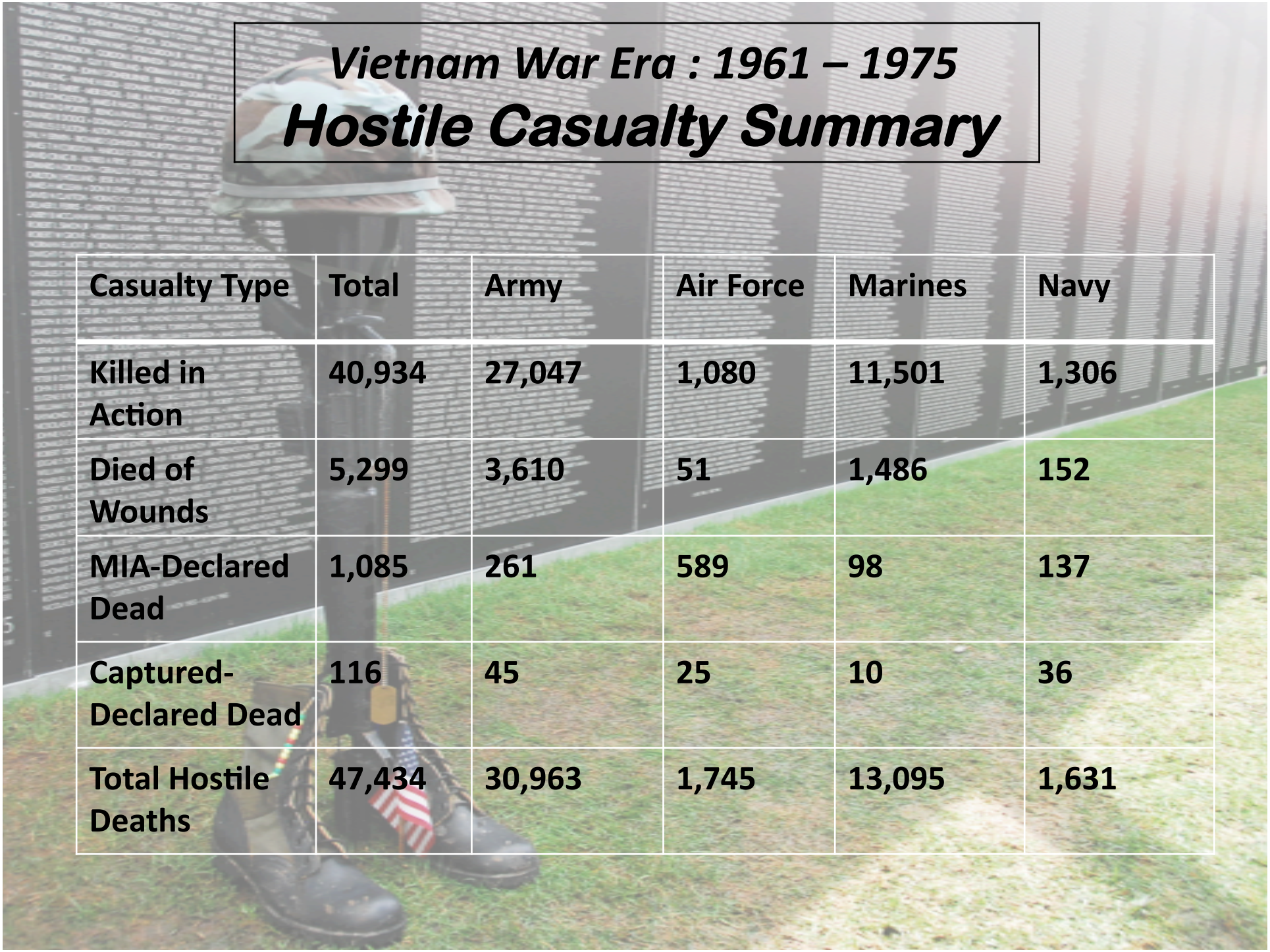
Limb loss

POW mistreatment

Starvation

Korean Forces

Citizenry



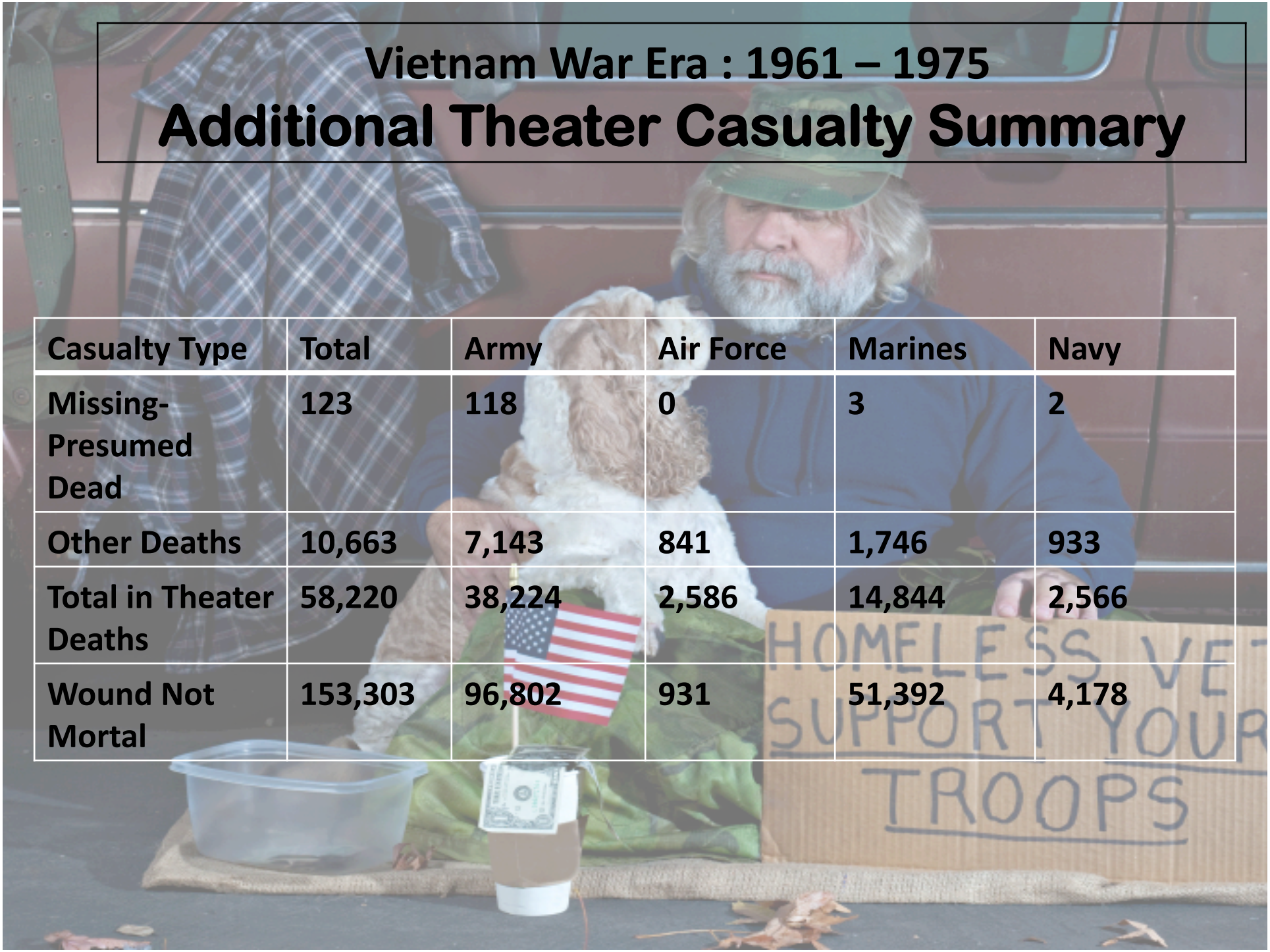
Vietnam War Era : 1961 – 1975
Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Killed in Action	40,934	27,047	1,080	11,501	1,306
Died of Wounds	5,299	3,610	51	1,486	152
MIA-Declared Dead	1,085	261	589	98	137
Captured-Declared Dead	116	45	25	10	36
Total Hostile Deaths	47,434	30,963	1,745	13,095	1,631

Vietnam War Era : 1961 – 1975

Additional Theater Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Missing-Presumed Dead	123	118	0	3	2
Other Deaths	10,663	7,143	841	1,746	933
Total in Theater Deaths	58,220	38,224	2,586	14,844	2,566
Wound Not Mortal	153,303	96,802	931	51,392	4,178



Vietnam War Era : 1961 – 1975

Signature Trauma's

Agent Orange
Other exposures?
Napalm
Malaria, insects, insecticides
Burning trash
Poor hygiene
sanitary conditions
Stress response syndrome
Situational disorders

Vietnam War Era : 1961 – 1975

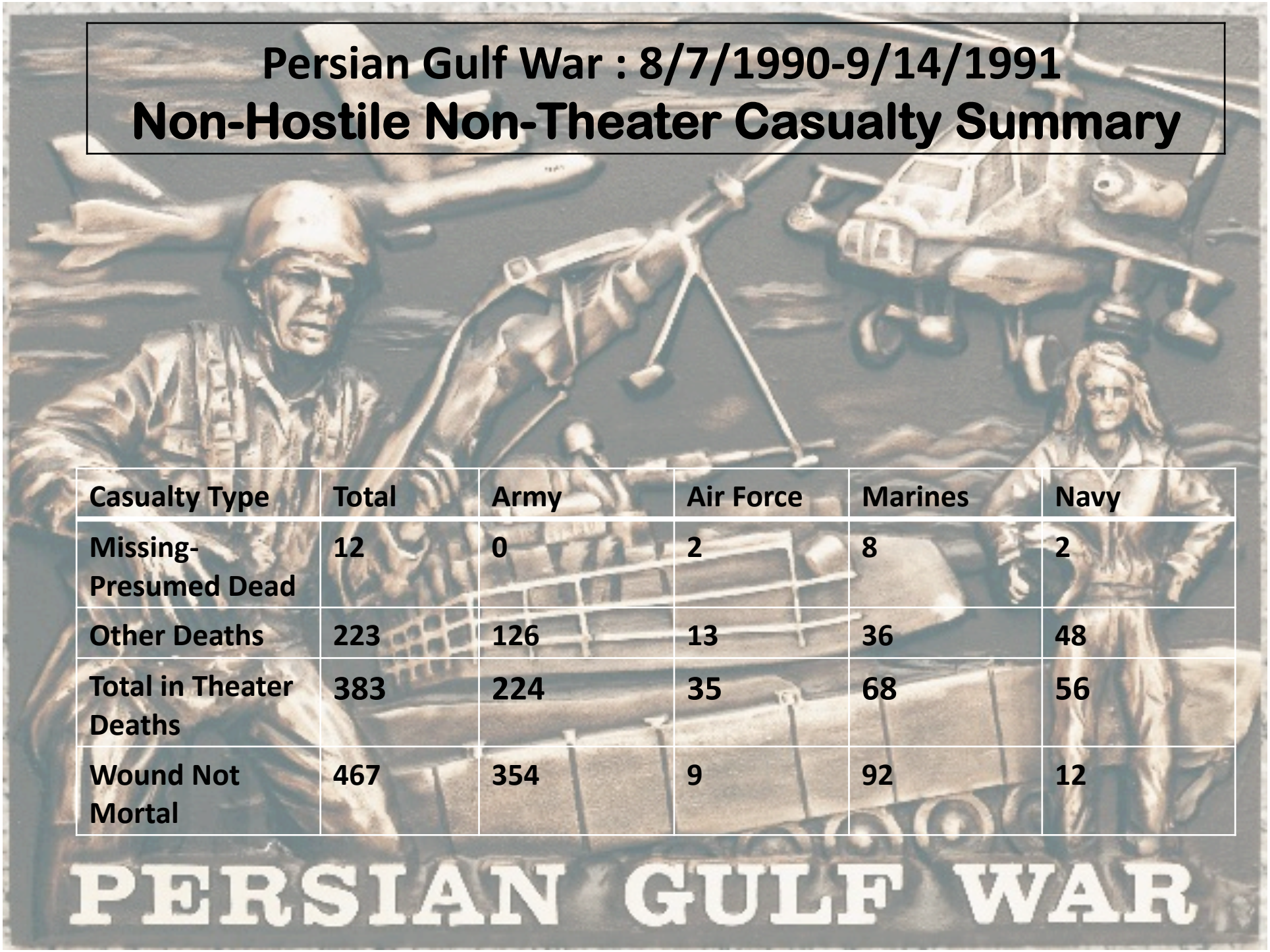
Agent Orange Presumptive List

- Acute and Sub-acute Peripheral Neuropathy
- AL Amyloidosis
- Chloracne
- Chronic Lymphocytic Leukemia
- Hodgkin’s Disease
- Multiple Myeloma
- Non-Hodgkin's Lymphoma
- Porphyria Cutanea Tarda
- Soft tissue Sarcoma
- Prostate Cancer
- Respiratory Track Cancer
- Diabetes Mellitus-Type II
- B Cell Leukemias
- Ischemic Heart Disease
- Parkinson’s Disease
- All sequelae thereof

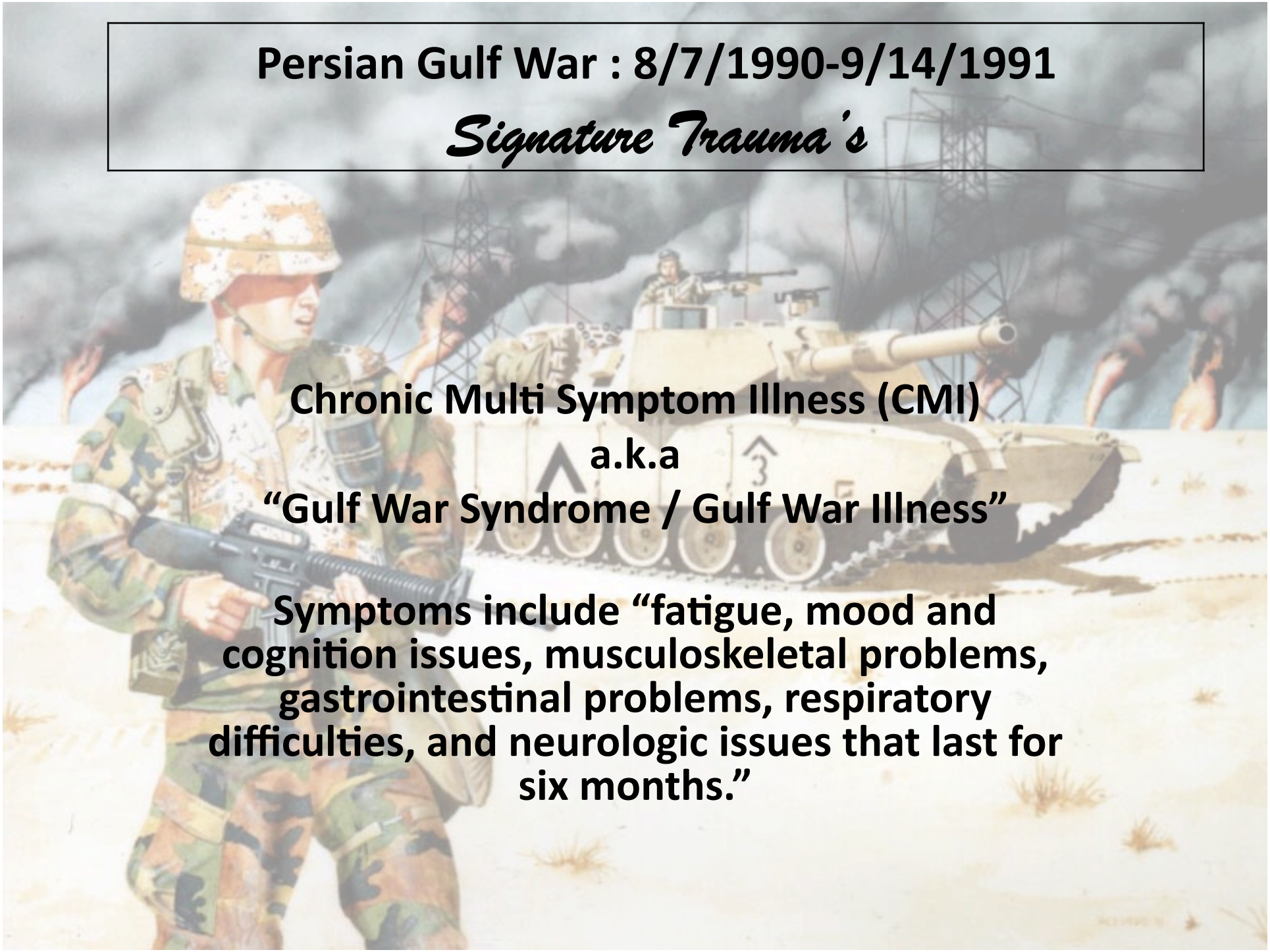
Persian Gulf War : 8/7/1990-9/14/1991
Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Killed in Action	144	96	20	22	6
Died of Wounds	4	2	0	2	0
MIA-Declared Dead	0	0	0	0	0
Captured-Declared Dead	0	0	0	0	0
Total Hostile Deaths	148	98	20	24	6

Persian Gulf War : 8/7/1990-9/14/1991
Non-Hostile Non-Theater Casualty Summary



Casualty Type	Total	Army	Air Force	Marines	Navy
Missing-Presumed Dead	12	0	2	8	2
Other Deaths	223	126	13	36	48
Total in Theater Deaths	383	224	35	68	56
Wound Not Mortal	467	354	9	92	12



Persian Gulf War : 8/7/1990-9/14/1991

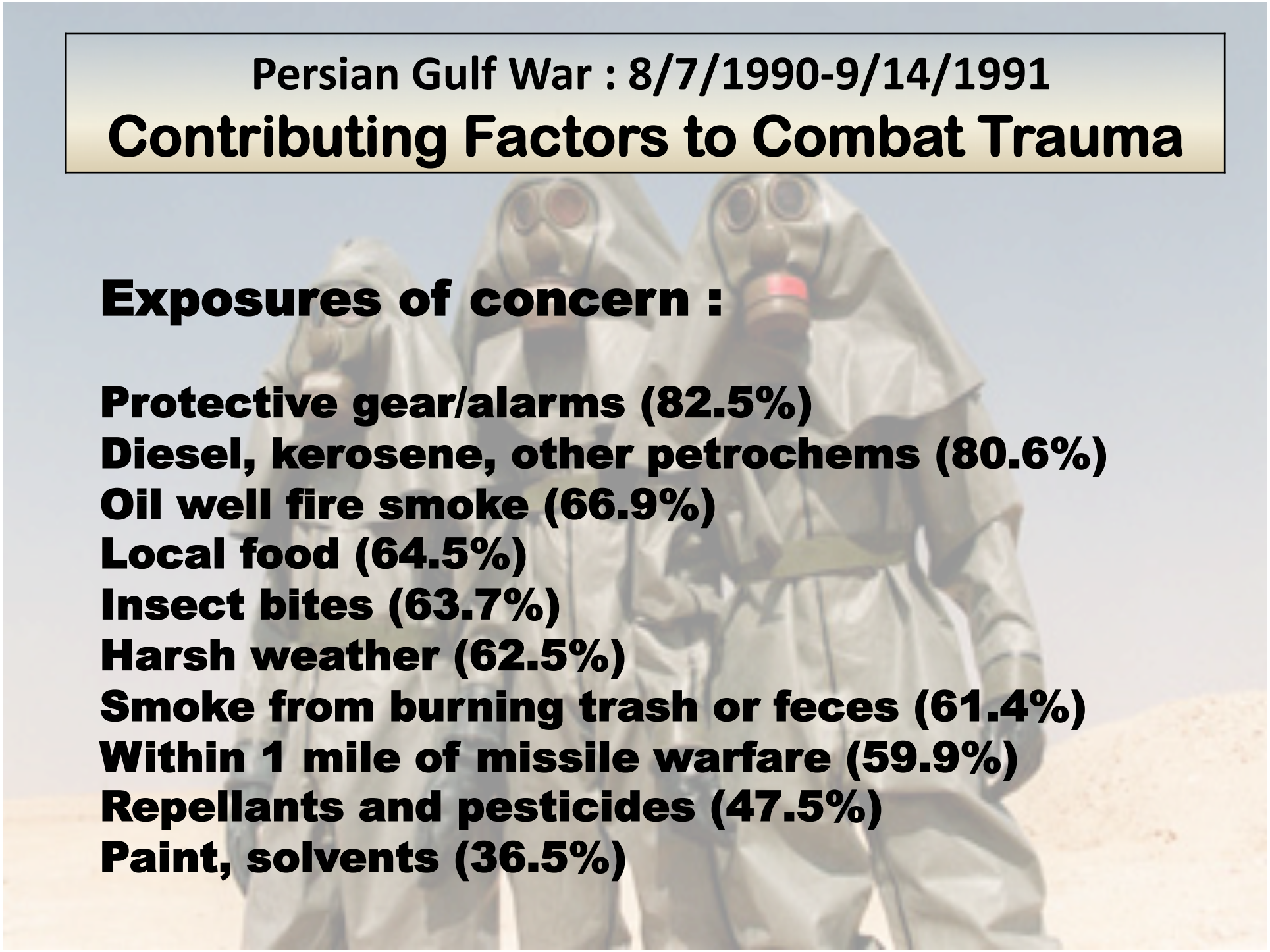
Signature Trauma's

Chronic Multi Symptom Illness (CMI)

a.k.a

"Gulf War Syndrome / Gulf War Illness"

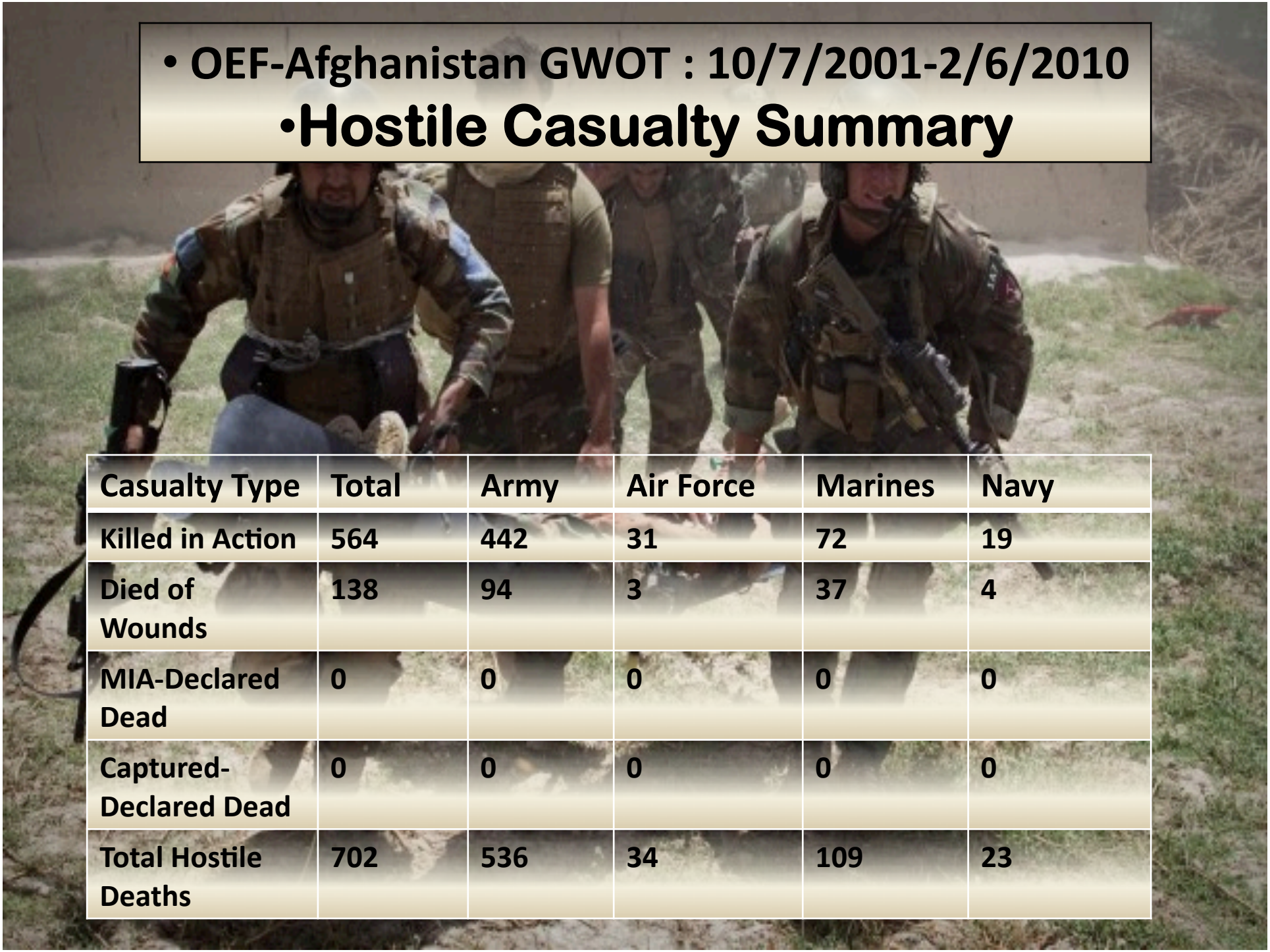
Symptoms include "fatigue, mood and cognition issues, musculoskeletal problems, gastrointestinal problems, respiratory difficulties, and neurologic issues that last for six months."



Persian Gulf War : 8/7/1990-9/14/1991
Contributing Factors to Combat Trauma

Exposures of concern :

Protective gear/alarms (82.5%)
Diesel, kerosene, other petrochems (80.6%)
Oil well fire smoke (66.9%)
Local food (64.5%)
Insect bites (63.7%)
Harsh weather (62.5%)
Smoke from burning trash or feces (61.4%)
Within 1 mile of missile warfare (59.9%)
Repellants and pesticides (47.5%)
Paint, solvents (36.5%)



• OEF-Afghanistan GWOT : 10/7/2001-2/6/2010
•Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Killed in Action	564	442	31	72	19
Died of Wounds	138	94	3	37	4
MIA-Declared Dead	0	0	0	0	0
Captured-Declared Dead	0	0	0	0	0
Total Hostile Deaths	702	536	34	109	23

OEF-Afghanistan GWOT : 10/7/2001-2/6/2010

Non-Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Accidental Deaths	177	122	9	28	18
Illness	28	16	7	3	2
Homicide	10	9	0	1	0
Self-Inflicted	35	27	3	3	2
Undetermined	*21*	*14*	*1*	*5*	*1*
Total Non-Hostile Deaths	271	188	20	40	23

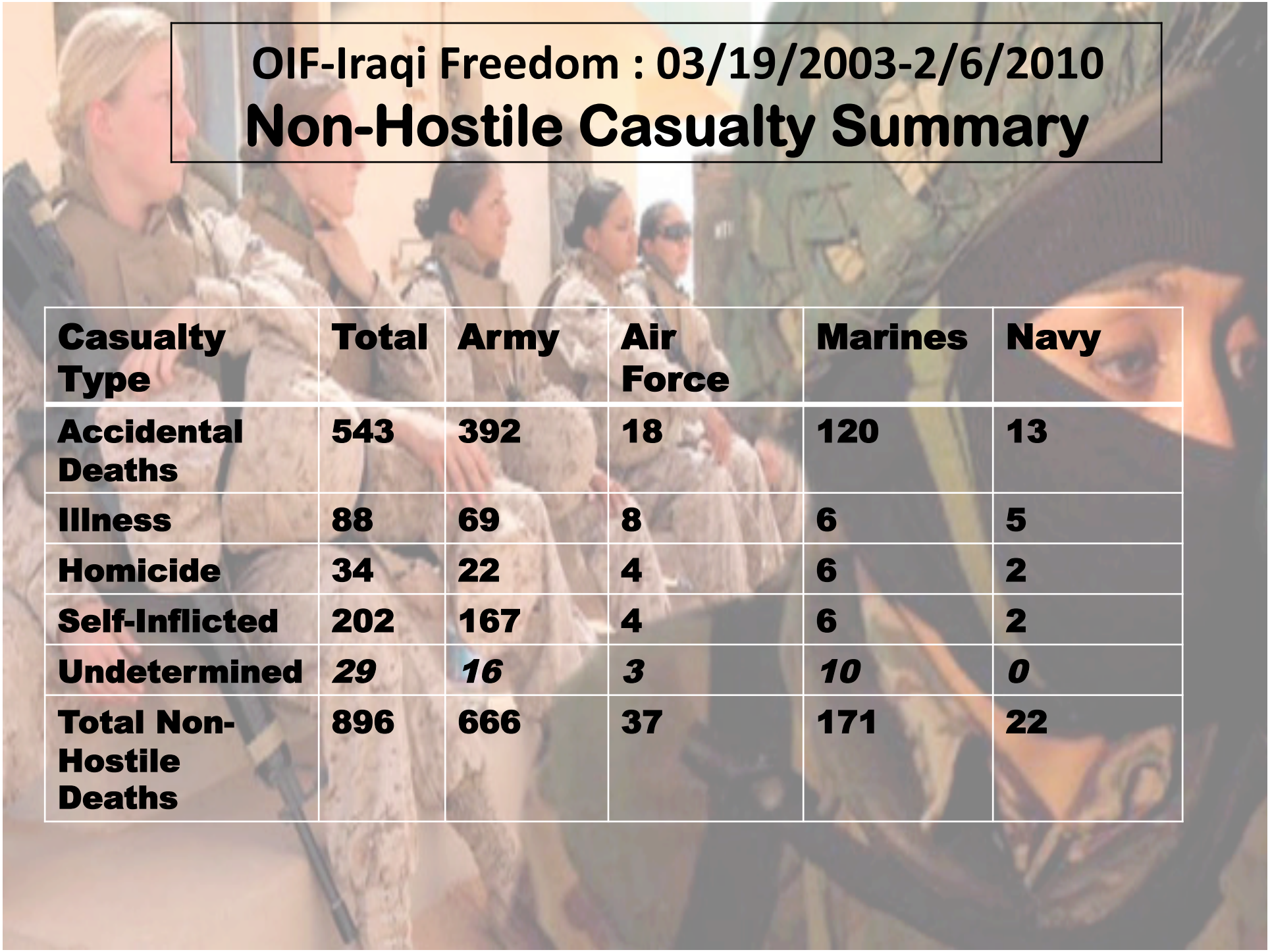
Casualty Type	Total	Army	Air Force	Marines	Navy
Wounded –No Medical Air Transport Required	3303	2341	44	571	77
Wounded AirTransport	1916	1469	46	340	61
Total in Theater WIA	4949	3810	90	911	138
Non-Hostile Injuries	*2276*	*1626*	*131*	*231*	*288*
Disease / Other	6762	5074	325	393	970

OEF-Afghanistan GWOT : 10/7/2001-2/6/2010

Hostile and Non-Hostile Injury Summary

OIF-Iraqi Freedom : 03/19/2003-2/6/2010
Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Killed in Action	2664	1908	63	664	29
Died of Wounds	793	604	2	187	0
MIA-Declared Dead	7	7	0	0	0
Captured-Declared Dead	5	5	0	0	0
Total Hostile Deaths	3469	2524	65	851	29



OIF-Iraqi Freedom : 03/19/2003-2/6/2010
Non-Hostile Casualty Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Accidental Deaths	543	392	18	120	13
Illness	88	69	8	6	5
Homicide	34	22	4	6	2
Self-Inflicted	202	167	4	6	2
Undetermined	*29*	*16*	*3*	*10*	*0*
Total Non-Hostile Deaths	896	666	37	171	22

OIF-Iraqi Freedom : 03/19/2003-2/6/2010
Hostile and Non-Hostile Injury Summary

Casualty Type	Total	Army	Air Force	Marines	Navy
Wounded –No Medical Air Transport Required	22754	15305	472	6649	328
Wounded –Medical Air Transport Required	8897	6665	161	1974	97
Total in Theater Wounded In Action	31651	21970	633	8623	425
Non-Hostile Injuries Medical Air Transports	9921	7770	380	1306	465
Disease / Other Medical Air Transports	28406	23992	1028	2003	1453

Iraq (OIF)/Afghanistan (OEF)

Signature Trauma's

Post Traumatic Stress Disorder (PTSD)

Traumatic Brain Injury (TBI)

Chronic Multi Symptom Illness (CMI)

Iraq (OIF)/Afghanistan (OEF)
Contributing Factors to Combat Trauma

IEDs, Snipers

Exposures
Weather/cold heat
Sand
Noise
Blasts
Smoke from trash
Vehicle exhaust
Jet propellant 8 (JP8)
or other fuel

When The Nightmare Finds You 50 Years Later

- The Korean War Vet


The Fallouts of
Combat Trauma

All wars have the same post-combat health problems

- physical injuries with residual pain
- diagnosable mental health conditions
- unexplained symptoms with general health decline
- hearing problems
- dental problems
- psychosocial distress: marriage/ work/social disruption
- post-war death/injury from "incidental trauma"

http://www.dcoe.mil/content/Navigation/Documents/Hunt%20-%20Integrated%20Care%20Integrative%20Care.pdf;
Stephen C. Hunt MD MPH; National Director, VA Post-Deployment Integrated Care Initiative

Physical Stressors of War

- Injury
- Noise
- Temperature
- Sleep
- deprivation
- Diet
- Austere conditions
- Toxic agents
- Infectious agents
- Multiple immunizations
- Blast wave/head injury

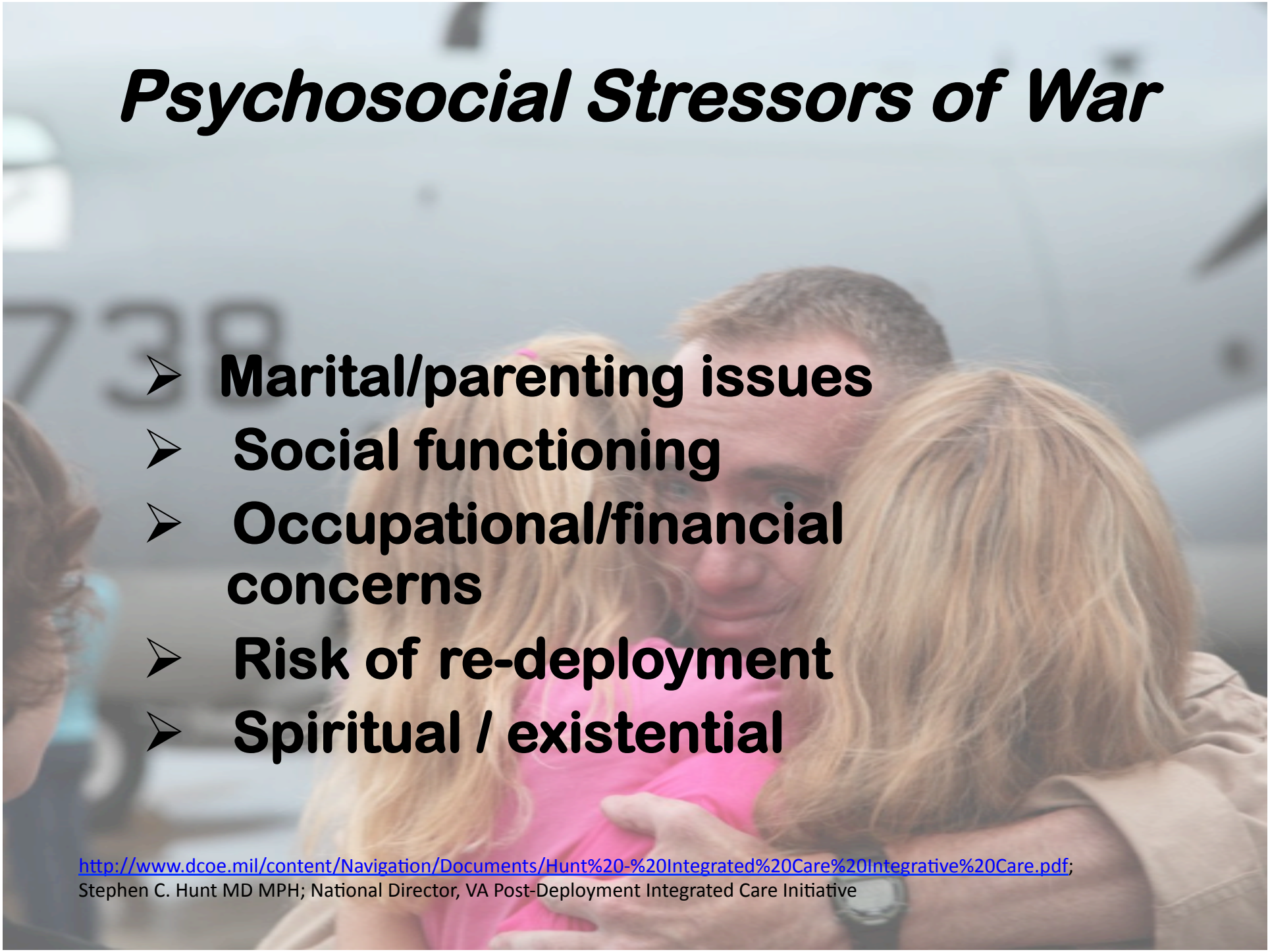
http://www.dcoe.mil/content/Navigation/Documents/Hunt%20-%20Integrated%20Care%20Integrative%20Care.pdf;
Stephen C. Hunt MD MPH; National Director, VA Post-Deployment Integrated Care Initiative

Psychological Stressor of War

- **Anticipation of combat**
- **Combat trauma**
- **Non-combat trauma**
- **Separation from family/home**
- **Deprivation**

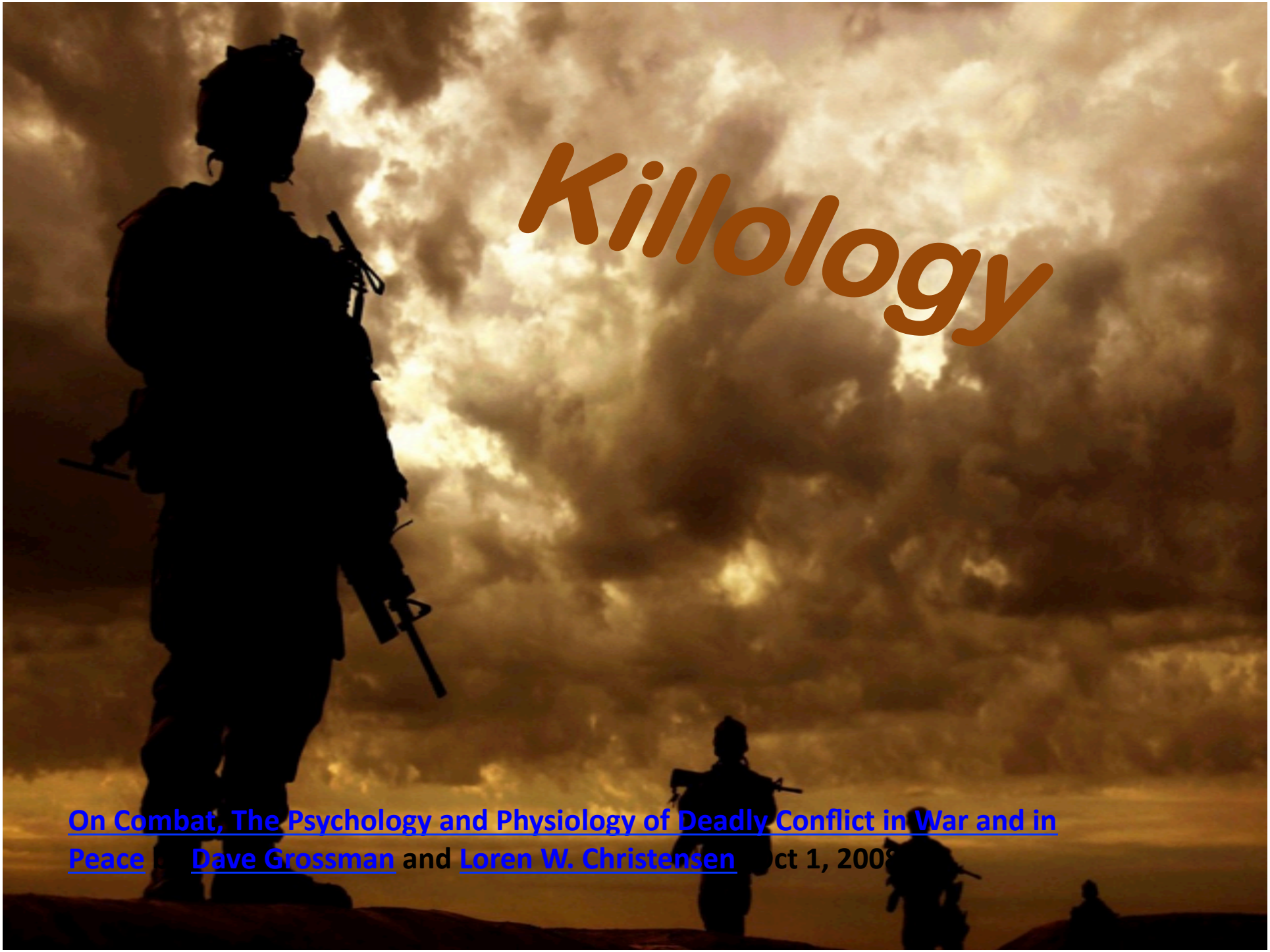
http://www.dcoe.mil/content/Navigation/Documents/Hunt%20-%20Integrated%20Care%20Integrative%20Care.pdf;
Stephen C. Hunt MD MPH; National Director, VA Post-Deployment Integrated Care Initiative

Psychosocial Stressors of War



- **Marital/parenting issues**
- **Social functioning**
- **Occupational/financial concerns**
- **Risk of re-deployment**
- **Spiritual / existential**

http://www.dcoe.mil/content/Navigation/Documents/Hunt%20-%20Integrated%20Care%20Integrative%20Care.pdf;
Stephen C. Hunt MD MPH; National Director, VA Post-Deployment Integrated Care Initiative


Killology
On Combat, The Psychology and Physiology of Deadly Conflict in War and in Peace Dave Grossman and Loren W. Christensen ct 1, 200

The Impact of Killing

"One important event that is not addressed as directly as it should be is Killing. Killing the enemy is what a warrior is train to do, and success in this, like any other occupational success can be gratifying"

* Col. Charles W. Hoge, Once a Warrior, Always a Warrior (2010)

To Kill or not to Kill

This is a very hard decision for a soldier to make and a great many factors can influence the soldiers ability to kill his fellow man.

Most sane humans, if given the choice, will not kill their fellow man and are extremely reluctant to do so, despite what Hollywood would like you to believe. **When they are forced to do so, many can experience a great deal of psychological trauma.**

* **It is interesting to note that most kills in war are from artillery or other mass destruction type weapons.**

To Kill or not to Kill-WWII

In World War Two, it is a fact that only 15-20 percent of the soldiers fired at the enemy.

In WW2 only one percent of the pilots accounted for thirty to forty percent of enemy fighters shot down in the air. Some pilots didn't shoot down a single enemy plane..

While this rate may have increased in desperate situations, in most combat situations soldiers were reluctant to kill each other.

To Kill or not to Kill - Korea

In Korea, the rate of soldiers unwilling to fire on the enemy decreased and fifty five percent of the soldiers fired at the enemy.

In Vietnam, this rate increased to about ninety five percent.

.. but this doesn't mean they were trying to hit the target. It usually took around fifty-two thousand bullets to score one kill in regular infantry units in Vietnam!

The Impact of a Soldiers Perceptions of *Distance to Killing..*

- **Emotional distance** allows a person to kill at closer ranges and allows him to justify it more easily.

- **Cultural distance** is defined as viewing the enemy as an inferior life form. The enemy is dehumanized and considered inferior.

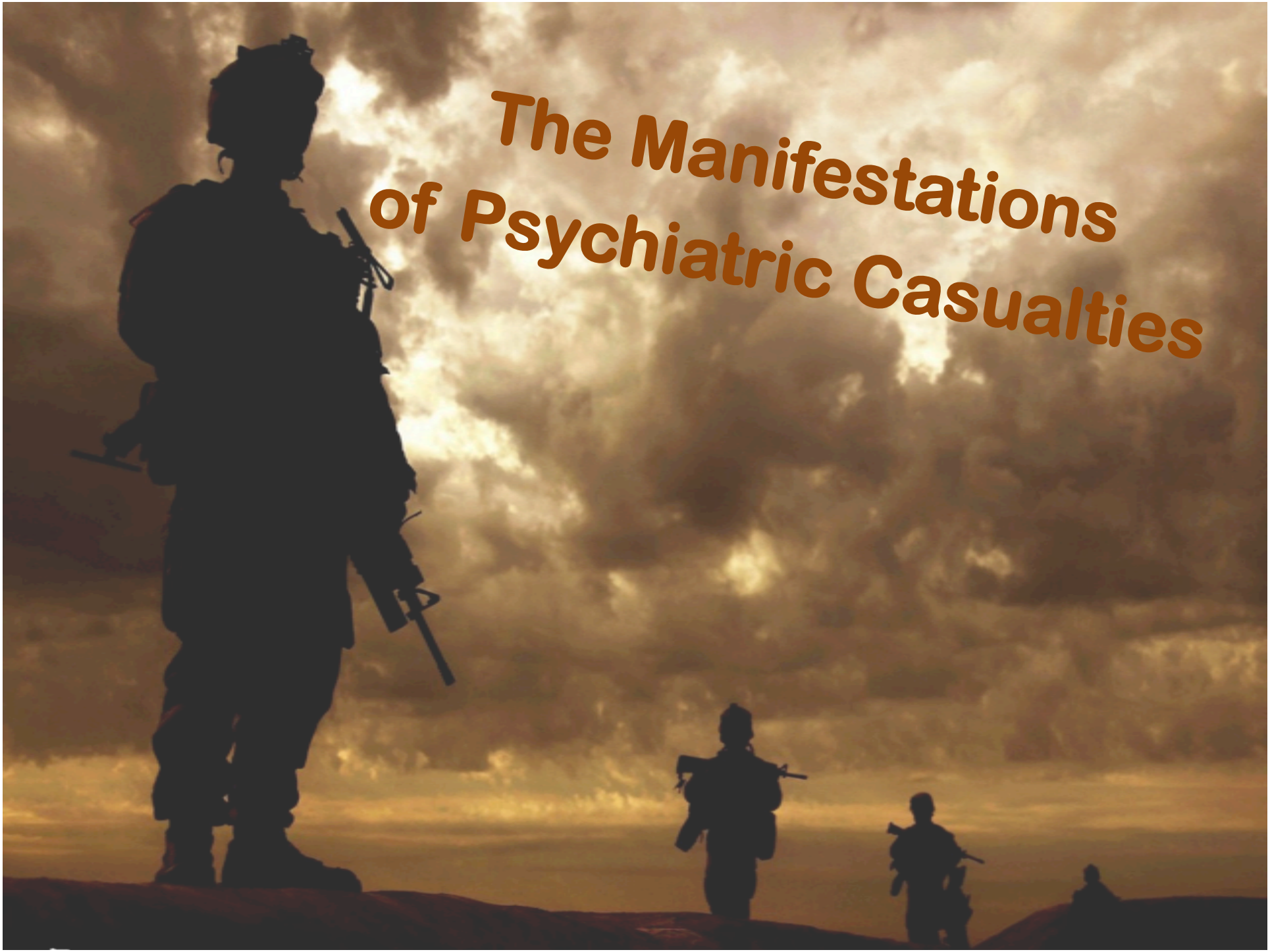
- **Moral distance** is classifying the enemy as morally wrong.
- Social Distance is a form of classifying others as lesser beings.

- **Mechanical distance** is viewing the enemy through some device like a scope or on a screen. It allows the killer to dehumanize the target.

He Wants To Go Back to the Battle…

"Is He Nuts?"

- The Warrior Archetype


The Manifestations
of Psychiatric Casualties

Psychiatric Casualties

A psychiatric casualty from a combat situation can manifest in different forms and various degrees.

Psychiatric Casualties

Fatigue

- Fatigue: Best described as the soldier becoming 'tired' and is unwilling to do anything.
- He/She doesn't want to associate with friends or participate in any physical or mental activity or responsibility.
- He/She may be subject to sensitivity to loud noises, crying spells or fits of anxiety. In many ways all he/she wants to do is vegetate but he/she is subject to mood swings.

Psychiatric Casualties

Confusion

- Confusion States: psychiatric casualty **begins to lose track of time, place,** and cannot deal with his environment.
- Fatigue can quickly shift into this state and become psychotic.
- Some symptoms include **delirium, psychotic dissociation, and manic-depressive mood swings**.
- Another possible effect is called the **Ganzer Syndrome.** When a psychiatric casualty suffers from Ganzer syndrome he will make jokes, act silly , **avoids the horror and fear with humor**.

Psychiatric Casualties

Hysteria

- Conversion Hysteria can happen during combat or years later. This is a severe form of the Confusion state.
- The sufferer loses all touch with reality and may wander around regardless of dangers, like mines, enemy snipers, ect.
- The soldier may ball up into the fetal position and try to deny his surroundings or shake violently.
- Large portions of a person's memory may be blocked out to protect the conscious mind from the horror.
- Another possibility is a certain portion of a person's body may not function, like the arm that pulls the trigger.
- Conversion Hysteria can appear in a soldier post TBI.

Psychiatric Casualties

Anxiety

- No matter how much sleep or rest he gets he is always tired.
- Dreams may be plagued by nightmares and the soldier may become obsessed with death.
- Begins to fear he/she may be a coward, might fail comrades or others might find out he/she is a coward.
- Some of the symptoms of anxiety are shortness of breath, weakness, pain, blurred vision, giddiness, temporary paralysis and fainting.
- PTSD: Years after combat the soldier's blood pressure may rise dramatically along with sweating, nervousness and so on.

Psychiatric Casualties

Obsessive / Compulsive

- Obsession and Compulsive States are like Conversion Hysteria except the soldier is more aware of what is going on.
- The soldier understands that fear is causing everything but he cannot do anything about it.
- This can be manifested by uncontrollable tremors, palpitations, stammers, tics and so on.
- After a while the soldier may find some kind of hysteria that allows him to escape psychic responsibility for the physical symptoms.

Psychiatric Casualties

Character

- Character Disorders: a soldier becomes fixated on certain actions or things.
- Paranoia may include irascibility, depression and anxiety about his personal safety.
- Schizoids become hypersensitive and prefer to be alone.
- Epileptoids become more prone to violent and sometimes unpredictable rages.
- Some become obsessed with religion and some become psychotic.
- The essence a person's very character changes.

Psychiatric Casualties and Suicide Are Not Exclusive to the Battlefield

- The Chaplain's Assistant


The Realities of
Combat Trauma


FIGHTING


friends
DREAM
HELP
help
medical
team
HEALTH
TEAM
concussion
SERVICEMEMBERS
TBI
health
dream
HELP
service
faith
dream
team
brain injury
TREATMENT
HEALTH
NEUROCOGNITIVE
treatment
TBI
friends
pain
TBI
TEAM
family
mild
faith
treatment
severe
FAITH
faith
TBI
TEAM
pain
dream
TBI
faith
reintegration
recovery
pain
concussion

Veteran Suicides

PHOTO: MARK WILSON/GETTY IMAGES


Veterans
with Military
Sexual Trauma
warriors in a battle that has no name


HOMELESS
VETS

The Moral / Spiritual Wounds

Life Changing MST

- Vietnam Veteran Western MO


The Personal
Barrier's to Seeking
Treatment

Fear of Losing Their Career .....

"Off the record, can I get your ear for a second?'"

Stigma of Seeking Care

***What will my buddies think?**

***How will this effect my security clearance?**

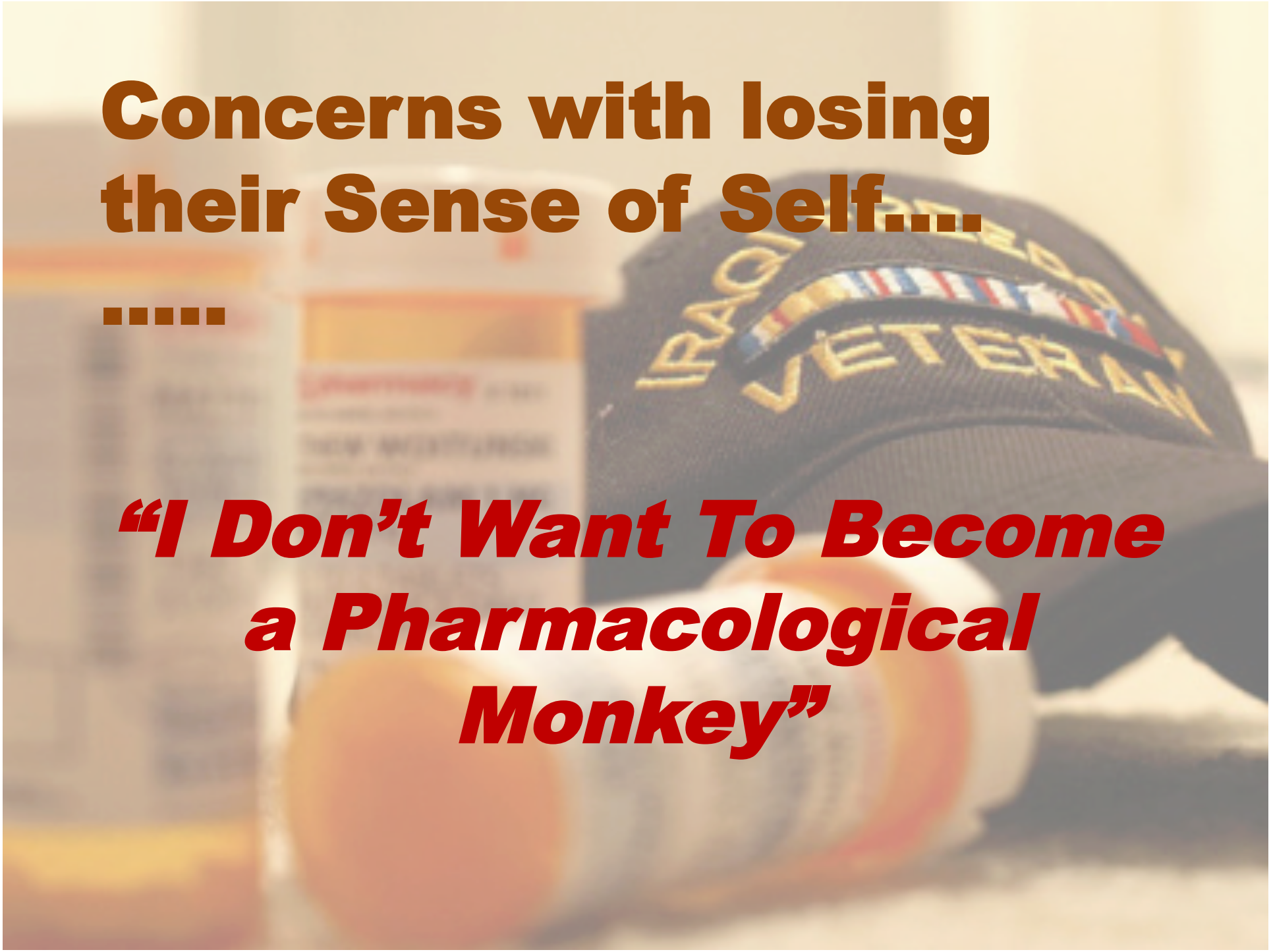
*** How will my senior command react?**

http://www.realwarriors.net

Toxic Leadership….

The toxic leader operates with an inflated sense of self-worth and from acute self-interest. Toxic leaders consistently use dysfunctional behaviors to deceive, intimidate, coerce, or unfairly punish others to get what they want for themselves.

http://www.forbes.com/sites/darwinatwork/2014/01/10/toxic-leaders-and-the-social-environments-that-breed-them/

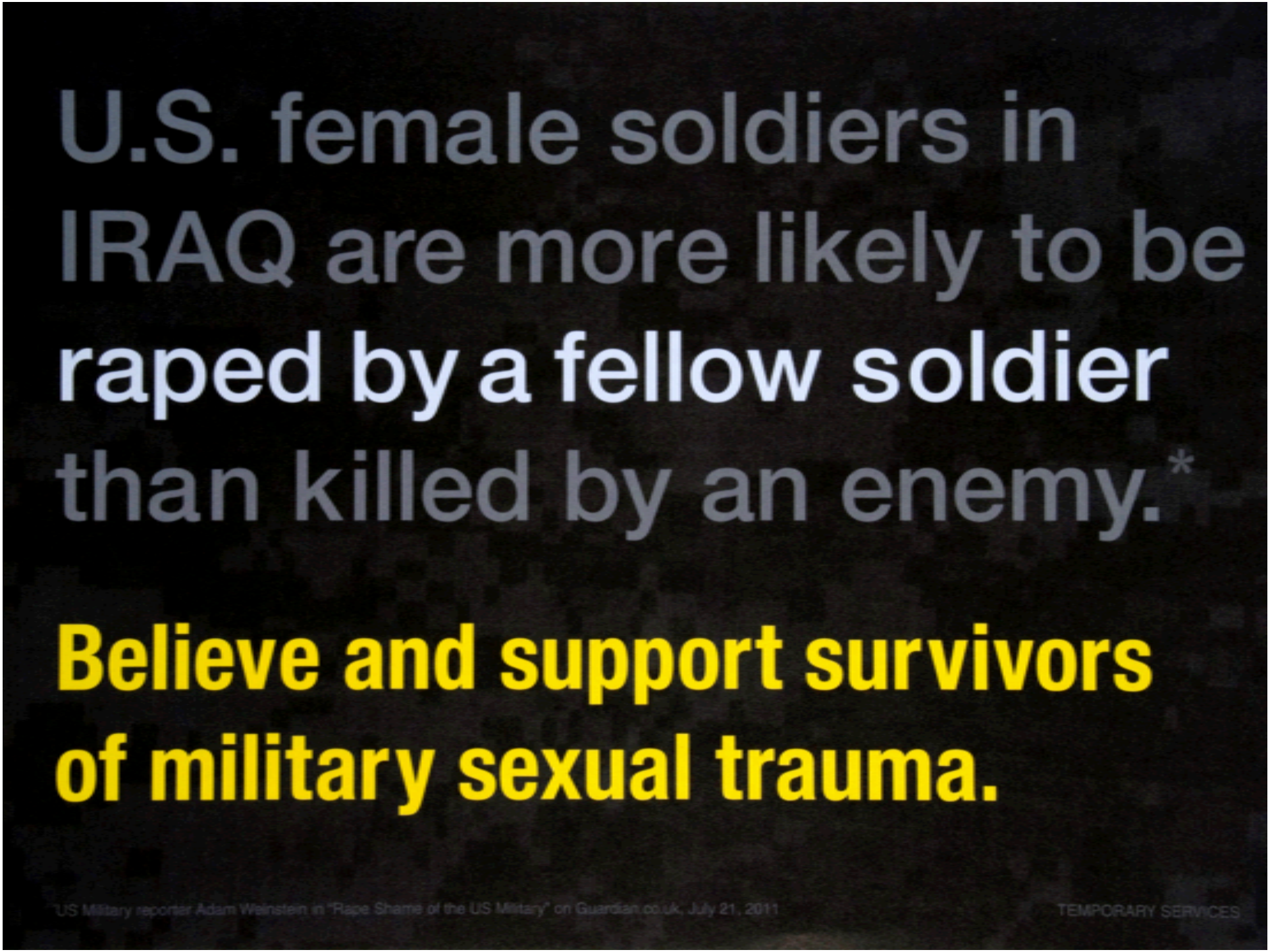


Concerns with losing their Sense of Self....

.....

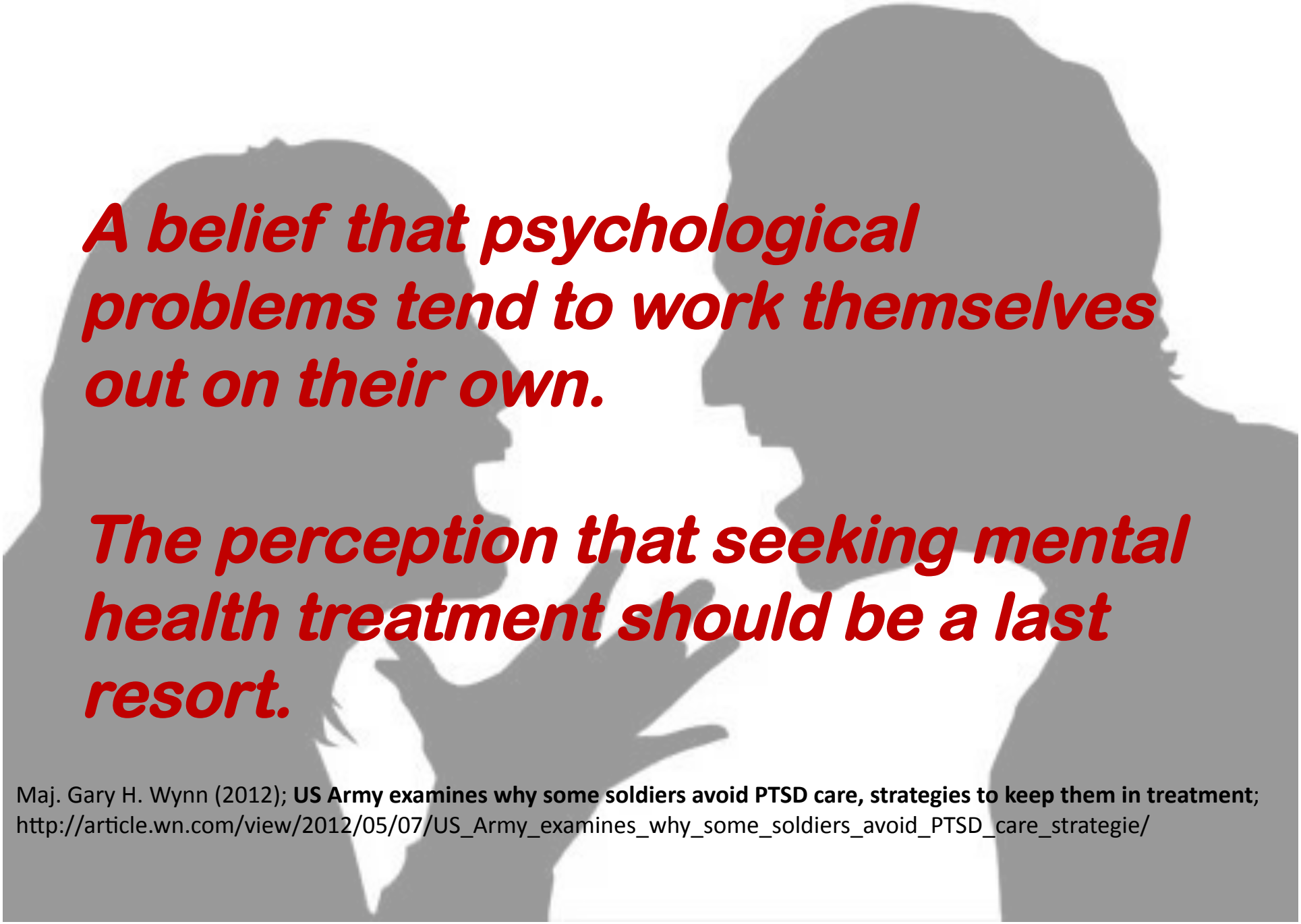
"I Don't Want To Become a Pharmacological Monkey"

History of Not Being Heard…..


U.S. female soldiers in IRAQ are more likely to be raped by a fellow soldier than killed by an enemy.*
Believe and support survivors of military sexual trauma.
*US Military reporter Adam Weinstein in "Rape Shame of the US Military" on Guardian.co.uk, July 21, 2011
TEMPORARY SERVICES

Missed Communications in Therapy…..

"I Can't Believe Someone Could Experience All of That…."



A belief that psychological problems tend to work themselves out on their own.

The perception that seeking mental health treatment should be a last resort.

Maj. Gary H. Wynn (2012); **US Army examines why some soldiers avoid PTSD care, strategies to keep them in treatment**; http://article.wn.com/view/2012/05/07/US_Army_examines_why_some_soldiers_avoid_PTSD_care_strategie/

#1 Reason: Absence of Trust for any type of mental health and wellness Professional…..

Maj. Gary H. Wynn (2012); **US Army examines why some soldiers avoid PTSD care, strategies to keep them in treatment**; http://article.wn.com/view/2012/05/07/US_Army_examines_why_some_soldiers_avoid_PTSD_care_strategie/

Are You Really What Your Diagnosis Says You Are?

- Dual Dx Group Experience


Understanding
the Warrior

Warrior Values & Norms

- It's not about the self – it's about the team and the mission.
- Status comes, not from being rich or well-educated or good-looking (things most 20 year olds have no control over) but from behaving with courage and watching out for others (acquired behavior).
- It's not about feelings; it's about actions.
- Humility and understatement are expected. Self dramatizing, boasting, faking, overstating gets you nowhere (or worse).
- Same with getting caught up with your own authority or hiding behind your official status or professional role.
- Informality, slang and swearing are OK with line soldiers, lance corporals; not so much with commanding officers.

http://www.future-artillery.com/Media/8588/15343.pdf

Warrior Values & Norms

(Continued)

- Flexibility, change, speed, reassignments are expected. Mulling, pondering, indecision – not so much.
- Speak to the point. Say what you mean. Then stop talking.
- Take your lumps without whining or making excuses.
- Be gracious, give credit to others for successes and take responsibility for your failures.
- Warrior brotherhood (or sisterhood) is uniquely powerful and intense, and hard for civilians to understand.

http://www.future-artillery.com/Media/8588/15343.pdf

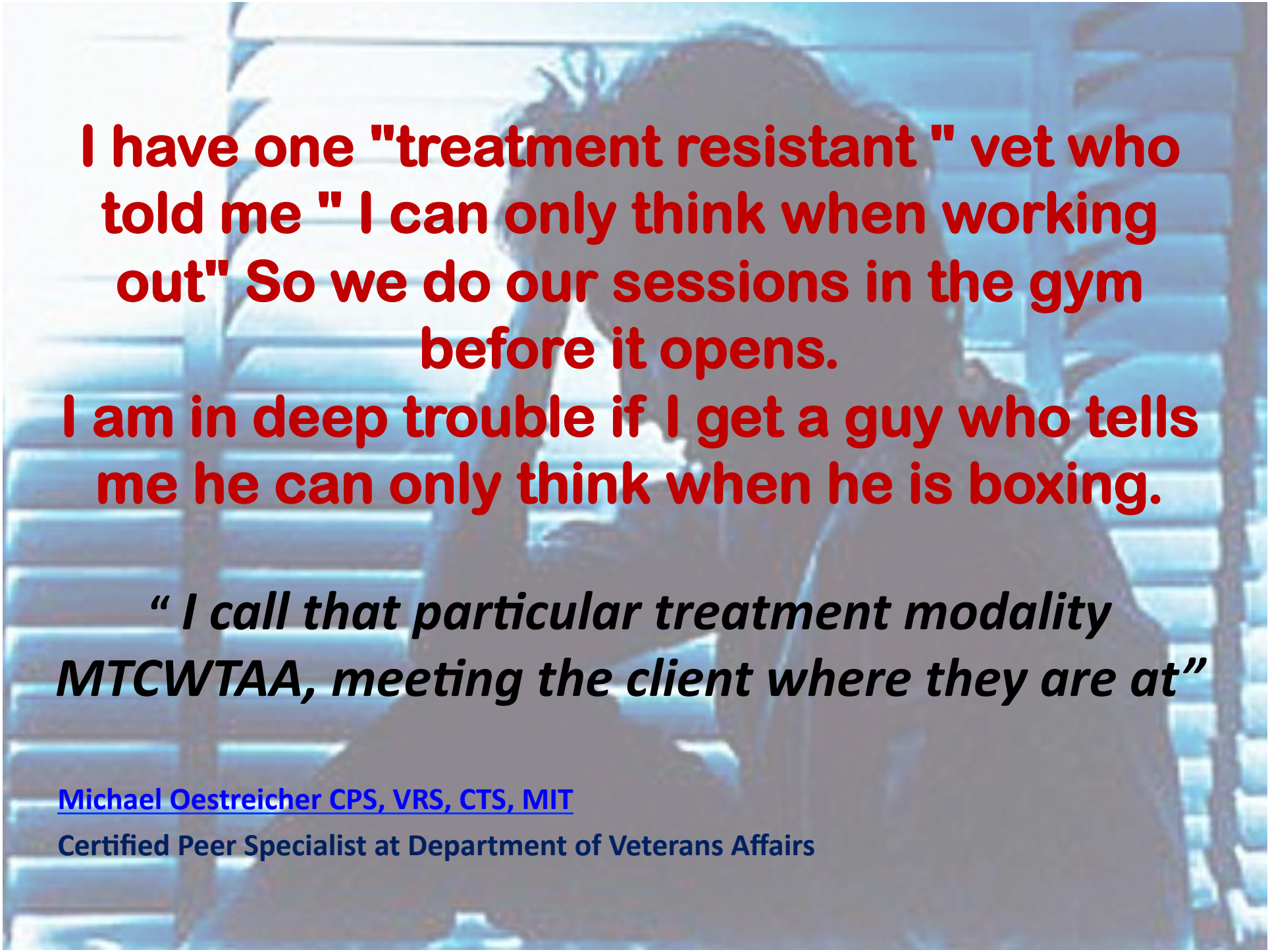
Warrior Language

- 1. Hypervigilance = Situational Awareness
- 2. Guided imagery = Mental Rehearsal or Simulation
- 3. Relaxation = Breath Control
- 4. PTSD = Combat & Occupational Stress
- 5. Symptoms = Impacts, Reactions
- 6. Therapy = Training or Skills Set Acquisition or Self- Mastery Strategies
- 7. Behavioral Health = Wellness, Resilience
- 8. Trauma Treatment = Combat Stress Mitigation or Resiliency Training or Performance Optimization

http://www.future-artillery.com/Media/8588/15343.pdf

The Day Vietnam Met OIF In Rural Missouri

- A Lesson Pasted Down



I have one "treatment resistant " vet who told me " I can only think when working out" So we do our sessions in the gym before it opens.

I am in deep trouble if I get a guy who tells me he can only think when he is boxing.

" I call that particular treatment modality MTCWTAA, meeting the client where they are at"

Michael Oestreicher CPS, VRS, CTS, MIT

Certified Peer Specialist at Department of Veterans Affairs

Therapist Tips – Do's

Part 1

- 1. **Listen carefully** and patiently
- 2. Be respectful
- 3. **Be authentic** – soldiers & service members are on the lookout for phonies (**Finely Tuned BS Meters**).
- 4. **Make direct eye contact**.
- 5. **Lead with questions about physical or behavioral issues** rather than feelings or emotions, unless they start there
- 6. **Let the Soldier tell his story in his own words**, without interruption or interpretation or reframing, **and use those words back in conversation**.
- 7. Rather than the standard "How does that make you feel?" you may want to try something more cognitive, like "What do you make of that?"

http://www.future-artillery.com/Media/8588/15343.pdf

Therapist Tip – Do's

Part 2

- 8. Empathic mirroring that works well in other contexts, like "That has to be hard" may be taken as an annoying invitation to whine and wallow.
- 9. Be aware that the *moral injury warriors suffer when* exposed to the worst that humanity has to offer creates a profound existential crisis, unlike most of what you've seen.
- 10.If you've been in the Service yourself, display proof around the office or bring it up in a casual way.
- 11.If you haven't, say that you're aware that this is a disadvantage to you both; but that you have listened and you have learned (and will continue to do so).
- 12.Create a comfortable, welcoming, relaxed therapeutic setting – don't sit behind the desk.
- 13.Engage in back and forth dialogue, respectful sharing and conversation about options, ideas.

http://www.future-artillery.com/Media/8588/15343.pdf

Therapist Tip – Do's

Part 3

- 14. **Add psycho-educational components** on the neurophysiologic nature of traumatic stress – get out of the realm of mental illness.
- 15. Don't be abrupt with "Our time is up" – work a transition.
- 16. **Dump the "D" in PTSD**.
- 17. **Brush up on** PTG or **Posttraumatic Growth**
- 18.Learn some of the new, specific modalities that work well for traumatic stress. You don't have to know how to do them all, but you should know those who can provide these services in your community.

http://www.future-artillery.com/Media/8588/15343.pdf

Therapist – Don'ts

- 1. Don't compare combat trauma to civilian trauma.
- 2. Don't ask about killing, violence.
- 3. Don't be in a hurry to push meds or up the dosage.
- 4. Don't say you understand if you haven't been there.
- 5. Don't make assumptions – listen.
- 6. Don't bring your politics into it, whether pro-war or con.
- 7. Don't automatically ask about childhood or history.
- 8. Don't flash your resume or credentials.
- 9. Don't hide behind your desk.
- 10.Don't offer false reassurance: they will *not be the* same. (But they can be OK and grow into their healing in ways that may be even better than before.)

http://www.future-artillery.com/Media/8588/15343.pdf

Effective Methods For Combat Trauma

Part 1

- 1. Self-Regulation through Breathwork
- 2. Yoga
- 3. Tai Chi
- 4. Yoga Nidra or iRest
- 5. Biofeedback and Neurofeedback
- 6. EMDR – Eye Movement Desensitization & Reprocessing
- 7. EFT – Emotional Freedom Technique
- 8. SE – Somatic Experiencing
- 9. Acupressure
- 10. TIR - Trauma Incident Reduction

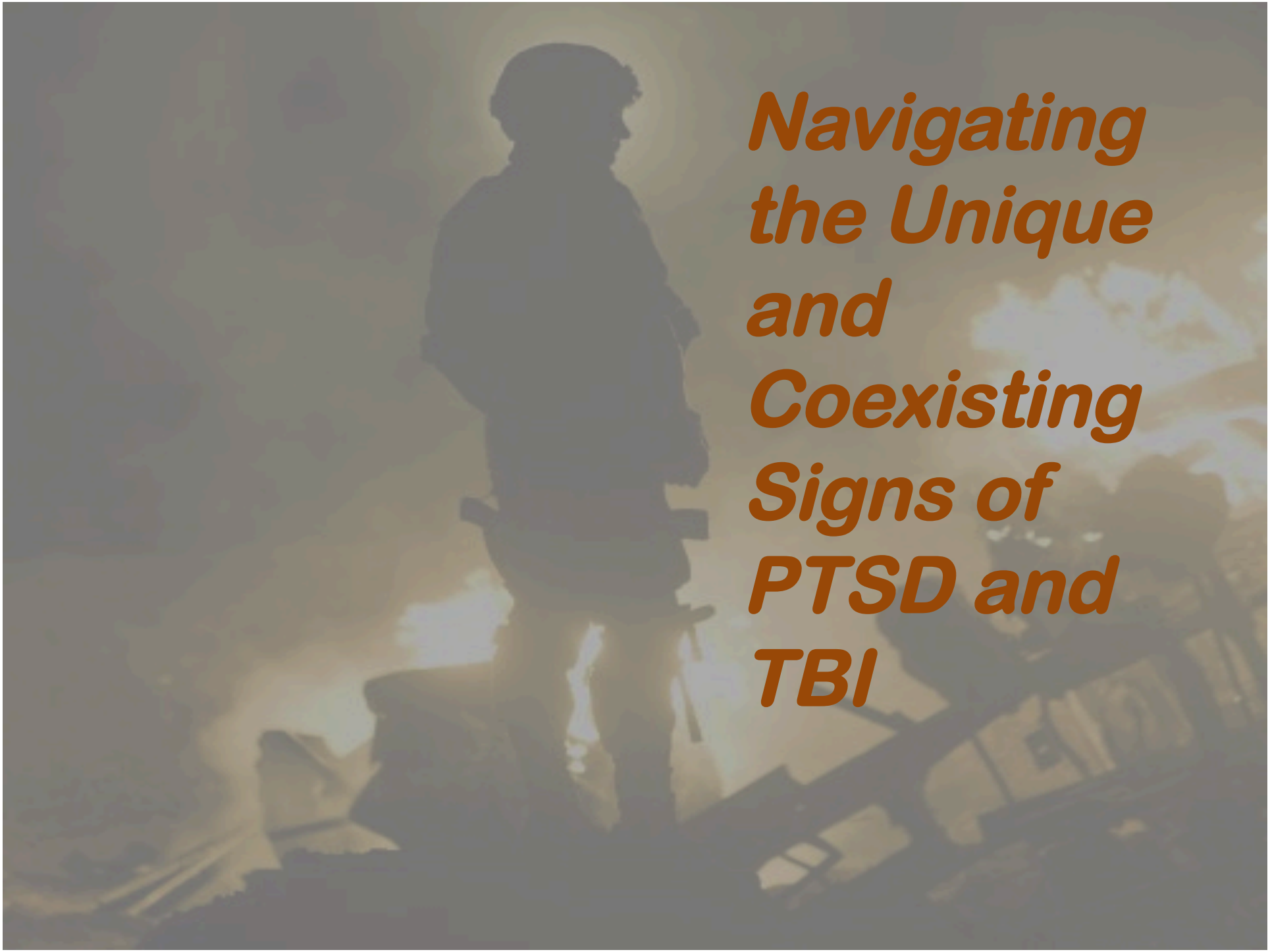
http://www.future-artillery.com/Media/8588/15343.pdf

Effective Methods For Combat Trauma

Part 2

- 11.TAT – Tapas Acupressure Technique
- 12.TRE or Trauma Releasing Exercises
- 13.Mindfulness Meditation or MBSR
- 14.Prolonged Exposure (It works, but for many, this is doing it the hard way)
- 15. IRT – Imagery Rehearsal Therapy
- 16.Therapeutic Massage
- 17.Reiki, Therapeutic Touch, Healing Touch
- 18.Community Volunteering, helping others
- 19.Physical exercise
- 20.Guided Imagery

http://www.future-artillery.com/Media/8588/15343.pdf

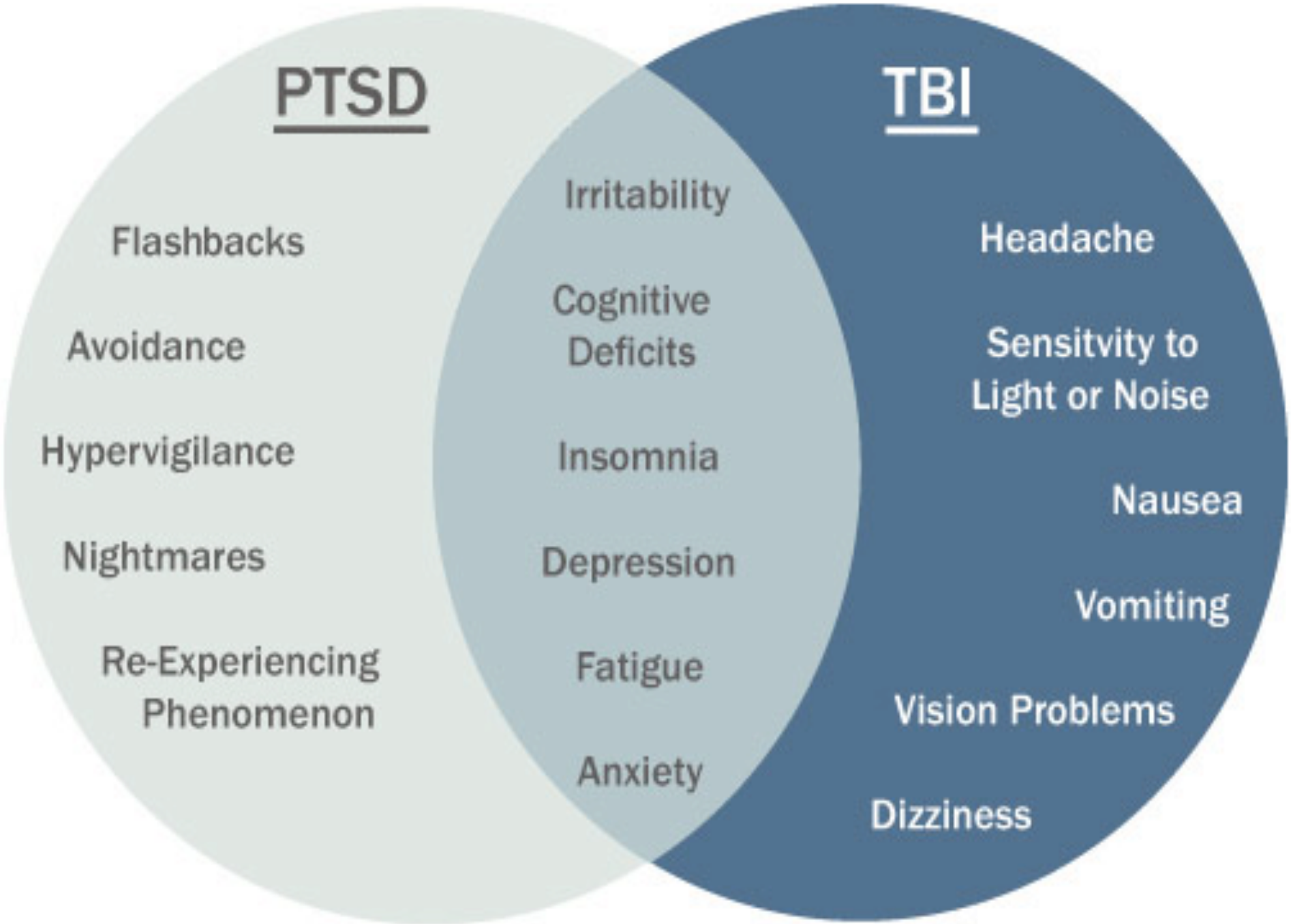

Navigating
the Unique
and
Coexisting
Signs of
PTSD and
TBI

Symptoms of Combat PTSD

- Flashbacks
- Avoidance
- Hyper vigilance
- Nightmares
- Re-Experiencing Phenomenon
- Irritability
- Insomnia
- Depression
- Fatigue
- Cognitive Deficits
- Anxiety
- Self-Medication

Symptoms of Combat TBI

- Headaches
- Nausea
- Vomiting
- Vision Problems
- Dizziness
- Sensitivity to Light or Noise
- Irritability
- Insomnia
- Depression
- Fatigue
- Cognitive Deficits
- Anxiety


PTSD
Flashbacks
Avoidance
Hypervigilance
Nightmares
Re-Experiencing Phenomenon
Irritability
Cognitive Deficits
Insomnia
Depression
Fatigue
Anxiety
TBI
Headache
Sensitvity to Light or Noise
Nausea
Vomiting
Vision Problems
Dizziness

The Lines Between PTSD and TBI

Memory

- **TBI: A period of amnesia for what went on just before (retrograde amnesia) or after (anterograde amnesia) the injury occurred is common. The length of time (minutes, hours, days, or weeks) of amnesia is an indicator of the severity of the brain injury. For example, the person may have no memory of what happened just before or after the car crash or IED explosion.**

- **PTSD: In contrast, the person with PTSD is plagued and often haunted by unwanted and continuing intrusive thoughts and memories of what happened. The memories keep coming at any time of day or night in such excruciating detail that the person relives the trauma over and over again.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Sleep

- **TBI: Sleep disorders are very common after brain injury. Whether it is trouble falling asleep, staying asleep, or waking early, normal sleep patterns are disrupted, making it hard to get the restorative rest of sleep so badly needed.**

- **PTSD: The mental state of hypervigilance interferes with slowing the body and mind down for sleep. Nightmares are so common with PTSD that many individuals dread going to bed and spend long nights watching TV or lying on the couch to avoid the night's terrors. Waking up with night sweats so drenching that sheets and clothing are soaked. Flashbacks so powerful that bed partners have been struck or strangled while sleep battles waged.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Isolation

- **TBI: Many survivors of TBI recall the early support and visits of friends, relatives, and coworkers who gradually visited or called less often over time. Loss of friends and coworkers leads to social isolation, one of the most common long-term consequences of TBI.**

- **PTSD: The isolation with PTSD is different as it is self-imposed. For many it is simply too hard to interact with people. The feeling of exposure outside the safe confines of the house is simply too great. The person may avoid leaving the house as a way of containing stimuli and limiting exposure to possible triggers of memories. As a result, the individual's world becomes smaller and smaller.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Emotions

- **TBI: When the areas of the brain that control emotions are damaged, the survivor of a TBI may have what is called "emotional lability." This means that emotions are unpredictable and swing from one extreme to the other. The person may unexpectedly burst into tears or laughter for no apparent reason. This can give the mistaken impression that the person is mentally ill or unstable.**

- **PTSD: Emotional numbness and deadened feelings are a major symptom of PTSD. It's hard for the person to feel emotions or to find any joy in life. This emotional shutdown creates distance and conflicts with spouses, partners and children. It is a major cause of loss of intimacy with spouses.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Fatigue

- **TBI: Cognitive fatigue is a hallmark of brain injury. Thinking and learning are simply harder. This cognitive fatigue feels "like hitting the wall," and everything becomes more challenging. Building rest periods or naps into a daily routine helps prevent cognitive fatigue and restore alertness.**

- **PTSD: The cascading effects of PTSD symptoms make it so difficult to get a decent night's sleep that fatigue often becomes a constant companion spilling over into many areas. The fatigue is physical, cognitive, and emotional. Feeling wrung out, tempers shorten, frustration mounts, concentration lessens, and behaviors escalate.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Depression

- **TBI: Depression is the most common psychiatric diagnosis after brain injury; the rate is close to 50%. Depression can affect every aspect of life. While people with more severe brain injuries have higher rates of depression, those with mild brain injuries have higher rates of depression than persons without brain injuries.**

- **PTSD: Depression is the second most common diagnosis after PTSD in OEF and OIF veterans. It is very treatable with mental health therapy and/or medication, but veterans in particular often avoid or delay treatment due to the stigma of mental health care.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Anxiety

- **TBI: Rather than appearing anxious, the person acts as if nothing matters. Passive behavior can look like laziness or "doing nothing all day," but in fact it is an initiation problem, not an attitude. Brain injury can affect the ability to initiate or start an activity; the person needs cues, prompts, and structure to get started.**

- **PTSD: Anxiety can rise to such levels that the person cannot contain it and becomes overwhelmed by feelings of panic and stress. It may be prompted by a specific event, such as being left alone, or it can occur for no apparent reason, but the enveloping wave of anxiety makes it difficult to think, reason or act clearly.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Talking about the Trauma

- **TBI: The person may retell an experience repetitively in excruciating detail to anyone who will listen. Such repetition may be symptomatic of a cognitive communication disorder, but it may also be due to a memory impairment. Events and stories are repeated endlessly to the frustration and exasperation of caregivers, friends, and families who have heard it all before.**

- **PTSD: Avoidance and reluctance to talk about the trauma of what was seen and done is a classic symptom of PTSD, especially among combat veterans.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Anger

- **TBI: Damage to the frontal lobes of the brain can cause more volatile behavior. The person may be more irritable and anger more easily, especially when overloaded or frustrated. Arguments can escalate quickly, and attempts to reason or calm the person are often not effective.**

- **PTSD: Domestic violence is a pattern of controlling abusive behavior. PTSD does not cause domestic violence, but it can increase physical aggression against partners. Weapons or guns in the home increase the risks for family members. Any spouse or partner who feels fearful or threatened should have an emergency safety plan for protection.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Substance Abuse

- **TBI: The effects of alcohol are magnified after a brain injury. Drinking alcohol increases the risks of seizures, slows reactions, affects cognition, alters judgment, interacts with medications, and increases the risk for another brain injury. The only safe amount of alcohol after a brain injury is none.**

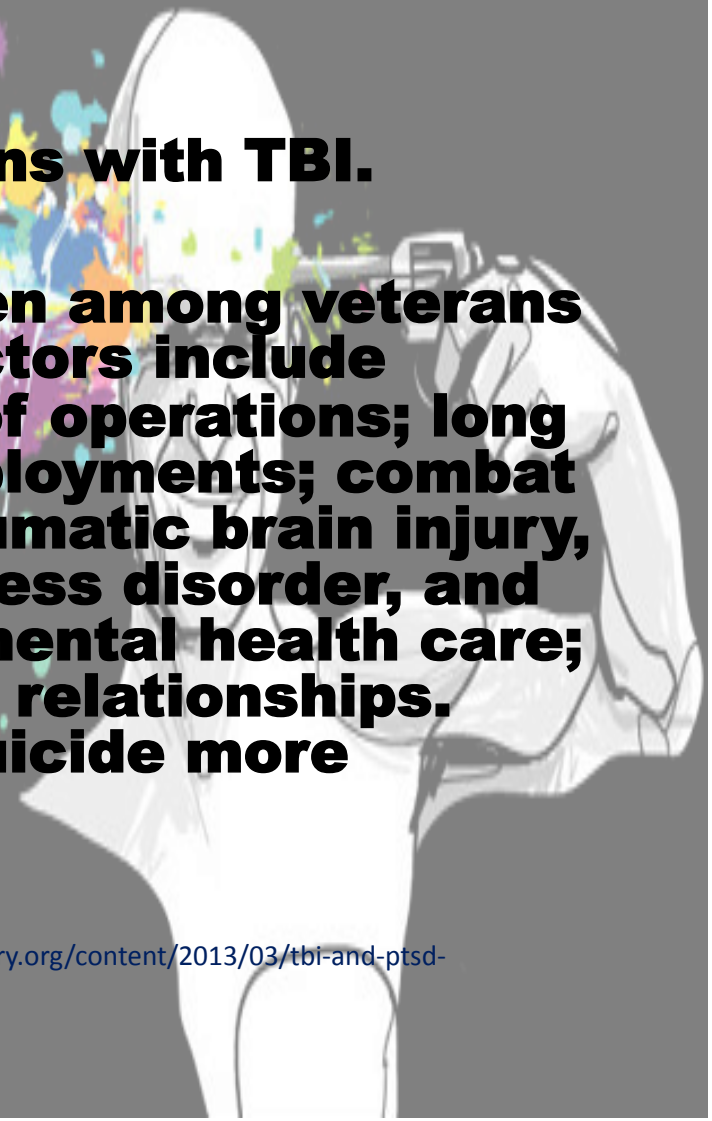
- **PTSD: Using alcohol and drugs to self-medicate is dangerous. Military veterans drink more heavily and binge drink more often than civilian peers. Alcohol and drugs are being used often by veterans to cope with and dull symptoms of PTSD and depression, but in fact create further problems with memory, thinking, and behavior.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Suicide

- **TBI: Suicide is unusual in civilians with TBI.**
- **PTSD: Rates of suicide have risen among veterans of OEF and OIF. Contributing factors include difficult and dangerous nature of operations; long deployments and multiple redeployments; combat exposure; and diagnoses of traumatic brain injury, chronic pain, post-traumatic stress disorder, and depression; poor continuity of mental health care; and strain on marital and family relationships. Veterans use guns to commit suicide more frequently than civilians.**



Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Lines Between PTSD and TBI

Summary

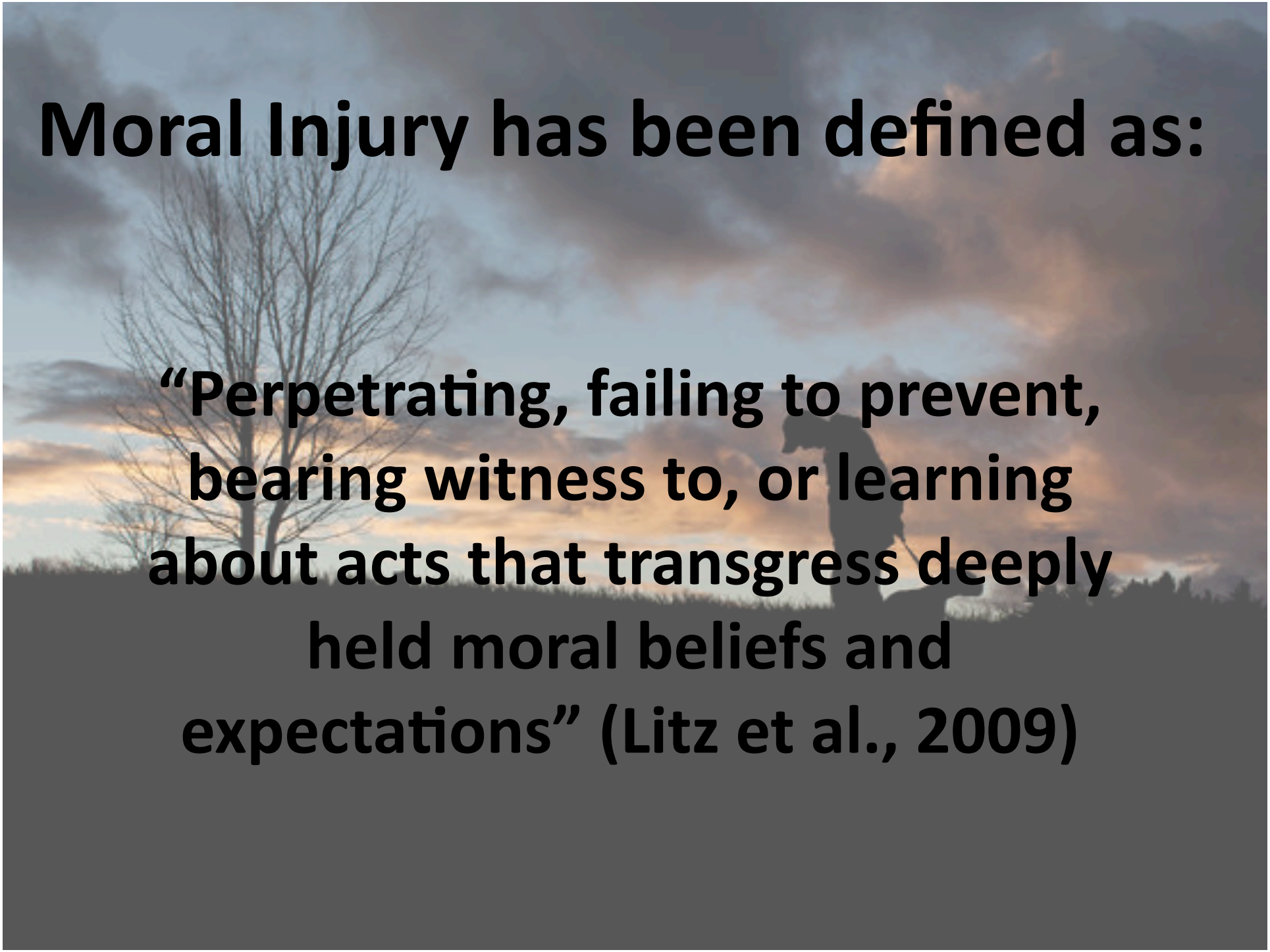
- **There is no easy "either/or" when it comes to describing the impact of TBI and PTSD. While each diagnosis has distinguishing characteristics, there is an enormous overlap and interplay among the symptoms. Navigating this "perfect storm" is challenging for the survivors, the family, the caregivers, and the treatment team. By pursuing the quest for effective treatment by experienced clinicians, gathering accurate information, and enlisting the support of peers and family, it is possible to chart a course through the troubled waters to a safe haven.**

Marilyn Lash, MSW, Brain Injury Journey magazine; http://www.brainlinemilitary.org/content/2013/03/tbi-and-ptsd-navigating-the-perfect-storm_pageall.html

The Fine Lines of TBI and PTSD
(And Other Behaviors)

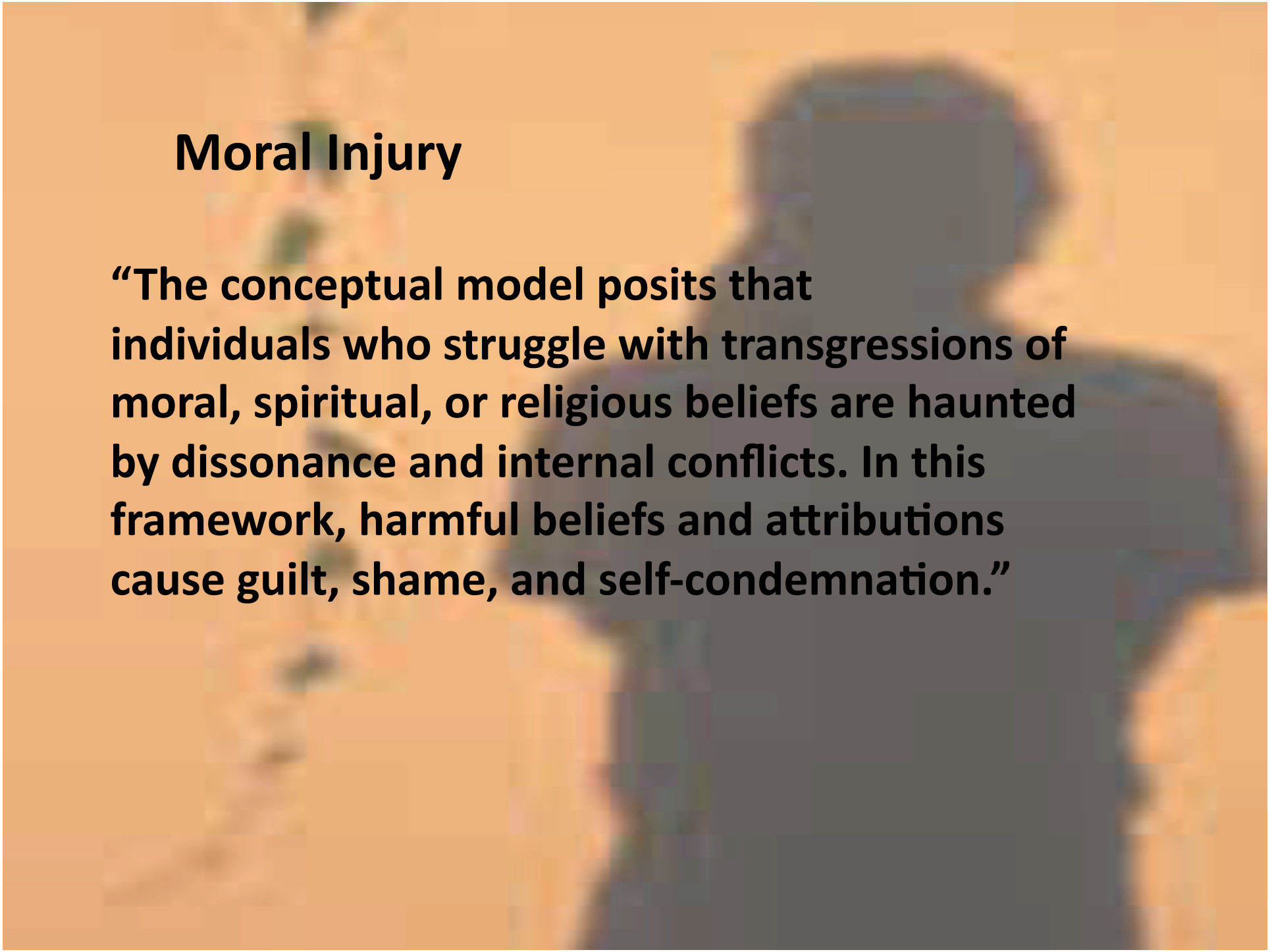
- *The Rocking Inmate*


The Silent Lynch
Pin of
Combat Trauma
Therapy



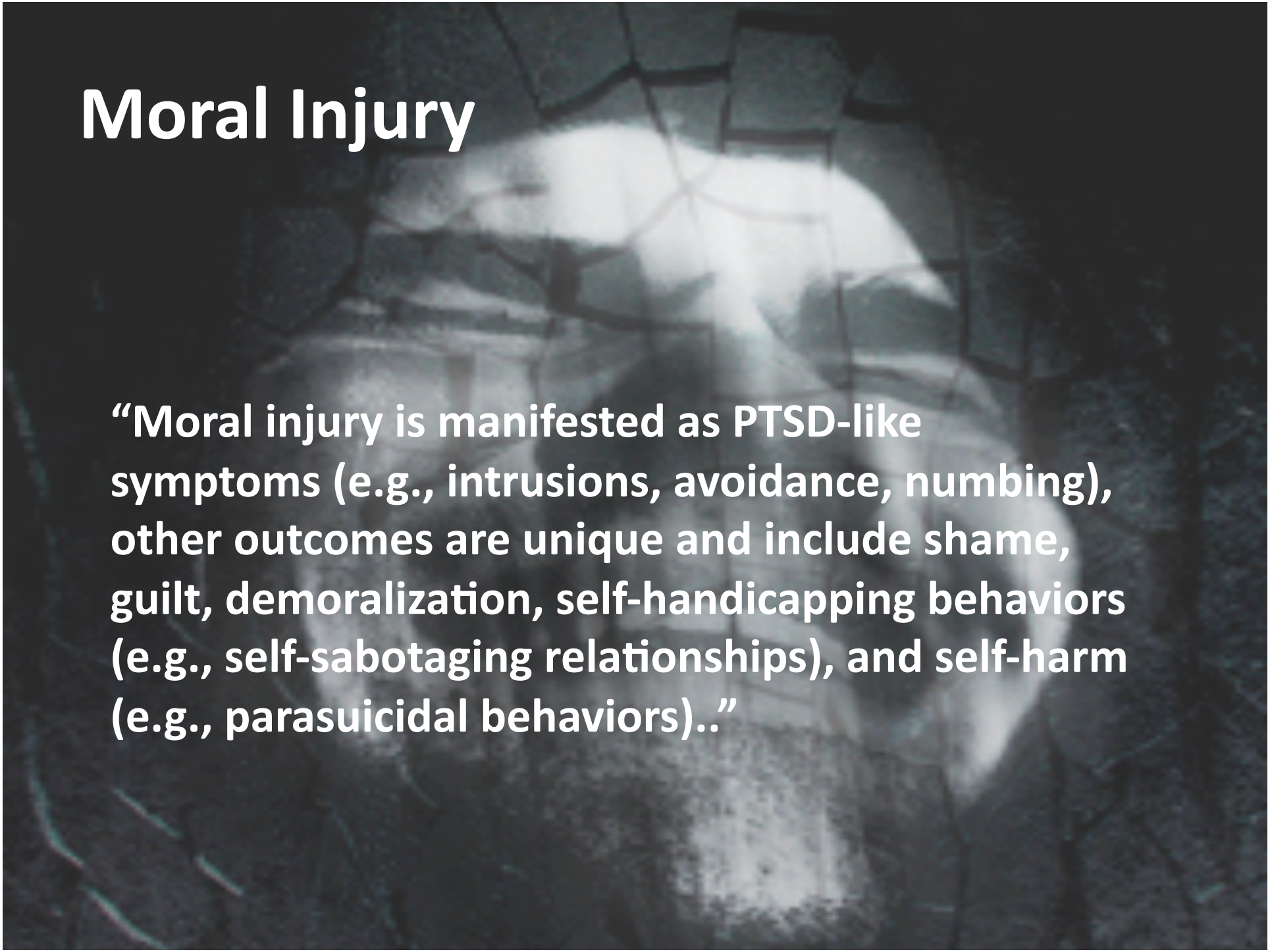
Moral Injury has been defined as:

"Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009)



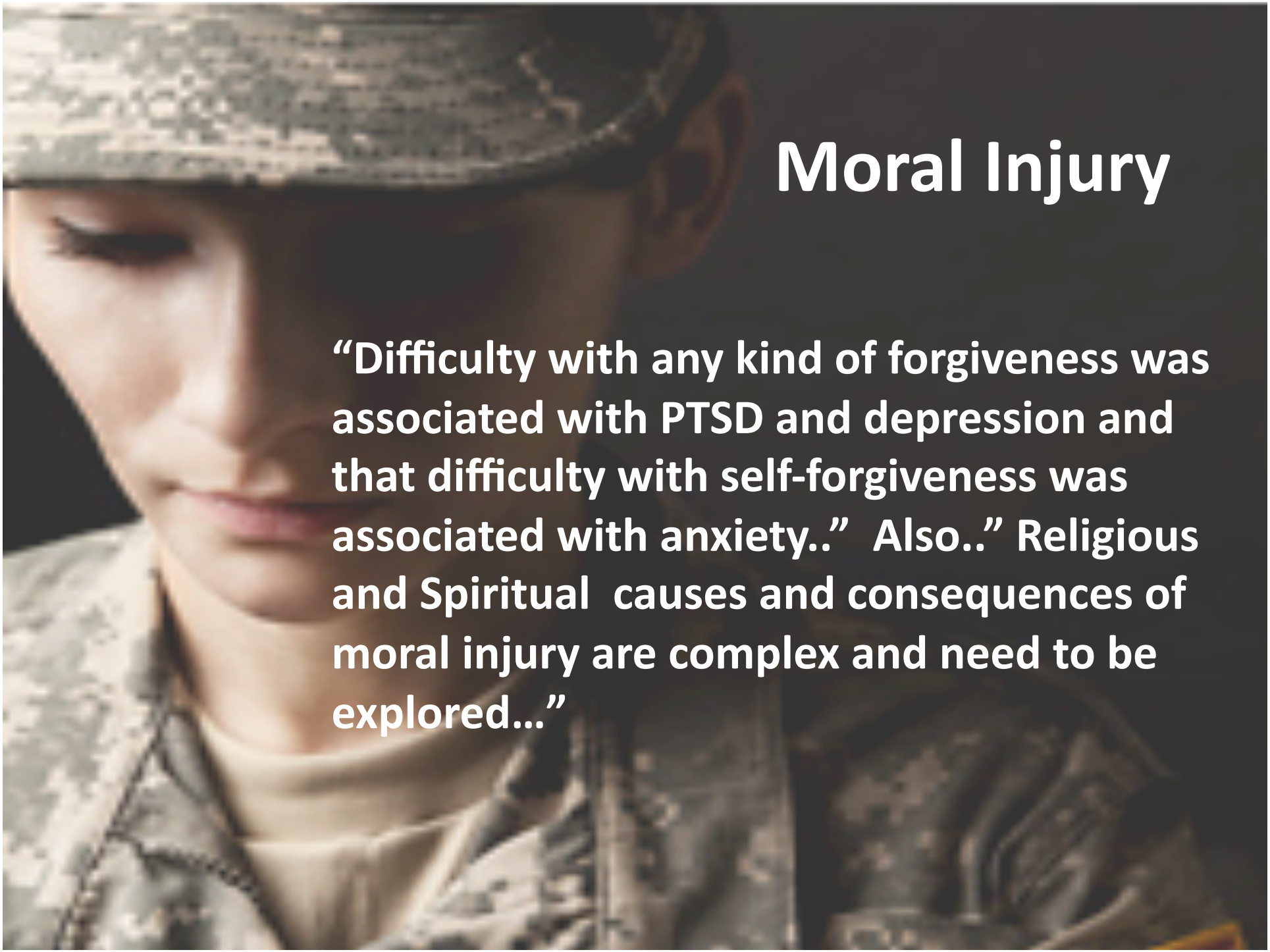
Moral Injury

“The conceptual model posits that individuals who struggle with transgressions of moral, spiritual, or religious beliefs are haunted by dissonance and internal conflicts. In this framework, harmful beliefs and attributions cause guilt, shame, and self-condemnation.”



Moral Injury

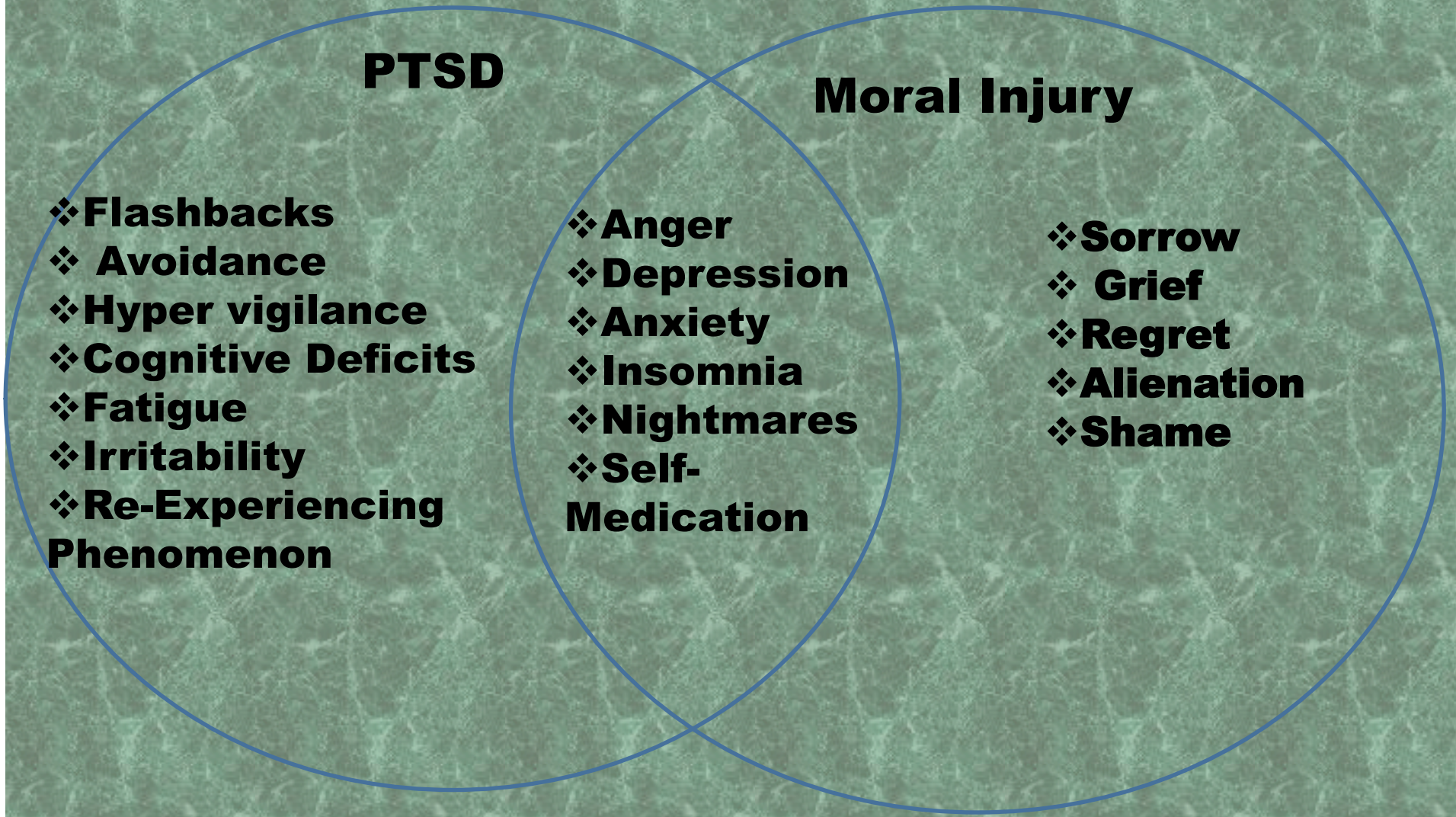
"Moral injury is manifested as PTSD-like symptoms (e.g., intrusions, avoidance, numbing), other outcomes are unique and include shame, guilt, demoralization, self-handicapping behaviors (e.g., self-sabotaging relationships), and self-harm (e.g., parasuicidal behaviors).."


Moral Injury
“Difficulty with any kind of forgiveness was associated with PTSD and depression and that difficulty with self-forgiveness was associated with anxiety..” Also..” Religious and Spiritual causes and consequences of moral injury are complex and need to be explored…”

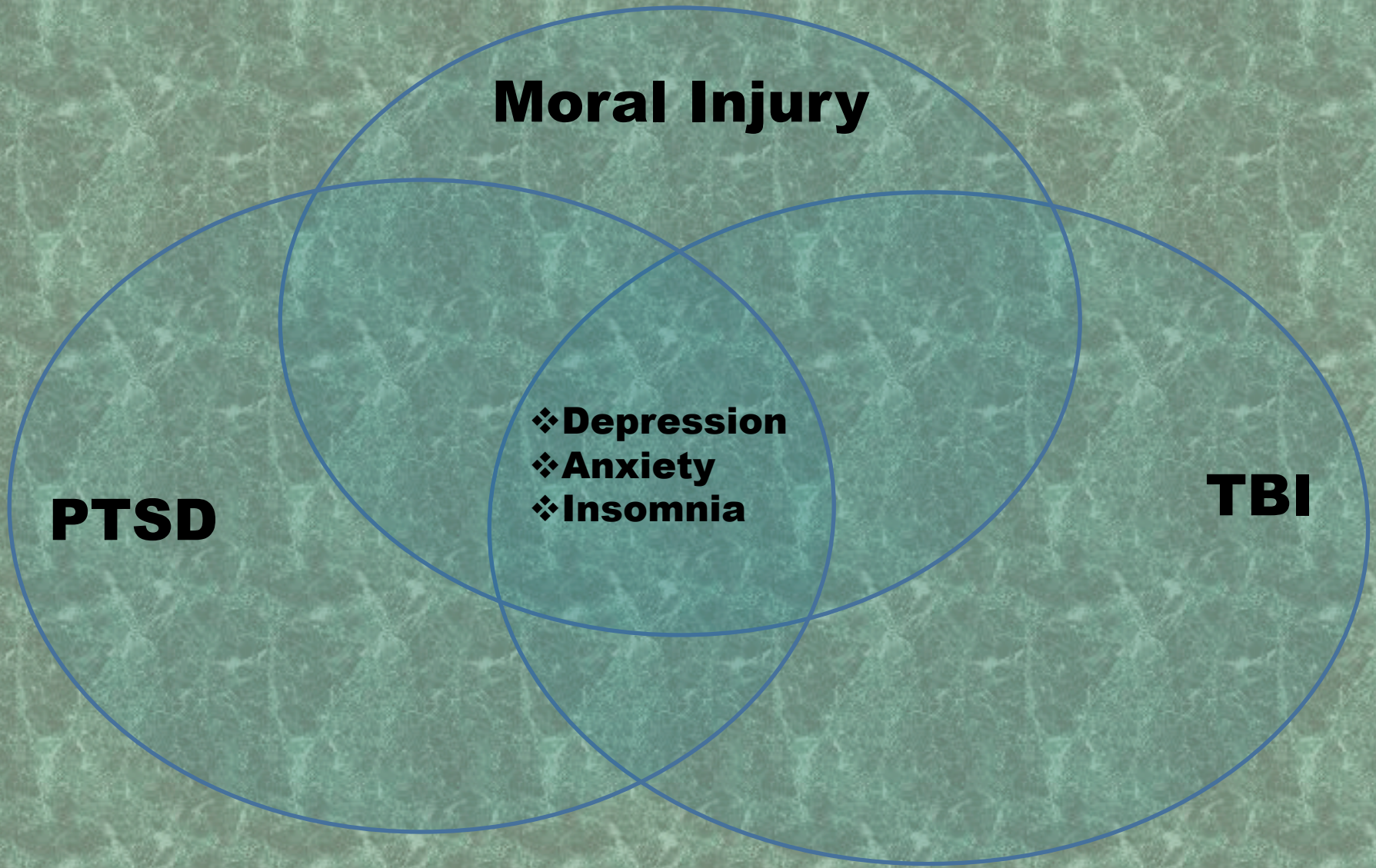
Symptoms of Moral Injuries

- **Sorrow**
- **Grief**
- **Regret**
- **Shame**
- **Alienation**
- **Self-Medication**
- **Anger**
- **Insomnia**
- **Depression**
- **Anxiety**
- **Nightmares**

Symptoms PTSD & Moral Injury



The Crossroads of TBI, PTSD & Moral Injury



When Moral Injuries Are Life Long
(A Native Story)

- The Biography of a Home Native American Veteran


Missouri - VA
Service Programs

Veterans Healthcare Administration
Substance Abuse Programs

SARRTP
Substance Abuse Residential Rehabilitation Treatment Program

SARRTP is a customized residential recovery treatment program that lasts approximately 21 days. Programming includes daily classes about recovery and life skills, 12-Step and SMART Recovery Meetings, case management services, social work services and psychiatric services. To access SARRTP, start at the Behavioral Health Clinic.

VA Outpatient Substance Abuse Programs

VA Vet Centers
Mobile and Outpatient Outreach
Combat Trauma, Marriage and Family, Military Sexual Trauma

VA SUD Coordinators in Missouri
(VA National Center for PTSD)

Harry S. Truman Memorial
800 Hospital Drive Columbia, MO 65201-5297 Phone: 573-814-6000 Or 573-814-6000 SUD Intensive Outpatient Randall Rogers, Addictions Treatment Program: (573) 814-6480

John J. Pershing VA Medical Center
1500 N. Westwood Blvd. Poplar Bluff, MO 63901 Phone: 573-686-4151 Or 573-686-4151 SUD Intensive Outpatient Angela Dickerson, Substance Abuse Treatment Program: (573) 686-4151

Kansas City VA Medical Center
4801 Linwood Boulevard Kansas City, MO 64128 Phone: 816-861-4700 SUD 24-Hour Care (Residential) and SUD Intensive Outpatient Peggy Krieshok, SARRTP: (816) 922-2681

VA St. Louis Health Care System - Jefferson Barracks Division
1 Jefferson Barracks Drive Saint Louis, MO 63125 Phone: 314-652-4100 Or 314-652-4100 SUD 24-Hour Care (Residential) and SUD Intensive Outpatient Ann Lovell, Opioid Treatment Program/ Buprenorphine, Methadone & SARRTP: (314) 652-4100 X 66376

VA St. Louis Health Care System - John Cochran Division
915 North Grand Blvd. Saint Louis, MO 63106 Phone: 314-652-4100 Or 314-652-4100 Opioid Treatment Program Ann Lovell, Opioid Treatment Program/Buprenorphine, Methadone & SARRTP: (314) 652-4100 X 66376 SUD Standard Outpatient Ann Lovell, Opioid Treatment Program/ Buprenorphine, Methadone & SARRTP: (314) 652-4100 X 66376

Veterans Healthcare Administration

Outpatient Mental Health Programs

Behavioral Health Clinic

The Behavioral Health Clinic services include individual and group therapy, psychiatric services and social work services. Specialized services for women include treatment for Military Sexual Trauma. To begin the process of getting Mental Health Services, walk in during Clinic hours.

PTSD Clinic - (Post Traumatic Stress Disorder)

The PTSD Clinic services include individual and couples/family therapy, PTSD education groups for veterans and families, PTSD therapy groups and psychiatric services. To begin the process of getting PTSD services, walk into the Behavioral Health Clinic.

Veterans Healthcare Administration
More Intensive Mental Health Programs

PRRC
(Psychosocial Rehabilitation and Recovery Center)
The PRRC is an outpatient recovery-oriented program offering educational and therapeutic groups/activities to help Veterans with mental illness live meaningful lives. Veterans receive case management, social work services, nursing services and psychiatric services. Veterans must be referred to PRRC by a mental health provider as there are specific criteria for admission.

MHICM
(Mental Health Intensive Case Management)
MHICM provides community-based intensive case management services to help Veterans with severe mental illness remain in the community. Veterans receive case management, social/living skills training, supportive counseling, medication management and advocacy. Veterans must be referred to MHICM by a mental health provider as there are specific criteria for admission.

Veterans Healthcare Administration
Compensated Work Therapy (CWT) Programs

TWE
Transitional Work Experience
TWE helps Veterans in recovery develop vocational skills while completing work assignments. Work is paid on an hourly basis and veterans are in the program approximately 6 months. Must be referred by VA provider.

SE – Supported Employment
SE helps Veterans with severe mental illness reach their goal of finding a job in the community. Veterans are taught the skills necessary to find and keep a job and receive ongoing support after they start working. Must be referred by VA provider.

Veterans Healthcare Administration
Homeless Programs

Emergency Housing

Emergency Housing can help Veterans who are homeless and need immediate or short-term housing. Veterans go to sites in the community that contract with KCVA. While there, they receive assistance with moving toward permanent housing. To access Homeless Program services, go to the Behavioral Health Clinic.

GPD –Grant and Per Diem Transitional Housing

GPD Transitional Housing is for Veterans who may not be ready for permanent housing. Veterans are housed at community sites that have received a VA grant and take part in programming, get assistance with finding a job and move towards permanent housing. Veterans must meet certain criteria. To access Homeless Program services, go to the Behavioral Health Clinic.

HUD-VASH (Housing and Urban Development-Veterans Administration Supported Housing)

HUD-VASH houses Veterans who are homeless & their immediate family by providing a Section 8 voucher and KCVA case management services. Veterans must meet specific criteria in order to take part in this program. To access Homeless Program services, go to the Behavioral Health Clinic.

Veterans Healthcare Administration
Justice Outreach Programs

VJO - Veterans Justice Outreach Program
VJO helps veterans with mental illness and/or substance abuse avoid unnecessary convictions/incarcerations by diverting them from being arrested and into treatment. These may be veterans who are either pretrial or serving a sentence in a local jail, or veterans involved in adjudication or monitoring by the court.

Health Care for Re-Entry Veterans (HCRV)
- **VA Federal initiative under the VA homeless programs**
- **The HCRV program was designed to address community re-entry needs of incarcerated Veterans under state and federal supervision.**
- **VA partners with state Department of Corrections (DOC), Federal Bureau of Prisons (BOP), parole, probation and Community service providers to:**
- **Deliver outreach services to Veterans in state and federal prisons**
- **Assist in the creation of unified re-entry plans**
- **Provide unified post-release services**
- **Connect eligible veterans with VA, social security and disability benefits**
- **Connect eligible veterans into the health and mental health services provided by the VA**

Veterans Healthcare Administration
MISSOURI FACILITIES

Columbia
Harry S. Truman Memorial
800 Hospital Drive
Columbia, MO 65201
573-814-6000

St Louis
John J. Cochran
915 N. Grand Blvd
St. Louis, MO 63106
314-652-4100

Jefferson Barracks Division
One Jefferson Barracks Drive
St. Louis, MO 63125
314-652-4100

Kansas City
4801 Linwood Blvd
Kansas City, M O 64128
816-861-4700

Poplar Bluff
John J Pershing
1500 N. Westwood Blvd
Poplar Bluff, MO 63901
573-686-4151


Learning Opportunities for Community Agencies and Professional Service Providers

DEFENSE CENTERS OF EXCELLENCE

For Psychological Health & Traumatic Brain Injury

Defense and Veterans Brain Injury Center

DVBIC serves military and family members with traumatic brain injuries through state-of-the-art clinical care, research, and education. http://dvbic.dcoe.mil/

National Center for Telehealth and Technology

T2 develops telehealth and technology solutions for psychological health and traumatic brain injury to improve the lives of our nation's warriors and their families

DCoE DEFENSE CENTERS OF EXCELLENCE for Psychological Health and Traumatic Brain Injury

Webinar SERIES 2014

JANUARY	TBI	
	16	Cumulative Concussion
	Psychological Health	
	23	Imagery Rehearsal Therapy and Treating Sleep Disorders
FEBRUARY	TBI	
	13	Joint Theater Trauma Systems Practice Guidelines/ Recommendations
	Psychological Health	
	27	Smoking Cessation in Military and Veteran Populations
MARCH	TBI	
	13	Simulation Technology and Functional Assessment: Use of Standardized Technology-mediated Performance Measures
	Psychological Health	
	27	Mild TBI and Co-occurring Psychological Health Disorders
APRIL	TBI	
	10	Family Functioning and TBI
	Psychological Health	
	24	Military Children; Mild TBI and PTSD
MAY	TBI	
	8	Post-traumatic Headache
	Psychological Health	
	22	The Role of the Chaplain on the Departments of Defense and Veterans Affairs Mental Health Team
JUNE	TBI	
	12	Unique Male Risk Factors for Mild TBI
	Psychological Health	
	26	Depression and Men in the Military
JULY	TBI	
	10	Safety and TBI
	Psychological Health	
	24	Safety and PTSD
AUGUST	TBI	
	14	TBI and ICD-10 Coding
	Psychological Health	
	28	Empowering Patient Engagement in Care
SEPTEMBER	TBI	
	11	Suicide and TBI
	Psychological Health	
	25	Supporting Family Members Surviving Suicide
OCTOBER	TBI	
	9	Gender Difference and TBI
	Psychological Health	
	23	Mental Health and Women in the Military
NOVEMBER	TBI	
	13	Technology Interventions for TBI
	Psychological Health	
	20	Technology Interventions for Psychological Health
DECEMBER	TBI	
	11	TBI Prevention and Safety Awareness
	Psychological Health	
	18	Military Culture 101: What Does the Health Care Provider Need to Know?

Volunteer & Outreach Opportunities

To Experience Working With Veterans

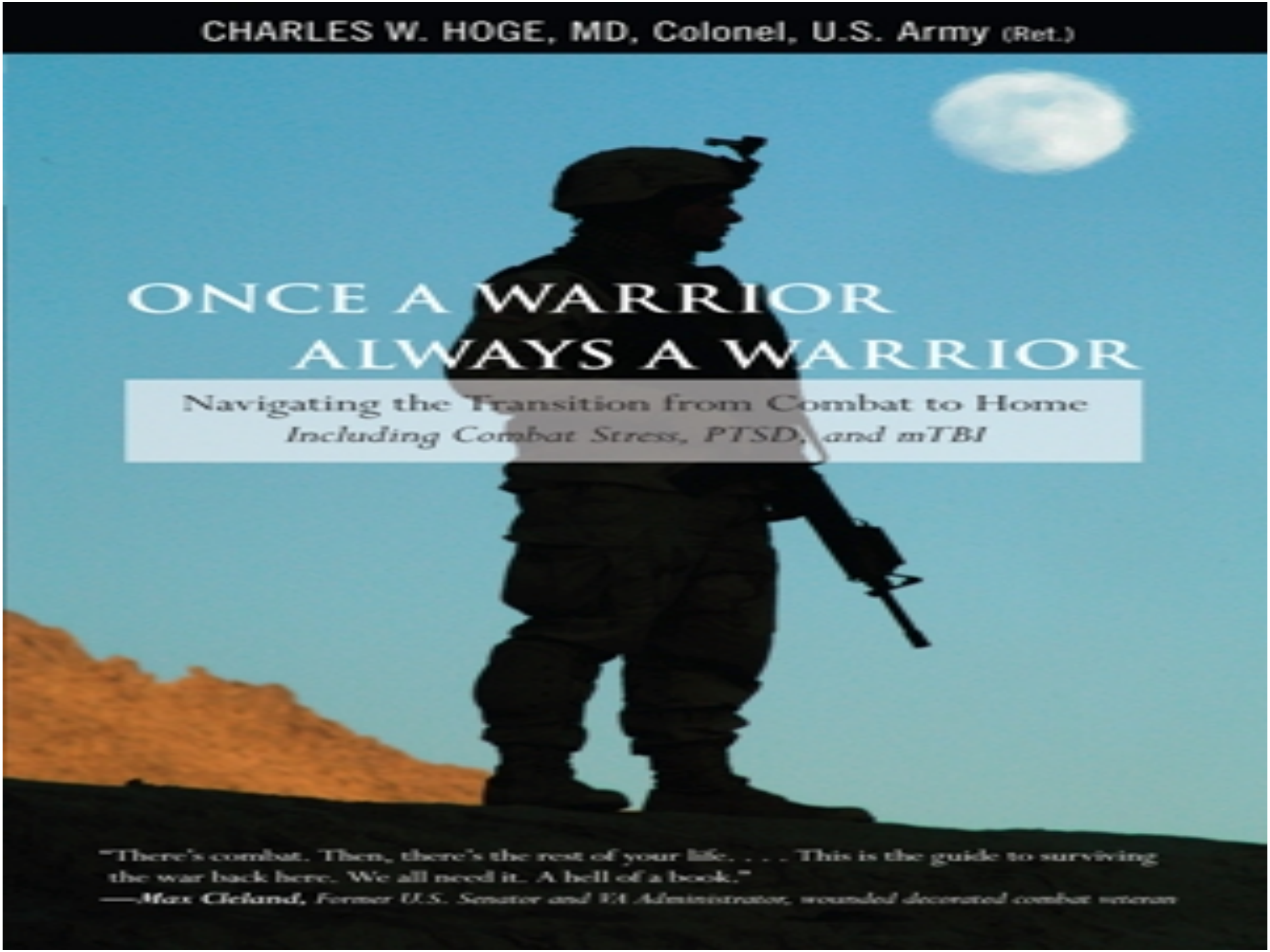
- Veterans Stand Downs
- VA Supported Homeless Shelters
- Local Homeless and Veterans Council
- Soup Kitchens / Homeless Day Centers
- Veteran's Courts
- NAMI "Give an Hour"

Opportunities To Meet Emerging Needs

Working With Veterans

- "The Coffee Bunker" Model
- Transitional Housing
- LTC Programs for Severe and Moderate TBI
- Outside the Box – "Cars for Heroes"

CHARLES W. HOGE, MD, Colonel, U.S. Army (Ret.)



ONCE A WARRIOR ALWAYS A WARRIOR

Navigating the Transition from Combat to Home

Including Combat Stress, PTSD, and mTBI

"There's combat. Then, there's the rest of your life. . . . This is the guide to surviving the war back here. We all need it. A hell of a book."

—**Max Cleland,** *Former U.S. Senator and VA Administrator, wounded decorated combat veteran*

War and the Soul

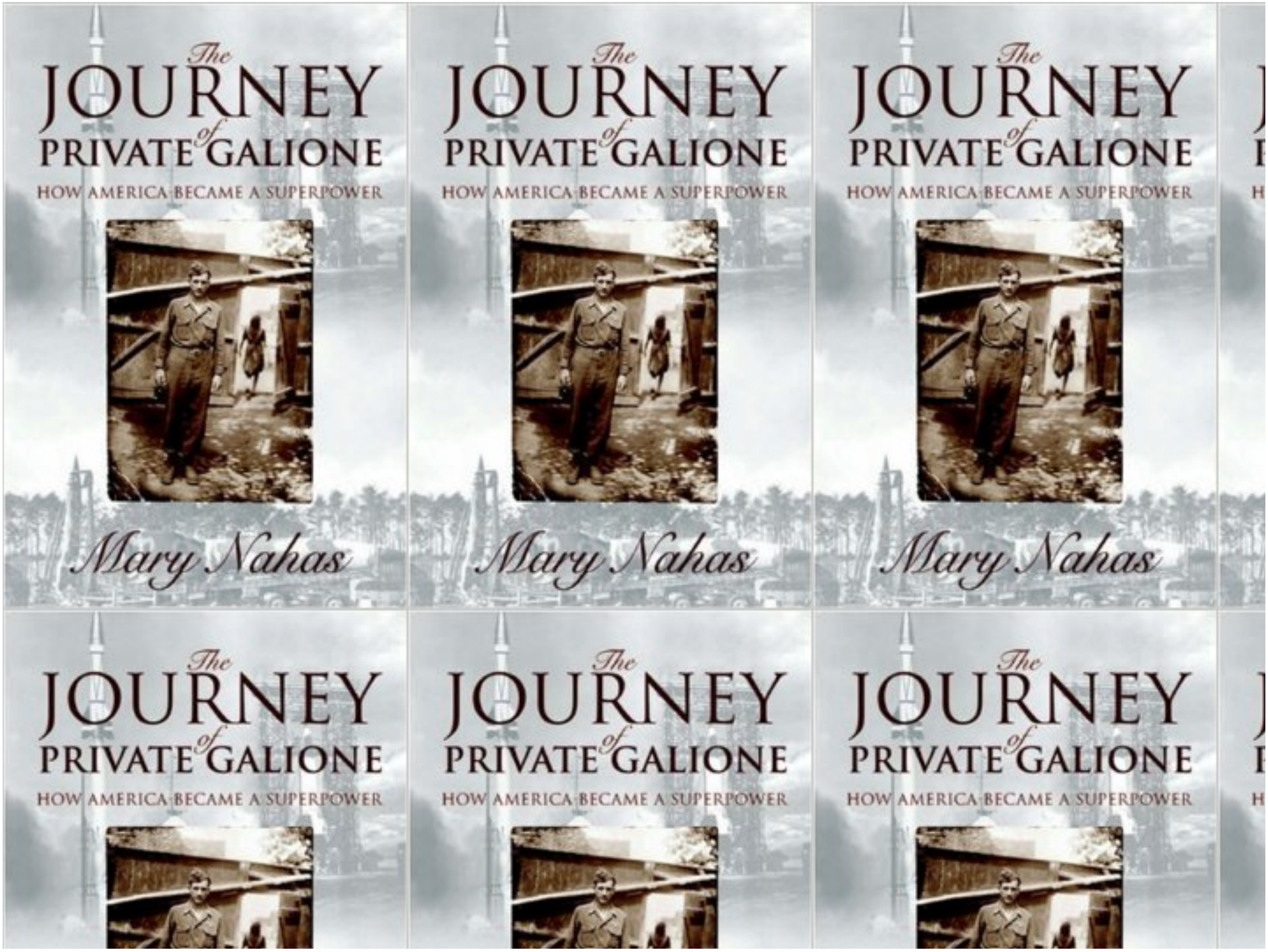
Healing Our Nation's Veterans from Post-traumatic Stress Disorder

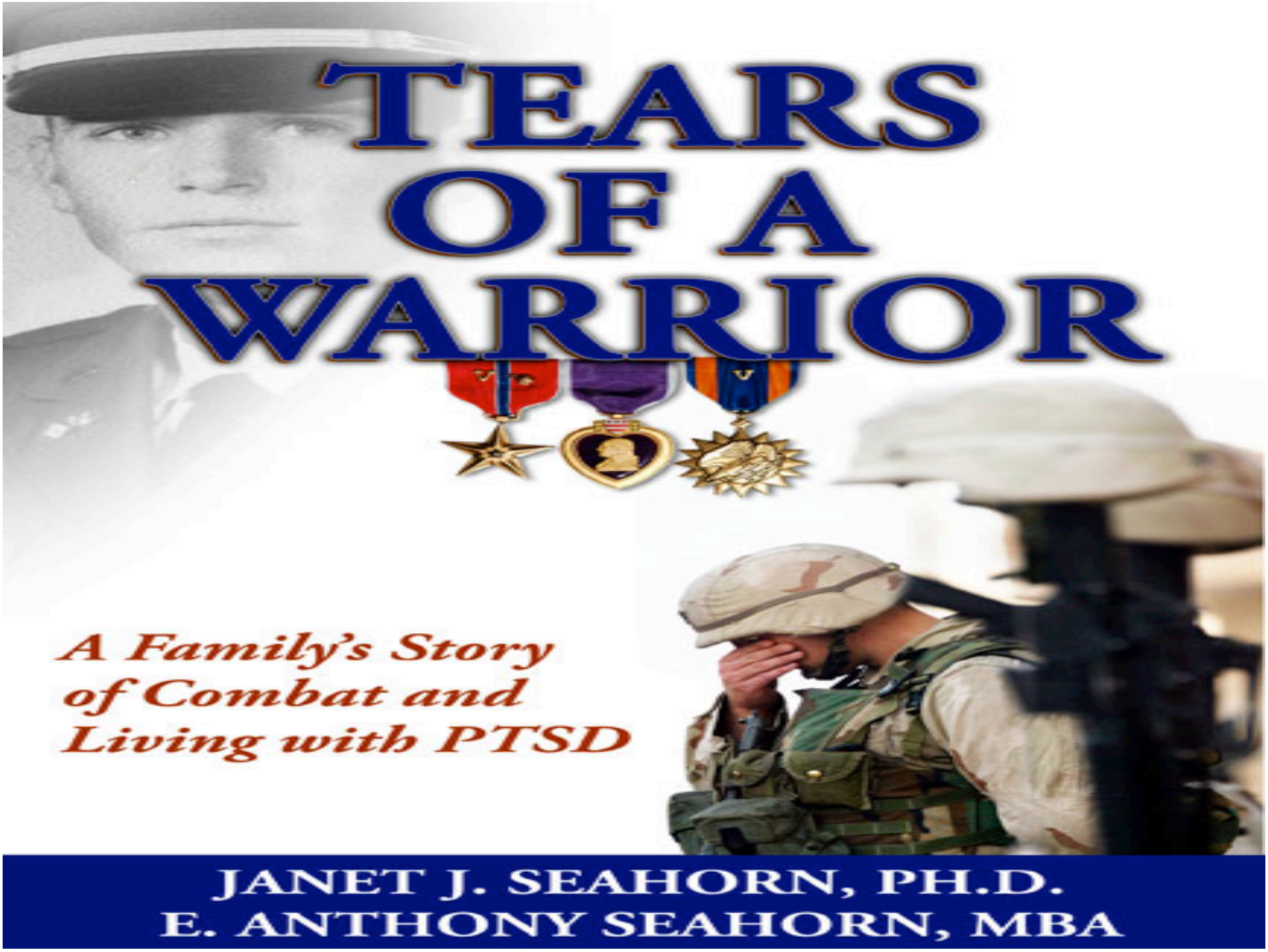
Edward Tick, Ph.D.

Plenty of Time When We Get Home

Love and Recovery in the Aftermath of War

KAYLA WILLIAMS


The
JOURNEY
of
PRIVATE GALIONE
HOW AMERICA BECAME A SUPERPOWER
Mary Nahas


TEARS OF A WARRIOR
A Family's Story of Combat and Living with PTSD
JANET J. SEAHORN, PH.D.
E. ANTHONY SEAHORN, MBA


Bill of Rights
For the Freedoms
that we all enjoy...
Our Thanks go to the
young men and women
serving in all
branches of the military.
We Salute You !


Questions?????

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Once a Warrior--Always a Warrior: Navigating the Transition from Combat to Home--Including Combat Stress, PTSD... by Charles W. Hoge M.D. (Feb 23, 2010)

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