PTSD and Suicide in the Military

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Abstract

The stress of Military Deployment of American Soldiers has led to increased rates of Post Traumatic Stress Disorder (PTSD) and suicide that is evident in those who are returning from the wars in Afghanistan and Iraq. Even though these soldiers have survived combat, or situations related to combat, the mental and emotional cost is high. They are unable to escape the images of war that are etched within their minds. Evidence based therapy practices such as Eye Movement Desensitization Reprocessing (EMDR) and Cognitive Behavioral Therapy (CBT) are already recognized by the Department of Defense (DoD; C. f. D.Psychology, 2015). Other techniques such as Prolonged Exposure Therapy and Virtual Reality Exposure Therapy have been used with Cognitive Processing Therapy emerging as the model most often utilized by Military Mental Health Providers. This literature review provided an Adlerian perspective on PTSD and suicide in veterans.
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# Table of Contents

PTSD AND SUICIDE IN THE MILITARY ................................................................. 5  
  Military Belief System .................................................................................. 5  
  Post Traumatic Stress Disorder ................................................................. 6  
  Diagnostic Criteria ....................................................................................... 6  
  Barriers to Treatment ................................................................................... 7  
  The Need for Treatment ............................................................................... 8  
  Suicide .......................................................................................................... 11  
    Prevalence .................................................................................................. 11  
    The Need for Treatment ........................................................................... 12  
    Issues with Current Treatment Methods .................................................. 12  
    Barriers to Treatment ............................................................................... 13  
    Theory of Suicidal Behavior ..................................................................... 14  
    Suicidal Assessment .................................................................................. 15  
    Mistaken Beliefs ....................................................................................... 17  
    Suicidal Warning Signs ............................................................................ 18  
  Psychotherapies ............................................................................................. 22  
    Eye Movement Desensitization Reprocessing .......................................... 22  
    Prolonged Exposure Therapy .................................................................... 28  
    Virtual Reality Exposure Therapy ............................................................ 34  
  Adlerian Perspective .................................................................................... 42  
  Conclusion .................................................................................................... 43  
  References .................................................................................................... 49
PTSD and Suicide in the Military

Military personnel perform dangerous jobs around the world and witness human atrocities at their very worst. Upon returning, these images are not easily erased from their memories. Reliving these images and memories is a constant uphill battle, which they face daily. Some of the hardest of warriors will crumble at the slightest sound and become terrified. To make matters worse, these hardened warriors will not seek out help, because it makes them appear weak and vulnerable. They will attempt to work through the problems alone, suffering the horrifying images being replayed in their minds. When they are not able to deal with it any longer, they often turn to suicide as a solution, believing this to be their only option to escape the horrors.

Military Belief System

On the battlefield, the military pledges to leave no soldier behind. As a nation, let it be our pledge that when they return home, we leave no veteran behind. —Dan Lipinski

Military personnel sometimes deal with horrific memories, dreams, flashbacks, and other symptoms that they may not be able to cope with and work through. These men and women feel that they have no place to go to express their feelings. When these men and women enlist into the military, they are expected to learn and abide by a warriors creed (Army, nd). Because of this creed, the way it is written and learned, they may feel as if they are letting comrades down or appearing to be weak.

Imagine hearing this creed being expressed by 200 men and women who have just completed their basic training and are expressing it to their family and loved ones with great emotion and belief: “I am an American Soldier. I am a warrior and member of a team. I serve the people of the United States and live the Army Values. I will always place the mission first. I will never accept defeat. I will never quit. I will never leave a fallen comrade. I am
disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. I always maintain my arms, my equipment and myself. I am an expert and I am a professional. I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat. I am a guardian of freedom and the American way of life. **I AM AN AMERICAN SOLDIER!**” (Army, nd).

Most people do not understand why our service members do not seek out help when they need it. Because of the creed, according to what they have learned, they feel they are to take care of themselves. So when they seek treatment, they feel as if they have not accomplished this task, they have quit, they have been defeated, they are no longer mentally tough, and they may even feel as if they let their comrades down or taken it as far as leaving their comrades behind.

The United States Military is working to provide the help our Reservists, active duty and retired service members need to become healthy. Post Traumatic Stress Disorder (PTSD) does not discriminate. Both men and women may have exposure to traumatic events. The exposure may vary from actual combat to dealing with medical evacuations as a helicopter pilot, or being the individual whose responsibility it is to prepare the service members remains to be shipped home for loved ones to lay to rest. Each individual’s experience varied and will impact each person differently.

**POST TRAUMATIC STRESS DISORDER**

**Diagnostic Criteria**

*Societies which ask men to fight on their behalf should be aware of what the consequences of their actions may so easily be. —Richard Holmes “Acts of War” (Grossman, 1996).*

PTSD is commonly thought of as being the result of one big event (T) where something tragic happens. PTSD can also occur after exposure to a collection of smaller traumatic (t)
events. Regardless of relative “size”, these events can affect people in different ways. In order to diagnose someone with PTSD, according to the DSM V, the person needs to be exposed to actual or threatened death, serious injury; or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic events(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (DSM V, p. 271, 2013).

Even though the person may have been exposed to one of a previously-listed issue it does not necessarily mean that they are going to be diagnosed with PTSD. The person will also need to experience one or more of the following symptoms:

1. Recurrent, involuntary, and intrusive distressing memories
2. Recurrent distressing dreams where the content is related to the memory.
3. Having flashbacks where the person feels or acts as if the traumatic event is occurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues.
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event. (American Psychiatric Association, p. 271, 2013).

**Barriers to treatment.** Unfortunately, the service member is less likely to seek mental health treatment because they view the following five reasons:

1. Medications have significant side effects
2. Treatment could negatively affect their career
3. Treatment could cause denial of security clearance
4. Family and friends are more helpful than mental health providers


This list summarizes what our service members believe are the potential ramifications if they do have to seek treatment for dealing with PTSD. Communication with the service member is key to help them understand that seeking treatment is not a sign of weakness. Additionally, the therapist is there to work with them and not against them. The role of the therapist is to walk alongside the person in the journey they are walking and give them some direction when needed. This will help the service member open up to the thought of working with a therapist, especially if they see that the therapist is on their side and becomes part of a team.

The need for treatment. Because of the prominence of PTSD being diagnosed within our service members, the Department of Defense (DoD) has recognized some evidenced based therapies. These include Eye Movement Desensitization Reprocessing (EMDR) and Prolonged Exposure (PE) Therapy among others. Virtual Reality Exposure Therapy (VRET) is also starting to gain notoriety as a therapeutic technique. In one case study, the effectiveness of VRET was demonstrated. A PTSD patient with a checklist-military version had a completed pretreatment score of 58 had a post VRET treatment score of 29, with significant functional improvement (Gerardi, Cukor, Difede, Rizzo, & Olasov-Rothbaum, 2010). Whether using these therapies alone or together, the result of improved mental health for the service member is significant, when compared to no treatment at all.

There is further evidence that supports the use of PE and EMDR together possessing the most empirical evidence (Sharpless, 2011). Because PTSD is becoming increasingly recognized within society, the cost of treatment is becoming staggering (Sharpless & Barber, 2011).
For the individual there are four significant issues. First, comorbidity is high with only 17% of veterans with PTSD are diagnosed solely with PTSD. Second, PTSD often demonstrates a chronic course, with as many as 40% of individuals exhibiting significant symptoms 10 years after onset. Third, PTSD is also a risk factor for suicide. Finally, other physical health problems are more common in individuals with PTSD (Sharpless, 2011). The likelihood of a veteran to be diagnosed solely with PTSD is quite low. The veteran will most likely have some other mental illness associated with the PTSD. Further contributing to health issues are the increased likelihood of alcohol or narcotic use as a form of self-medication (Center, 2004).

There is a sharp increase of Vietnam Veterans being diagnosed with PTSD in the Veterans Health Administration (VHA). As early as 2009, there had been a 22% increase of Vietnam Veterans being diagnosed with PTSD and seeking treatment for it. These veterans were experiencing new traumas, such as life changes (i.e. retirements or death of a spouse) which compounded the stress they were feeling. The number of Vietnam Veterans with PTSD seeking mental health treatment now is four times the proportional increase of those without PTSD, some 30 years after the end of the Vietnam War (Hermes, Hoff, & Rosenbeck, 2014).

Further, PTSD has a risk of suicide within our military personnel. According to the U.S. Army, 32 veterans committed suicide in June 2010. Ten of the 21 active duty service members had been deployed to the Middle East two to four times (Lee, 2011). Veterans who were deployed during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) and had previous mental disorders, and were five times more likely to develop PTSD after returning home (Lee, 2011).

Finally, veterans may develop health problems after being diagnosed with PTSD. Musculoskeletal and connective tissue disorders, such as spine and knee joint problems, were
most commonly diagnosed (57%), and symptoms or signs of ill-defined conditions were the second most common (44%). The latter category includes various symptoms, such as fatigue, headaches, and memory loss that cannot be linked to an objective medical condition, and includes problems typical of what has previously been described as Gulf War Syndrome (Possemato, Wade, Anderson, & Ouimette, 2010).

Other studies indicated that veterans who served in Iraq and Afghanistan had increased the probability of tobacco use, hypertension, dyslipidemia, obesity and diabetes. Also, with combat related PTSD, symptoms associated with cardiovascular disease such as angina, nonfatal myocardial infarction, and fatal coronary heart disease were found. When the veterans were older, such as 55 years old, they were twice as likely to develop dementia, with or without substance use disorders and depression (Lee, 2011).

When a service member was struggling with the symptoms of PTSD, they found that things that would have been easy to do became a real struggle for them. He or she may find it difficult to find or hold down a job. If the individual was going to school, he or she may find it difficult to remain in school. This transition from the structured military lifestyle to becoming a civilian again was probably the hardest ordeal our service members experienced. It has been said: “You can take the man out of the Corps, but you can’t take the Corps out of the man” (Meuller, 2009).

It could be safe to say that when a person is dealing with PTSD, they are afraid for their life. Because they may realize that their mind and body is breaking down, and they are not used to it. Remember, they are “an American Soldier who will maintain their equipment, keep themselves physical fit and mentally tough” (Army, nd). When the service member feels or sees
these signs happening to them, they realize that they have not lived up to the creed and believe they have let everyone down, even themselves.

**Suicide Prevalence**

*DON’T ASSUME THAT DOING GOOD ALLOWS YOU TO KEEP A FEW VICES. The enemy you ignore is the one who conquers you.* —Erasmus’ (Grossman, 2008).

The number of veterans who are committing suicide has become alarming. When they do commit suicide, it is often through violent means. Most of the OEF/OIF veterans who committed suicide, did so with firearms (73%) followed by hanging (21%; Lee, 2011). When a military service member is at the point of committing suicide, it is hard for them to get away from the mental anguish. They feel guilty because of what has happened, and their mistaken belief is that they could have stopped it or possibly even prevented it. Thus the reason for the violent act of using a firearm or hanging; maybe is a way for them to bring closure to what they did or did not do.

The suicide rate in today’s military has grown significantly. In the past few years, the rate of suicide among the United States Army, as compared to the civilian population has grown from a ratio of 8:1 to 11:1 (Bryan, Cukrowicz, West, & Monroe, 2010). Being deployed to OEF/OIF and other areas of the world where atrocities occur, lays a heavy burden on service members. Not only because of what they are going to be facing, also that they are going to be leaving their families behind. This can be a great hardship and stressor for them.

Since OEF/OIF operations began in 2001, there have been 4700 documented suicides among soldiers. Of those 4700 suicides, approximately 2810 were active duty members (McCarl, 2013). These numbers are distressing when compared to past conflicts. For example, during World War II, the military suicide rates were at the national average (McCarl, 2013).
When comparing suicide numbers between active duty members, Reservists, or National Guard service members, the suicide rate is higher in Reservists or National Guardsmen. Since 2005, 40% of Reservists or National Guard members have been deployed overseas once (McCarl, 2013). Because of the unexpected or unpredictable deployment of these service members, the stress of being deployed is high. They are being taken out of the civilian life and shipped off to a combat zone in a day’s time. With this type of stress being placed on them, the service member has a difficult time coming to terms with what the military wants from them and they feel they have no recourse. When the service member does get deployed, and he or she has problems with depression or undiagnosed PTSD, the military may start treating them with medication to get the service member combat ready. Treating them with medication only pushes the service member through the doors quicker to get them to the battlefield sooner (McCarl, 2013).

The need for treatment. The numbers of military service members who have died in Iraq or Afghanistan is larger than what it is thought to be. When taking into account the service members being killed in action (KIA) and the numbers of service members committing suicide or a delay causality of war, the numbers change. As of December 14, 2012 there were 6,567 military service members KIA in Iraq and Afghanistan combined. When figuring in the suicides of those who were deployed to those regions the number rises dramatically. One military service member commits suicide every 80 minutes (per current trends), or 18 per day which equals 6570 per year. If this trend continues there will be more post 9/11 veteran suicides on the near horizon than there are names on the Vietnam Wall (58, 261; Parker, 2012).

Issues with current treatment methods. Treating PTSD with medication has been found to be ineffective. In fact, psychoactive prescription drugs have been implicated as one of
the causative agents of the high rate of suicide among our troops. Antidepressants have been linked to suicidal thoughts and behaviors (Wheeler, 2014). If the medication for PTSD is not being effective, then why are the clinicians not using psychotherapeutic interventions to help our service men and women? One PTSD study illustrates the benefit of therapy over medication. A group of people who were diagnosed with PTSD was given medication, a placebo, or psychotherapy. The results showed that 60% of those on medication and 58% of those on a placebo still had PTSD, compared to only 20% of those who received psychotherapy (Wheeler, 2014).

Currently, what is happening is that medical professionals in the states are notifying the medical staff in combat zones to have psychotherapeutic drugs in stock as there may be some personnel coming over who are dealing with depression and possible PTSD (McCarl, 2013). Knowing that the effectiveness of drug therapy for PTSD is limited, the question arises then, are our military personnel being treated ethically according to medical standards to ensure he or she is receiving the best medical care needed for his or her health?

**Barriers to treatment.** Military personnel at all levels are dealing with the problem of suicide and suicidal ideation. In addition to experienced active duty, Reservist or National Guard members, suicide is also a problem even at the entry level or in Basic Combat Training (BCT; Bryan, 2010). During this time in the service member’s life, many of them have not been away from home for any length of time. The strict regimen of daily tasks can weigh heavily on a person. They are not prepared for what they experience and do not know how to cope.

When the service member is deployed, the chance of the suicidal ideation and self-harm actions begin to increase, because the avenues to relieve the mental fatigue decreases (Lee, 2012). Here the thoughts of what happened to them while being deployed start to overwhelm
them. They are not able to mentally get away from what they experienced. These service members need to be able to have someone to talk to, however, as mentioned earlier, they are going to have to realize that getting help is not a weakness. It is just another tool for them to use.

**Theory of suicidal behavior.** One model that is gaining support from interpersonal-psychological theory of suicidal behavior is the Joiner’s Model (Bryan, 2010). Joiner’s Model proposed that three distinct variables need to be present for an individual to die by suicide. One is perceived burdensomeness. This is the sense that the person is a burden to those around them and to society. They feel guilty that someone has to take care of them, and they do not want to be a problem. Second is that they have a thwarted sense of belongingness. This means that they do not have any strong connections to other people. The friendships that they thought they had are no longer there, or are strained. These two concepts or ideas are the reasons why someone would want to die by suicide. The last variable, the acquired capability for suicide, is the degree to which an individual is able to enact a lethal suicide attempt. This is the who can attempt factor (Bryan, 2010). People have a natural tendency to avoid pain, but when someone is able to get past the fear of the pain, this is a pre-requisite for serious suicidal behavior. According to Joiner, when someone is going to commit suicide, each of the three variables listed above need to exist. Joiner asserted that a person will commit suicide when both desire and capability are present (Bryan, 2010).

The question is how do we help these service members conquer this troubling condition? Some believe that using selective serotonin reuptake inhibitors (SSRI’s) is the best way to treat someone who is dealing with PTSD. This is predicated upon the belief that an underlying issue is the person dealing with depression. This is partly true. PTSD may have co-morbidity with
depression. The use of SSRI’s is not always effective. Half of the studies conducted from 1980 to June 2007 demonstrated no benefit for PTSD from SSRI’s (Lee, 2011).

**Suicidal assessment.** In order to determine a service member’s psychological status, there are some assessments that may be utilized. Use of assessment tools helps the therapist understand the condition as well as the severity. These include, but are not limited to, the following: Interpersonal Needs Questionnaire (INQ) (Joiner, et al., 2009), Acquired Capability for Suicide Scale (ACSS) (VanOrden, Cukrowitz, Witte, and Joiner 2011), Behavioral Health Measure (BHM) (Kopta & Lowry, 2002), Combat Experiences Scale (CES) (US Dept. of VA), PTSD Checklist-Military Version (PCL-M) (Weathers, Litz, Herman, Huska, & Keane, 1993), and Suicidal Behaviors Questionnaire-Revised (SBQ-R) (Osman, et.al., 2001). These assessments or tools will assist the therapist in determining the severity of the PTSD or suicidal ideation among the veterans. Does using these determine whether or not a combat experienced veteran will have suicidal tendencies?

The INQ is a 10-item self-report that measures current beliefs regarding whether someone is a burden to others and whether or not they feel connected (burdensomeness and belongingness). When measuring this assessment, the higher the score the more likelihood there is for someone to have suicidal ideation (Bryan, 2010).

The ACSS is another self-report form. This form assesses the person’s fearlessness about lethal self-injury. This assessment, however, does not correlate with mood ratings, where it may indicate emotional distress (Bryan, 2010).

BHM is a 20-item self-report questionnaire that assesses global mental health function. This assessment measures depression symptoms and is comprised of six items: mood, decreased motivation and energy, hopelessness, suicidal ideation, self-image and concentration. Higher
scores indicate greater health and well-being, while lower scores show depressive states (Bryan, 2010).

The CES is a checklist of what the military service member experienced while in combat. Ranging from firing his or her weapon, being shot at, seeing death or experiencing someone dying. The total score tallied is a measurement to help the therapist understand where the service member is coming from or what they experienced during his or her deployment.

The PCL-M assesses the severity of the PTSD symptoms. This assessment is easy to use. The DoD and the Veteran Affairs (VA) use this assessment due to its high reliability and validity (Yoder, Tuerk, Price, Grubaugh, Strachan, Myrick, & Acierno, 2012).

Finally, the SBQ-R is a brief self-report that measures past suicidal behaviors. It measures four domains: previous suicide attempts, frequency of suicide ideation, previous suicidal communication, and subjective likelihood of future suicidal attempts (Bryan, 2010). This assessment or report will aid the therapist to differentiate if the person is suicidal or not. When used, it functions to provide a continuous measurement of the person’s suicidal history.

These assessments will help the therapist understand their client’s mental status and whether or not they are a danger to themselves or others. These tools rely heavily on the information divulged by the patient. It is important for the service members to be honest with themselves and with the therapist in order to receive the best possible care.

**Mistaken beliefs.** Adler understood mistaken beliefs, or as he called them interfering beliefs (Powers & Griffith, 1987), to be those thoughts of a person who have a belief structure that would be considered untrue. For example, the person may feel like they are a failure in life because they failed a test at some point in their life. Military service members end up developing a mistaken belief that if they get help they are weak and have let their comrades down.
The therapist has to understand that it may take time for the service member to open up to what they are experiencing. The person may not want to share, as they may still feel that they may be forced out of the military because of a mental health diagnosis. Or they may feel like they have failed to their mental strength. The therapist needs to remember that this population is a special set of people. They are not like the general population. The needs of service members are unique; therefore, the care required is also unique. Unfortunately, the needs for belongingness, significance and self-worth are extremely strong within them. This can create an additional obstacle that must be overcome. By nature, humans adhere strongly to what we believe.

The mistaken beliefs of service members who seek treatment are understandably strong within his or her mind. They may think that everyone in their unit will discover their weakness, or that they will lose the trust of their unit. They may fear that they will lose their leadership role, or their security clearance, or that his or her career will be damaged up to and including being administratively or medically separated (C. f. D. Psychology, 2015). The therapist needs to understand these that mistaken beliefs are powerful. It will be hard for the service member to break away from this.

**Suicidal warning signs.** The Center for Deployment Psychology developed an acronym to help identify the warning signs for suicidality: The acronym stands for - IS PATH WARM (C. f. D. Psychology, 2015).

“T”=Ideation

“S”=Substance Abuse

“P”=Purposelessness

“A”=Anxiety
“T”=Trapped
“H”=Hopelessness
“W”=Withdrawal
“A”=Anger
“R”=Recklessness
“M”=Mood Changes

If a person is exhibiting these within a period of time the therapist, or those around them, need to take notice. The probability and possibility of the person having suicidal tendencies are greatly elevated.

Just as civilians have risk factors, so do military personnel. Some of these factors may be similar. Those who are close to the service member need to pay attention as these may be affecting the ones that they love. The risk factors listed, may or may not be seen in someone who is suicidal. These may be an indication that someone is dealing with something for which they need help.

When a service member is experiencing a relationship problem, with a spouse or other family member, the conflict may exacerbate the risk factor of withdrawal (C. f. D. Psychology, 2015). Human relationships and close-knit ties with others help promote feelings of connection and worthiness.

When the service member starts to feel hopeless or worthless, they start to have a negative image about themselves. They start to believe that anything they do does not matter or what they attempt to accomplish is not good enough. This is another risk factor and it needs attention. The person is starting on a downward spiral and may need professional help if this starts to worsen.
Service members who are abusing or becoming dependent on alcohol are starting to numb the memories or pain from what they experienced or saw (Meuller, 2009). This action can lead to other risk factors, for instance driving recklessly or taking unnecessary chances. When people confront them on their alcohol use they may start to feel disgraced and become isolated, as they do not want to face those who may criticize them for what they have done (Meuller, 2009).

**Suicidal risk factors.** Stressful military life events may be another risk factor for suicidal ideation. As stated earlier, BCT can be a stressful life event for some or even service members who are in their Advanced Individual Training (AIT). When he or she is taken out of the normal routine that they were accustomed to for so long and everything is turned around, the stress maybe too much to bear (C. f. D. Psychology, 2015).

Access to firearms is another risk factor. Because military personnel have increased access to firearms, this is a risk factor that is unavoidable. Because those who are serving at the front lines need their weapons to do their jobs and having easy access to them, others may be in shock when someone does commit suicide. Those who encounter service members can help by watching for drastic mood changes or signs of being depressed. Once these signs are noticed, they can encourage the service member to seek help (C. f. D. Psychology, 2015). Because having easy access to firearms is not the best for them when they are in this state of mind.

Other risk factors that could weigh heavily on a military service member’ minds are financial, legal or job performance problems. If they are dealing with financial problems before deployment and are unable to resolve them, the feeling of letting down the team may contribute to the risk factors. They do not want to be embarrassed by not having their personal affairs in order (C. f. D. Psychology, 2015)
If they are dealing with a legal matter, such as a divorce, the embarrassment of not being able to lead their family could weigh heavily on them (C. f. D. Psychology, 2015). Having that professional image before the ones that they are leading is very important to the military psyche. If this flounders, then they may feel that their unit will do the same when they are deployed.

Job performance problems are another issue for military personnel. Service members want to get promoted and move up in the ranks for their own professional reasons. If they are not able to accomplish the goals that they have set for themselves and have fallen short, this could be devastating for them. Their psyche could be damaged, and they may feel hopeless and worthless in their eyes and take it out on themselves (C. f. D. Psychology, 2015).

When individuals decide that they are going to join the military, they work very hard. From physical training, to being away from home, to dealing with training instructors who are shaping them into the best they can be. If all of their hard work and dedication is cut short, and not because of something they had control of, it is very hard for the service member to walk away. For example if the person develops a life changing disease (i.e. diabetes or asthma), the military will medically discharge them. Because of strict rules and guidelines, the military is not able to keep people who have been diagnosed with diseases that could cause harm to the person or those around them (C. f. D. Psychology, 2015).

If someone is having sleeping problems, this could be a risk factor. Not getting enough sleep or too much sleep is not good for the person. If this is the case, people who are not sleeping enough are going to have a difficult time performing out in the field. They may make mistakes that could lead to someone getting hurt or killed. If they are sleeping too much, they may miss training, and again, their performance may suffer as they are not able to perform to the
best of their ability compared to others. This could instill a mistaken belief that they are not
good enough and that they are worthless and will not amount to anything.

The final risk factor is previous suicide attempts. When a service member does attempt
suicide, it could be a cry for help. The leaders within the unit will need to get the person the help
that they need, so they are on the road to better health. PTSD is not a death sentence to those
within the military. It is treatable. Seeking and receiving treatment is not a sign of weakness, as
some service members may believe (Meuller, 2009). Actually, it could be perceived as the
opposite. The service member is taking care of his or her equipment and not leaving a fallen
comrade behind by receiving help for their PTSD.

Essentially it is hard for the service member to understand that by receiving a diagnosis
of PTSD it is not his or her fault. They are not the cause of the issue. Unfortunately, everyone is
not affected by the PTSD symptoms, whereas others are. People believe they are unique in the
circumstances and the outcome could have been different, only if they would have done
something different. Thus, this individual unique belief system is the dirty little secret our
military service members hide within themselves each and every day (Meuller, 2009).

Consequently then, what type of therapy are military service members going to be
receiving? There are some that are recognized by the DoD, as mentioned earlier. But is there
any one form better than another? More soldiers have committed suicide than have died in the
war in Afghanistan (Wheeler, 2014). The mental health system is overwhelmed and needs to
implement all the evidence-based psychotherapies as treatments to alleviate human suffering
(Wheeler, 2014). Hence EMDR, PE and VRET are vitally important to explore and possibly
utilize when treating military personnel.
**Psychotherapies**

**Eye Movement Desensitization Reprocessing**

*Changing the memories that form the way we see ourselves also changes the way we view others. Therefore, our relationships, job performance, what we are willing to do or are able to resist, all move in a positive direction.* — Francine Shapiro (F. Shapiro, 2012).

The DoD recognizes Eye Movement Desensitization Reprocessing or EMDR as an evidenced based therapy. This technique developed by Francine Shapiro in 1987 began specifically for the treatment for people with PTSD (Shapiro, 2001). Whether it is for police officers, fire fighters, emergency workers or any others who help out people and are thought to tough it out, EMDR has been noticed to work (Shapiro & Forrest, 1997).

The goal of EMDR is not the retrieval of the trauma memory or any other particular memories, but rather a process of assimilation and accommodation of the disturbing experiences with the individual’s cognitive structures (Silver, Rogers & Russell, 2008). EMDR does not erase the memory; it helps the person to become free from the strangle hold the memory has on his or her life. The process of EMDR is an eight-phase psychotherapy. It is designed to address negative experiences, current triggers of the symptoms developed from those experiences, and any future blocks to effective function (Silver et al., 2008).

To begin EMDR, the person will provide a history or earliest example of the problem he or she is dealing with (Silver et al., 2008). Any triggers that could bring a flashback or negative response to his or her emotions are discussed.

The next step in the process of EMDR is client preparation (Shapiro, 2001). Like with any psychotherapy, education is important. Here the person is educated on what EMDR will accomplish. The advantages and the disadvantages of what may happen to them before, during and after. He or she is also taught tension reduction techniques to aid during treatment sessions (Silver et al., 2008).
Once these first two steps are completed, the assessment phase begins. This step focuses on a particular experience and deliberately sets out to galvanize it by having the client report on various aspects of the experience (Silver et al., 2008). These could include representative imagery, the current negative cognition, the desired, but unattained positive cognition, the current emotions associated with the experience, and physical sensations (Silver et al., 2008). What the therapist is looking for is a baseline of disturbance levels that they are able to compare during the course of the treatment with the person.

The next phase is desensitization (Shapiro, 2001). Here the therapist utilizes forms of alternating bilateral stimulation (typically eye movements, sounds, or physical taps). This phase of the treatment is where the person is working through the trauma (Silver et al., 2008). He or she is processing the trauma in their mind. The clinician will note their body or physical movements, even slight, as they are recounting the trauma (Silver et al., 2008). As the person is talking through the trauma, another issue may arise that could be associated with it in some way. Anything that is brought up during the desensitization process is helping the person move towards a better dealing of the trauma. The person is encouraged to talk about what they are experiencing and what they felt during the event.

The desensitization phase is performed until the client no longer reports any disturbance associated with the original event. They are able to access it for a few moments and then move on to the next (Silver et al., 2008). At this time, the therapist will be able to move to the next phase of the process, called installation.

Installation is the process of instilling positive cognitions (Shapiro, 2001). When the negative memory has been removed, and there is a void, it is important to add positive thoughts and memories in to the void so as to not reverse the process. If someone has a mistaken belief
that they were at fault for someone’s death, and they were not able to save them because they were involved in a firefight, the positive cognition could be, they saved other lives by staying in the fight.

The sixth phase of EMDR is called the body scan. During this phase and during the treatment of EMDR, the therapist would ask what the client was feeling (Shapiro, 2001). The client needs to note any disturbing sensations. At that time, the sensations are focused on and the bilateral stimulation is used to dissipate the feelings (Silver et al., 2008). Once the negative feelings are processed, positive feelings are utilized to replace them. During the process of the EMDR therapy, if any more disturbing feelings arise, those are treated the same way until there are no more negative cognitions being associated with the event.

Phase seven is the closure phase. This phase recognizes for an evaluation of the client’s state prior to ending a treatment session (Silver et al., 2008). Meaning during EMDR, there may be some disturbing material that is brought to the forefront of the person’s mind where it may not have an opportunity to process through. During the closure phase, it will provide the client a way to express what they are dealing with (Shapiro, 2001). Also, the therapist will let the client know that even after EMDR has been finished, more processing may occur. For example, a military combat veteran is being treated for PTSD through EMDR, and after the session the veteran goes out to his or her car, hears a firework go off, and experience a mental visual dump of what they experienced in combat in less than a second. If the therapist does not prepare the client that this may happen, the client may go into a shock like state of mind.

The last phase, reevaluation, assesses progress in treatment and usually will open subsequent sessions (Silver et al., 2008). During this process, the therapist and client will discuss any newly emerged problems and deal with them similarly as with the original issue
(Silver et al., 2008). Once the EMDR treatment is completed, usually 8 to 10 weeks, clients are starting to see significant differences within his or her lives. When people are able to work through the problems they have been dealing with for so long, his or her health becomes better and the sleeping patterns are more regular. Because of the bilateral stimulation, EMDR has been known to have links to being Rapid Eye Movement when people are sleeping (Shapiro & Forrest, 1997).

**EMDR and sleep.** EMDR is similar to the process of Rapid Eye Movement or REM or dream sleep. REM state is known for processing experiences, learning skills, and reducing emotional disturbances (Shapiro & Forrest, 1997). It has been shown that REM and EMDR have similar effects. EMDR will stimulate the mind having the bilateral movement between the right brain and the left-brain. Meaning, EMDR therapy involves stimulating the natural information processing tendencies of the brain, while also restricting or dictating the clients reactions (Shapiro & Forrest, 1997). When working with a service member who has seen combat, they need to realize and understand two things in order to help them to become healthy.

First, if he or she believes they are as bad as they think they are, he or she would not still be suffering (Shapiro, 2001). What this says is, if a person honestly believes that they are a bad person, then they would forget about what happened and not even suffer. Or a bad person does not have a conscience and really does not care.

Secondly, his or her suffering now does not help those who were harmed, but it does keep them from doing something worthwhile (Shapiro, 2001). Simply, if a person continues to live their lives in the past on what could have been or what should have happened, they are missing out on life. The person has a great amount of talents to provide to society.
Some veterans will not have a traumatic experience where there are bombs dropping around them. Or have the experience of being shot at while in combat. The trauma is likely to be the loss of ones battle buddy that they were not able to save. They become responsible for the other person dying. They may develop survivor’s remorse or guilt because they were not able to stop the other person from dying. With the help of EMDR, the veteran is able to work through the trauma and have it not control their lives.

The veteran needs to remember though, that when they are going through the process of EMDR, the memory is not going to be erased from his or her mind. The memory is still going to be there, because they experienced the trauma. The main thing about this is that the stimuli surrounding it, (the smells, the sounds, the sights, etc.) are not going to be controlling his or her life anymore. The person will be able to live their lives more functionally and not have to worry about what might happen if they are exposed to a certain stimulus.

In a study conducted on service members receiving manualized treatment, or treatment that has exact steps so individuals receive similar treatment to the therapy, EMDR was conducted on a group of service members the results were encouraging. Out of the 17 providers who participated in the use of EMDR 100% of the service members who used EMDR used at least one procedure of EMDR and 47% used all three of these procedures. Further, 91% identified the worst part of their trauma and any negative associated cognition. Additionally, 83% focused on the traumatic image, negative thoughts, and body sensations. While, 58% moved their eyes back and forth laterally, tracking the clinicians finger. Whereas, 31% tracked other auditory tones, tapped or used other tactile stimulations. And 64% thought of a preferred positive belief to replace negative beliefs associated with their traumas (Wilk, 2013).
With the use of EMDR, those who were suffering from PTSD the symptomology may be reduced. Service members will not have to suffer or continue to be controlled by the experience. They will be able to remember the experience, however, any senses that they may associate with the memory will no longer hold them captive. EMDR has helped Vietnam Veterans and current veterans of the Iraq and Afghanistan wars work through the traumas of what they experienced.

Using EMDR immediately after a traumatic event has been found to be very effective. Being able to process through the event can be done on nonconsecutive days, whereas, by doing it consecutively the symptoms of depression, anxiety and anger may be diminished. The use of EMDR immediately after the event can be an advantage for the client, because there is no homework for the client to perform. This is very beneficial for the client, especially if he or she is seeking treatment while he or she is in the middle of a deployment.

When military service members are being treated with EMDR, it has been found that the PTSD symptoms have gone into remission in 78% of soldiers, and there was a positive effect being maintained at follow-up (Wheeler, 2014). Of those who participated in the treatment, there was a 100% retention rate. This is significant, in that those who were being treated with other forms of psychotherapy, such as cognitive processing therapy and prolonged exposure therapy, 40% of the service members dropped out (Wheeler, 2014).

**Prolonged exposure therapy.** *You can't patch a wounded soul with a Band-Aid.* — **Michael Connelly**

Between 2002 and 2008, tens of thousands of veterans returning of OEF/OIF have received combat-related PTSD services from within the VA (Yoder, 2012). Making PTSD the most common health diagnosis among U.S. military veterans. For this reason, providing high-quality PTSD treatment is a critical mission to the VHA (Mott, 2014). Because of the possibility
PTSD AND SUICIDE

of multiple deployments, exposure to death and dying and the traumatic experience of being under combat situations, PTSD may develop within our service members. In order to help these men and women become healthy and overcome his or her PTSD, another therapeutic tool maybe utilized to help those recover. PE is now being used to help military service members become healthy and conquer their PTSD.

PE is an evidence-based therapy that has gained attention from the DoD for treatment of veterans and current service members for PTSD. Edna Foa, Ph.D. who is the Director of the Center for Treatment and Study of Anxiety at the University of Pennsylvania, developed PE. It is designed to help those who are suffering from anxiety or trauma related events. The therapy is generally ten to 15 sessions, and each session lasting up to one and half hours (C f. D. Psychology, 2015). Unlike EMDR the client is more involved in the therapeutic process, as they are given homework each week before the next session and the sessions are recorded for the client to review throughout the week.

To help determine where a client is in relation to his or her PTSD symptoms, two forms of measurement are taken. One form is the PTSD Checklist-military version or PCL-M. This measurement is a self-report measure that shows scores of 17 to 85. If scores are higher, it reveals severe PTSD. A second measurement is the Beck Depression Inventory-II or BDI-II. This is also a self-report measure that assesses behavioral and affective symptoms of depression that the client has experienced in the past two weeks. The scores for the BDI-II range from zero to 63 with higher scores revealing greater depression severity (Yoder, 2012). Because these two measurements work well together, PE has seen changes in these scores with the whole process.

PE is a manualized therapy, where there is a set process of what transpires for each client who receives this therapy. During the first session, the therapist explains to the client what he or
she expects during the therapeutic process. Explaining that the treatment is focusing on the PTSD and discussing different treatment procedures (C. f. D. Psychology, 2015). These procedures include breathing, education of the treatment process, imaginal exposure and in vivo exposure.

When the client is taught to breathe, he or she is becoming aware of what is happening to his or her body. Breathing helps in bringing down accelerated heart rates and calms the body down so that it is able to perform. It needs to be understood that there are some things that happen to the human body when it is put under stress.

From his research, Lt. Col. David Grossman, U.S. Army (Ret.) found that when a person is put under stress the body will do some amazing things. For example, if a person is shot in the abdomen, they may not bleed right away. The body starts protecting the vital organs from harm by restricting most of the blood from that region. When the stress finally diminishes, the body will relax and then the wound will start to bleed. The person may not even feel the pain of the wound right away, but after the body starts to settle itself down, the pain will become more evident. It is important to educate the client in regards to how breathing is important (Grossman, 1996).

Breathing is the human body’s way of controlling the person’s psychological and physiological processes. When a person’s heart rate is low or at the resting heart rate, the person is able to function normally. He or she is able to think clearly and bodily functions are normal. At rest a person’s heart rate will be around 60 to 80 beats per minute (bpm). When a person is placed under a stressful situation or what they perceive to be a stressful situation, his or her heart rate will increase. When this occurs, different bodily functions will dissipate or diminish. At the rate of 115 bpm, fine motor skills will deteriorate. Between 115-145 bpm the person will have
optimum survival and combat performance level for his or her complex motor skills, good visual and cognitive reaction time. However, when the person reaches 145 bpm, the complex motor skills deteriorate. As the heart rate increases, bodily functions deteriorate. At 175 bpm, cognitive processing deteriorates, vasoconstriction (reduced bleeding from wounds) occurs, loss of peripheral vision or tunnel vision happens, loss of depth perception, loss of near vision and auditory exclusion, temporary hearing loss happens (Grossman, 2008).

When service members are at 175 bpm, they are close to panicking and will most likely have a difficult time remembering what they experienced right after the incident occurred. Unfortunately, the dangerous aspect is when the service member’s heart rate exceeds 175 bpm. This is where he or she will have an irrational fight or flee response. The person will freeze, become submissive in their behavior, and possibly may experience voiding of his or her bladder and/or bowels. His or her gross motor skills will be lost, so that they will not be able to run or charge. And lastly, he or she will be past the highest performance level, meaning they will not be able to perform (Grossman, 2008).

Because breathing is implemented into the PE process, it is very important for the therapist to understand what the client may be experiencing or may have experienced so, to be aware of what is happened during the traumatic event and possibly during session. Having the client breathe by following pattern: of in through the nose 2…3…4…hold, out through the mouth 2…3…4 (Foa, 2007). Repeating this a few times will allow him or her to calm down.

During the education portion of the treatment process, the therapist explains the process of what the client is going to be doing. In the first session, the therapist will interview the client on the trauma by asking questions on what happened. Once the interview is completed, the therapist will teach the client the breathing technique as described earlier.
During the second session, the client will have an opportunity to tell his or her story and their reactions to the trauma they experienced. After this is accomplished, a hierarchy of fears is created. This is to help the client start to work through areas they are struggling with which may have a commonality with the traumatic event. These areas may include places or activities they avoid because it may trigger a reaction. This step is the in vivo exposure homework. The client is asked to do something on their hierarchy of fears and be in the moment with this situation for a period of no less than 45 minutes. The client is asked to document his or her subjective units of distress scale or SUDs before and after the in vivo exposure. When the SUDs scale is low, they are not allowed to leave the area. They are to remain in the moment for a minimum of 45 minutes but not more than an hour. Along with the homework, they are also encouraged to continue practicing his or her deep breathing, so it becomes automatic when they are in a situation, which may become stressful.

During session three, the client’s homework is reviewed. Here the client is able to discuss with the therapist what happened to them during their homework. Here the therapist may be able to assist the client by processing through any difficult situations they may have to deal with. Furthermore, the therapist will present the rationale for the imaginal exposure portion of the treatment process (Foa, Hembree, & Rothbaum, 2007). The client is asked to tell the trauma to the therapist. The length of this portion of the visit is usually 45 to 60 minutes. After the client tells their story about the trauma, the therapist and client will process the session for about 15 to 20 minutes.

As mentioned earlier, each session is recorded. As the client is retelling the traumatic event, they are placing themselves back into the traumatic situation or imagining the event again or working with imaginal exposure. After the session, the client is asked to listen to the
recording of the sessions once a day for the next week for his or her homework. This part of the therapy occurs each time the client and therapist meet.

The following sessions, four to nine (or more), are similar to session three. However, the therapist is looking for hot spots within the story to address (Foa, 2007). Hot spots are areas within the story that are troublesome for the client to talk about. He or she may skip over this moment and move to the next part of the story. For instance, the service member was walking on patrol, and they noticed a man walking in front of them and started yelling at them. They then are talking about being in a building in the dark with dust around them. There is part of the story that is missing, and the therapist needs to find out what this part is. Subsequently, as the sessions move along, the time spent will decrease in the imaginal exposure.

At the last session, the trauma will be discussed, and it will be reviewed as to how much the client was being influenced by the trauma. It also provided review for the client to see how far they have come from when they first started the process. Providing review for the client is healthy, and when the therapist feels he or she is ready to move on they may discuss termination of treatment or if other treatment is needed.

PE has been found to help service members with PTSD significantly. Before treatment started, in some cases, the symptoms of the PTSD were severe enough that the person was having a difficult time dealing with day-to-day issues. After treatment, the symptoms dropped dramatically and remained in a remission like status for over a year (C. f. D. Psychology, 2015).

The use of PE was also being used to help those who were suffering from PTSD and having guilt and shame associated with the traumatic event. It was suggested that PE can be used to address more complex symptoms in PTSD, including those involving shame and guilt (Paul, Gros, Stachan, Worsham, Foa, & Acierno, 2014). When the client was able to talk about
the trauma in a safe setting and realize they were not going to be judged or condemned, he or she would feel more at ease and able to open themselves up to being vulnerable.

When working with clients who were processing fear, guilt and shameful memories, some certain parameters need to be established. One is the activation of and sustained engagement with guilt and shame via the confrontation of identified triggers (Paul et al., 2014). When someone is dealing with the shame and guilt of the traumatic event, and they experience something that triggers these emotions, the person will tend to run away from it. Having the person dwell in the emotion of the shame and guilt can be helpful.

Secondly, retrieval of related cognitions to consciousness (Paul et al., 2014) is equally important. Having the client remember situations or memories and talking about them aid in the PE process. By having the client talk about related topics it will help them conquer the greater traumatic picture they are dealing with.

Lastly, letting the client know that they are going to be talking about or disclosing information in a safe, therapeutic environment (Paul et al., 2014). When individuals realize that they are safe, they are more apt to talk openly without reservation. With safety being one of the basic human needs, when people feel at ease, they feel more comfortable to talk about issues that are bothering them. When traumatic events occur, or they are dealing with shame and guilt from the traumatic event, being safe will help them.

Even having a nonspecific therapeutic style will help the client. When the client realizes and understands they are in a nonjudgmental, uncondemning therapist’s office (Paul et al., 2014) the lines of communication will open. Clients who feel they are being judged and condemned for something, are less likely to open up to someone they do not know. When they feel
comfortable and he or she knows they can share their traumatic experience along with the guilt and shame, the openness to share is more beneficial.

**Virtual reality exposure therapy.** When we stop caring what people think, we lose our capacity for connection. When we become defined by what people think of us we lose our capacity to be vulnerable.—Brene Brown

VRET is relatively new to the psychotherapy field. The first effort to apply VRET for PTSD began in 1997 when researchers at Georgia Tech and Emory University began testing the Virtual Vietnam VR scenario with Vietnam Veterans diagnosed with PTSD (Rizzo et al., 2015). One of the principle architects in the VRET process is Albert “Skip” Rizzo. Rizzo is the Associate Director for the Institute for Creative Technologies and Research Professor at the University of Southern California. Rizzo has found that when people are able to talk about the trauma they faced, physical, mental or emotional, when they are able to talk about it in a safe environment the trauma does not have as much of an effect on them. With today’s technology and the world we live in, the concept of VRET came into production.

The process is similar to PE, whereas there are nine to ten sessions. Just as the first two sessions, the therapist will work with the client to attain an alliance or working relationship so the client feels comfortable talking about his or her trauma. The second session the therapist will provide rationale as to why the therapy is beneficial and also describe the positive and negative aspects of what the client may feel during the therapeutic process.

During the second session, the therapist will have the client become familiar with the equipment. The client will try on the virtual head device so they are able to experience what it will feel like. The therapist will also hand to them a controller, similar to a game console controller or a replica of a military weapon they may have used when in combat. The client will be able to control the movements they see in the virtual headset.
At the third session, the client will start to describe the traumatic event to the therapist. The therapist is able to control what is being seen and heard within the virtual head set. The therapist is able to provide different scenes, sounds, people, and even smells that the client may have experienced. As the client is in the virtual world, the therapist is able to see and hear what the client is experiencing as they are providing virtual feedback to the client as they are describing the scene.

Just as with PE, the exposure is slow and progresses to the more intense aspects of the traumatic event. During the sessions, the therapist is observing the client and taking note of how his or her body is reacting to the process. The therapist is providing safe, reassuring and encouraging words to let the client know that they are ok and they are in a safe place.

As the client is processing through the virtual world and talking through the event, the therapist will need to pay attention to the hotspots, just like they would for PE. By encouraging the client to talk about the hotspots within the traumatic event, the therapist would be able to apply the necessary virtual effects into the simulator. The client will then be able to work through the difficult parts of the event within a safe environment.

During the recounting of the traumatic event, the therapist will ask the client what his or her Subjective Units of Distress Scale or SUDs are. This way the therapist is able to evaluate whether or not to increase the intensity of the virtual imagery or decrease with what he or she is working through.

After each session, the client is given homework to conduct before the next session. Similar to PE, the client is asked to practice deep breathing. When the client starts into the virtual sessions, the client is then asked to continue with the deep breathing and then also to listen to the session that was recorded.
The challenge of using VRET within the field of psychotherapy is why someone wants to re-expose someone to a traumatic event? This would only cause more harm to them and the process of recovery would be deterred, which is his or her thought process. PTSD is a significant problem in warriors returning from combat in Iraq and Afghanistan, however new treatment options are clearly needed for service members with PTSD (McLay et al., 2011).

Another concern is that would the virtual environment be realistic enough in order to trigger and then reduce anxiety? In fact, a study conducted involved soldiers, who were not diagnosed with PTSD, to see if the virtual world was accurate. These service members, who had been deployed several times, felt as if they had a presence within the scenario. When the scenarios was within the convoy, 86% felt it was real and accurate and 82% accurate for city environment (Nelson, 2012).

McLay, et al. (2011) conducted a study that showed the difference in scores from pretreatment to post-treatment. Using the clinician administered PTSD scale (CAPS) the differences that were seen by service members were significant. The study was conducted in a variety of time frames between 6 months to 3 years on different traumas experienced. Traumas experienced ranged from being shot, ambushed, IED blast, mortar attack, suicide bomber, firefight, or military medical trauma. The differences from pretreatment to post-treatment were as much as 90%. Having this much success in relieving PTSD symptomology is great news for this type of therapy.

Because of the number of service members being deployed to Iraq and Afghanistan, the risk of developing PTSD is strong. As of December 2012, DoD Defense Medical Surveillance System database reported 131,341 active-duty service members were diagnosed with PTSD (Rizzo, Hartholt, Grimani, Leeds, & Liewer, 2014). The sheer numbers of our military personnel
developing PTSD is staggering. Especially when 13.2% of operational infantry units met overall criteria for PTSD (Rizzo et al., 2014).

Having success working with military service members in the United States who were diagnosed with PTSD was very encouraging. Having doctors, physicians and psychologist from the military in the combat areas of Iraq and Afghanistan VRET therapy trained was introduced into the combat theater is the next step to helping service members. Those who were doing the research wanted to know whether or not results were going to be achieved similar to those from service members being treated at home. What was discovered was extremely encouraging.

Treating service members while they were in a combat theater showed promise. Even though there were a small number of participants in the study, what it indicated was very enlightening. Of six patients in virtual reality (VR) therapy, all showed improvements in their PCL-M scores. Five of the six showed improvements to the extent they no longer met the DSM criteria for PTSD by the end of treatment (McLay, McBrien, Wiederhold, Wiederhold, 2010). On average, the patients that were being seen while they were deployed saw a 67% decrease in their PTSD symptoms as it was measured on the PCL-M (McLay et al., 2010). During this time frame though, one person out of the six was cycled back to the United States as his or her time of deployment was finished.

How did this particular study happen when the service members were in the combat theater? Even though they were in this area for their unit, the service member participated in the therapy regardless of the issues. He or she would come in and sit through the therapy process, sometimes immediately after a traumatic event. This allowed them to process their emotions, thoughts and feelings in a non-judgmental fashion. It is possible, that when a person harbors a traumatic event and allows it to remain within his or mind, the event will have more of a grasp or
control of their lives. Being able to talk about it in a safe environment could be the keys to helping people conquer PTSD.

The U.S. Military has begun to see the urgent need for psychiatric care for their service members and veterans. With the increase of PTSD being diagnosed amongst them, the need for care is starting to change. The change needs to start within the U.S. Military. Meaning, by allowing the service members to feel they are able to seek treatment when they are feeling they need it, this will not make them feel inferior and weak. By encouraging them to make themselves better so that they are able to perform to the best of their ability the service member will have a sense of self-worth. When the service member or veteran is able to feel comfortable enough to seek help, they will be met with the necessary dignity and utmost respect, as they well deserve.

**Bravemind.** After a traumatic experience, the human system of self-preservation seems to go onto permanent alert, as if the danger might return at any moment.—Judith Lewis Herman

With the encouraging results that the VRET process was receiving from the research, Skip Rizzo developed a virtual reality system that surrounds the imagery and sounds of Iraq and Afghanistan. It is called Bravemind.

This tool is what the therapist will use to help a client with VRET. Where the client will virtually navigate through the virtual Iraq and Afghanistan and be exposed to virtual stimuli they may have experienced when they were deployed. The therapist will aid the client in the different scenarios they may have faced during his or her deployment. Because of the significant progress that has been seen by military personnel, *Bravemind* has grown over the years from only four scenes to now 14 different scenes. The scenes range from cities, to villages, checkpoints, forward operating bases to even Bagram Airbase. Different aspects of these scenes have been
updated as well. Where the therapist is able to input a civilian, combatants, helicopters, sounds and many more.

The great thing about this tool is that it is not only for combat military personnel. It has been used with medics and corpsmen also. These service members are subject to PTSD just as the combat service members because these service members have double the duty. Professionally he or she will have to do his or her job while on patrol and even possibly work on those who may become wounded. Secondly, he or she is going to be psychologically ready to handle the care they may provide for a wounded comrade. The added pressure of having to help a team member after they are wounded may be too much for them to handle.

He or she may develop PTSD, because they were not able to save the life of someone he or she was working on medically. The medic or corpsman may develop survivor’s guilt, as his or her mistaken belief could be that they were one that was supposed to die, or they could have done more to save his or her comrade.

One great thing about medics or corpsmen on the battlefield is that they work in the same environment as the combat service members do. Yet, his or her courage comes from within him or herself to save the life of those who are fallen, whereas the courage of the combat service member may be fueled by anger. Conversely, both are driven by fear, but the courage comes within another place within them (Rizzo et al., 2014).

Lauren Binyon, a World War I veteran penned a poem for those medics and corpsmen who served on the lines with combat service members.

*In a vision of the night I saw them, in the battles of the night. ‘Mid the roar of the reeling shadows of blood they were moving like light...With scrutiny calm, and with fingers patient as swift they bind up the hurts an the pain-writhen bodies uplift...But they take not*
their courage from anger that binds the hot being; they take not their pity from weakness; 
Tender yet seeing . . . They endure to have eyes of the watcher in hell and not swerve for 
an hour from the faith that they follow, the light that they serve. Man true to man, to his 
kindness that overflows all, to his spirit erect in the thunder when all his forts fall, -- This 
light, in the tiger-mad welter, they serve and they save. What song shall be worthy to sing 
them—Braver than the brave? (Grossman, 1996)

When working with service members who are in this field of service, the virtual reality 
scenarios need to be driven to their experience. Because of the intensity of his or her job, 
treating the wounded with gunfire and blasts happening around them, the fear of being killed or 
injured is intensified. Medical personnel who are on the battlefield, regardless of the era were 
considered prime targets. Because, if the medical personnel are killed, they will not be able to 
treat the wounded and in turn will have a greater amount of loss of fighting men on the field. 
Bravemind has been able to work these types of situations into the VR therapy process (Rizzo et al., 2014).

Being able to accommodate the differences in scenarios and adjust to the different types 
of trauma has been the greatest achievement this therapeutic process has been able to work 
through. Implementing scenes from villages with people walking around or seeing wounded or 
even dead people within the virtual reality world will provide as much realism to the client as 
safely as possible. Having the variety of scenarios in the program has helped many people in his 
or her traumatic events.

SimCoach. Build me a son, O Lord, who will be strong enough to know when he is weak, 
and brave enough to face himself when he is afraid, one who will be proud and unbending in 
honest defeat, and humble and gentle in victory. —Gen. Douglas MacArthur
SimCoach is another tool that was developed by a team from the University of Southern California Institute for Creative Technologies (USC ICT) (Rizzo, et al., 2013). This is similar to the VRET for the client, however, it is a little different. The client is able to interact with a virtual human (VH) on the computer screen.

When navigating through the website, the client will see that there are different topics on the right hand margin of the screen (Technologies, 2013). The topics of discussion could be about the VH, discussions about PTSD and topics of depression. SimCoach is an interactive website where the client is able to get answers to commonly asked questions (Technologies, 2013).

Currently there are only two VH’s on the website. One is a retired Sergeant Major and the other is a female civilian. There are two more coming soon. One will be a female aviator and the next one will be a battle buddy (Rizzo et al., 2013). With the help of these VH’s, clients will be able to get answers to commonly asked questions they have about seeking therapy or what someone like them may have experienced. In all providing a safe exposure to asking or dealing with tough questions they may have.

**Adlerian Perspective**

*Seeing with eyes of another, listening with the ears of another, and feeling with the heart of another.—Alfred Adler*

When working with military service members, the therapist needs to embrace the thought that these men and women are no different. Each person is treated the same and fairly. Alfred Adler said, “seeing with the eyes of another, listening with the ears of another, and feeling with the heart of another”, as cited in the book *Readings in the Theory of Individual Psychology*, is a testament of how therapists need to treat clients. If the therapist becomes curious and remains curious about the client, the client will become comfortable and open up. It is a crucial step to
understand that the military service member has a duty to fulfill their mission and it is the therapist who needs to understand what that mission is.

For the soldier to feel that they are successful in their “mission” the therapist needs to understand and become familiar with the culture of the military (C. f. D. Psychology, 2015). For the psychologist the first rule is to win the client (Ansbacher & Ansbacher 1956). By learning the language of the soldier, the therapist will be able to build the trust of the service member. Because at any given point the service member will challenge the therapist and attempt to hide from him the true reason as to why they are there for help.

Another reason it is important to establish a good client-therapist relationship is that successful outcomes are shown when there is a good cohesion between the two. When there is a good relationship, approximately 30% of the client’s improvement actually comes from the relationship itself (Carlson, Watts, & Maniaci, 2006).

When soldiers enlist into the military and recite the soldier’s creed, they strive for significance among their peers. They are making a pledge to themselves and to others that they will do what they are trained to do each and every day. They make it their goal to succeed as a goal of personal superiority, and their triumphs have a meaning only to themselves (Ansbacher & Ansbacher 1956). Soldiers who are suffering from PTSD need to have the feeling that they have succeeded and completed their mission, as they “put the mission first” (Army, nd).

Service members who are struggling with PTSD may be looking for safety, significance and belonging. When they are discharged from the military, the sense of safety that they had for several years is now gone. They are looking for something, someone, or somewhere to be safe. This is why some veterans remain inside their homes because they do not want to go outside (Meuller, 2009). When a service member is discharged their sense of significance disappears.
They are not with their comrades and they are wondering what they are doing. They have a desire to be with them and long for that sense of belonging. The service member knows that they belong with the people they have served with, because each of them knows what the other has been through.

**Conclusion**

*Mankind must put an end to war before war puts an end to mankind.*—John F. Kennedy

Our military service members are continuously fighting in the war where they were deployed. When they come home part of them remains. What he or she experienced is forever etched in his or her minds. For some, there is no escape, and they feel there is no way to conquer the demons that live inside them. Everything catches up to them and unfortunately become another casualty of the war.

Service members who are diagnosed with PTSD are more likely to have a second diagnosis or comorbidity (C. f. D. Psychology, 2015). With having PTSD, the service member is looking to cope with the trauma they experienced. Either by turning to alcohol, drugs or other risky behaviors the service member is looking for some type of outlet to escape the trauma (Meuller, 2009). Because of the comorbidity, the therapist needs to look at the root of the problem. The client may be coming in to talk about his or her depressive moods, alcohol or drug use, or even relationship situations. Consequently though, these issues could be indicative of what they are really hiding. For the therapist to be interested in the client and wanting to learn about them is valuable. More importantly, the therapist needs to show the client they are in a safe environment and they will not be judged or ridiculed for what they share within the office. That the client will understand and realize they are safe from the prejudgment of others.
PTSD is a wound that is not seen, but it is definitely problematic. Sometimes, the trauma could be fatal when service members do not seek the help needed. Service members need to seek help when they are starting to isolate themselves from others. They start to drink quite often, sometimes to the point of severe intoxication or blacking out. By drinking this heavily they want to escape the memories or pain they are having within their mind.

Those that are close to the service member or veteran need to look for the warning signs of suicidal ideation. By remembering the IS PATH WARM acronym. When the service member is talking about suicide or has a sudden interest in the suicide. They start to abuse drugs or alcohol. They begin to feel they have no purpose in their lives and begin to have anxiety about going anywhere or doing anything. They feel they are trapped within themselves and are not able to get away. They have hopeless feelings that they are not able to measure up to what they were once were. They begin to withdraw from family, friends or special functions. They want to be alone. They have sudden outbursts of anger and appear to be angry quite often. The service member may become reckless and start taking unnecessary risks and chances. Or their mood changes quite often (Mueller, 2009; C. f. D. Psychology, 2015).

When these signs are starting to be seen, the service member needs to be seen as soon as possible. The sooner they are able to get help, the better they are going to be. Failure to recognize or dismissing the symptoms the service member is having could have a tragic ending.

Thankfully there is hope for those who are courageous to strive for it.

The VA is working hard to find ways to help the military service members deal with PTSD. Thus the reason why there are different treatment options available.

EMDR has been proven to help those with PTSD work through the images and memories so they do not control them any longer. Helping the service member process through the
memory via bilateral stimulation of the brain helps to create an accommodation of the memories. Instead of being controlled and the service member suffering through the memories, they are able to process and work them. The memories are there as he or she has experienced it. The memories will not go away. With the help of a therapist who is working with him or her, they will be able to understand that there is room within themselves to have these memories. He or she does not need to be controlled by them.

When service members are able to talk about what they experienced, they may feel more at ease at what they experienced. The process of PE is such that service members are able to process through in a safe environment and be encouraged through the memory that they are safe.

Seeing changes in service members pretreatment and post-treatment of different inventories, such as CAPS (PTSD), PCL-M (PTSD), BDI (depression), BAI (anxiety) has to be very encouraging to veterans seeking treatment and also for the therapist. When scores are diminishing from 65 to 24 between pretreatment and post-treatment on the CAPS assessment and seeing a continued dropped in symptoms 6 months later to 20, the reliable change index (RCI) of 17.17 shows PE is working (Paul, 2014).

When a therapist uses PE with a client, regardless of background, the client will have a tendency to avoid certain issues of the trauma. They are unwilling to discuss or even remember a significant part of the trauma. This is one of the cardinal symptoms of PTSD (Rizzo et al., 2013). In order to disallow the client from avoiding the traumatic sequence in their memory, VRET will immerse them into the scene (Rizzo et al., 2013).

When the client is immersed into the VRET scene, the therapist controls it all. The client is able to confront the trauma. Beginning the process of movement for the client in the direction of better health is the ultimate goal of the therapist. By working through this process, the
therapist does not have to wait for the client to actively try to recall the memory or experience. The experience is brought out through the VRET therapeutic process (Rizzo et al., 2013). During this process, the therapist is actively engaging the client to recall the traumatic sequence they experienced. By encouraging them that they are safe and it is okay will allow the client to be comfortable to process through the traumatic event. The client is further encouraged to describe what environmental aspects they encountered. At that time the therapist is able to “produce” the stimuli from the VRET system. Producing explosions, gunfire, and a person walking down the street and even smells to stimulate olfactory senses to help trigger the senses that the client was experiencing in the traumatic scene again. All of this is brought on by the Bravemind system.

Bravemind is a tool that is not only being used to help current serving members of the U.S. Armed Forces, but also with veterans from past wars. The development of the system included the virtual world of the Vietnam War with scenarios indicative of that conflict. With the high influx of Vietnam Veterans coming to seek treatment for PTSD to the VA, this system has incorporated this population into the program (Rizzo et al., 2014). In addition to the Vietnam War scenarios, as mentioned earlier, the scenarios for Iraq and Afghanistan are available for today’s service members and veterans.

The experiences of these service members who fought in OEF/OIF have been created in the virtual world of Bravemind. The scenarios that are in the Bravemind system have been user-centered and tested by those who have served in these regions and also within an Army Combat Stress Control Team in Iraq (Rizzo et al., 2013). Because of the feedback of these service members, the realism of the scenarios has provided great decrease in PCL-M scores and a
significant decrease in the symptoms of those who are or were suffering from PTSD (Rizzo et al., 2013).

With the technological advancements of virtual reality, *SimCoach* is something that both the therapist and client will be able to use. The client will be able to ask questions to the VH that they are not really comfortable asking someone else. This will allow them to start to be a little more comfortable and provide an encouraging aspect to seek the help that they may need.

It will also help therapist too, in that, the therapist will be able to practice on a virtual client before actually working with an actual client (Rizzo et al., 2013) This way the therapist will be able to make mistake here, instead of in the office.

PTSD and suicide within the U.S. Military remains a troubling issue (McCarl, 2013). Fortunately, with the work of Francine Shapiro, Edna Foa and Albert “Skip” Rizzo the changes are coming to help those who are seeking help. Therapists need to remember these people have experienced traumas that they may never even know existed. The help the service members are seeking is not only to get past the PTSD symptom, they may have comorbid issues that need attention also. Having a thorough knowledge what the client has experienced and how they are dealing with it will help the therapist work with the service member. Remembering to be non-judgmental and encouraging will allow them to open up and talk about their traumas. The therapist, just like with any other client they may see, needs to work on establishing the therapeutic relationship first and foremost as this will help open the lines of communication.

U.S. Military members are a strong and determined type of personality. They live by the soldier’s creed daily. They believe it, expect it out of all of their comrades and accept nothing less. Being able to get the service member to realize that receiving help is not a sign of weakness, but actually a sign of strength and courage. That is probably the most crucial part the
therapist can relay to them. Becoming part of their team, learning their language and understanding their culture will bring trust with them and will aid in the service member becoming healthy.
References


PTSD AND SUICIDE


