

HJR

30

<TARGET><BILL>HJR 30</BILL><SUBJECT>HJR
30</SUBJECT><COMM>SSTA29</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 4/11/16

FURTHER:

DATE TURNED IN TO OFFICE: 4/14/16

State Affairs Committee considered CS FOR HOUSE JOINT RESOLUTION NO. 30(STA)

HJR 30-POST-TRAUMATIC STRESS INJURY

Urging the American Psychiatric Association to change the term "post-traumatic stress disorder" or "PTSD" to "post-traumatic stress injury" or "PTSI"; urging the governor to support usage of the term "post-traumatic stress injury"; respectfully requesting that the Alaska delegation in Congress champion this change of designation in the United States Congress; and designating June 27, 2016, as Post-Traumatic Stress Injury Awareness Day.

and recommends:

- be replaced with SCS _____ (_____) Same Title Technical Title Change New Title/SCR No. _____
- adopt previous SCS _____ (_____) Same Title Technical Title Change New Title/SCR No. _____
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
LEG			✓	1
MVA			✓	2

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	Do PASS	Do NOT PASS	NO REC	AMEND
	COGHILL	✓			
	HUGGINS	✓			
	MCGUIRE	✓			
	WIELECHOWSKI	✓			
CHAIR:	STOLTZE	✓			

ALASKA STATE LEGISLATURE




Representative Bob Herron
State Capitol Building, Room 406
Phone (907) 465-4942
Rep.Bob.Herron@akleg.gov

MEMORANDUM

Date: April 11, 2016

To: Senator Bill Stoltze
Senate State Affairs Committee

From: Representative Bob Herron 

RE: HJR 30 – Post Traumatic Stress Injury

I respectfully request a hearing for HJR 30, "Urging the American Psychiatric Association to change the term "post-traumatic stress disorder" or "PTSD" to "post-traumatic stress injury" or "PTSI"; and urging the governor to support usage of the term "post-traumatic stress injury" in the Senate State Affairs Committee.

If you have any questions or need additional information, please call Rob Earl at 465-5141.

Representative Bob Herron

Rep.Bob.Herron@akleg.gov

State Capitol • Juneau, Alaska 99801-1182

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House District 38

Kuskokwim, Yukon & Johnson Rivers

Kuskokwim Bay & Nelson Island

Akiachak

Akiak

Aniak

Atmautluak

Bethel

Chefornak

Chuathbaluk

Crooked Creek

Eek

Goodnews Bay

Kasigluk

Kipnuk

Kongiganak

Kwethluk

Kwigillingok

Lower Kalskag

Marshall

Mekoryuk

Mertarvik

Napakiaik

Napaskiak

Newtok

Nightmute

Nunapitchuk

Oscarville

Platinum

Quinhagak

Russian Mission

Toksook Bay

Tuluksak

Tununak

Tuntutuliak

Upper Kalskag

CS HJR 30 (MLV) Version "P"

Urging the American Psychiatric Association to change the term "post-traumatic stress disorder" to "post-traumatic stress injury"; and urging the governor to support usage of the term "post-traumatic stress injury"

Sponsor Statement

HJR 30 urges discontinuing the usage of the term "post-traumatic stress disorder" and encouraging the usage of the term "post-traumatic stress injury."

A post-traumatic stress injury occurs after a person has experienced a trauma resulting from the stress of combat, as well as rape, torture, child abuse, and other traumas and is characterized by numerous symptoms; including flashbacks, nightmares, insomnia, and thoughts of suicide.

The term post-traumatic stress disorder carries a stigma of misconceptions that the injury is an untreatable disorder – it is, in fact, a treatable injury. HJR 30 joins other national efforts to continue to make post-traumatic stress less stigmatizing in order to increase the number of those affected to voluntarily seek help and assistance. Proper and timely treatment can reduce negative outcomes and, in particular, suicide rates among all citizens, particularly our veterans.

HJR 30 specifically resolves that the Alaska State Legislature:

- Believes "post-traumatic stress disorder" be universally changed to "post-traumatic stress injury"
- Urges the American Psychiatric Association to consider changing the term "post-traumatic stress disorder" to "post-traumatic stress injury"
- Urges the Governor to support the usage of "post-traumatic stress injury"
- Requests that Alaska's Congressional Delegation champion this change of terminology in Congress
- Designates June 27, 2016 as PTSI Day
- Encourages DMVA and DHSS to continue PTSI education programs

ALASKA STATE LEGISLATURE



Representative Bob Herron
State Capitol Building, Room
406 Phone (907) 465-4942
Rep.Bob.Herron@akleg.gov

HJR 30, PTSI

Explanation of Changes

Changes in Military and Veterans' Affairs Committee

P.1, lines 3-6

INSERTED: "respectfully requesting that the Alaska delegation in Congress champion this change of designation in the United States Congress; and designating June 27, 2016, as Post-Traumatic Stress Injury Awareness Day."

P. 2 lines 2-8

INSERTED:

"**WHEREAS** combat-related post-traumatic stress is significantly pronounced, given that many men and women in the armed forces are highly exposed, often daily, to traumatic events, including life-and-death situations, for weeks, months, and even years; and

WHEREAS service members and veterans often struggle with combat-related post-traumatic stress for years after leaving service; and

WHEREAS the extreme survival skills and defensive behaviors acquired as a result of service are often difficult to manage; and"

P. 3, lines 7-8

INSERTED "who" after "affected" and **DELETED** "to" before "seek"

P.3 lines 12-13

DELETED “to defend the right to freedom” and **INSERTED** “our nation and defending our freedom”

P.3, line 26 to P.4 line 6

INSERTED:

“**FURTHER RESOLVED** that the Alaska State Legislature respectfully requests that the Alaska delegation in Congress champion this change of designation in the United States Congress, and be it

FURTHER RESOLVED that the Alaska State Legislature designates June 27, 2016, as Post-Traumatic Stress Injury Awareness Day to bring awareness to the people suffering from post-traumatic stress injury and encourages people to reach out to their fellow citizens to provide support and eliminate the stigma associated with this injury; and be it

FURTHER RESOLVED that the Alaska State Legislature encourages the Department of Military and Veterans’ Affairs and the Department of Health and Social Services to continue educating service members and veterans, victims of abuse, crime, and natural disaster, their respective families, and the public about the causes, symptoms, and possible treatment of post-traumatic stress injury.”

P. 4 lines 14-15

INSERTED “Joshua Sonkiss, M.D., President, Alaska Psychiatric Association”

Changes in State Affairs Committee

P. 3, line 13

INSERTED “**WHEREAS** this resolution does not advocate changing the current qualifications for the Purple Heart; and”

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSHJR 30(MLV)
Fiscal Note Number:	1
(H) Publish Date:	3/23/2016

Identifier: HJR30-LEG-SESS-03-14-16
 Title: POST-TRAUMATIC STRESS INJURY
 Sponsor: HERRON
 Requester: House Military & Veteran's Affairs

Department:
 Appropriation:
 Allocation:
 OMB Component Number: 0

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2017 Request	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES	FY 2017	FY 2017					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 (separate capital appropriation required)
 (discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency?
 If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

N/A Initial Version. One Page. Zero Note.

Prepared By: Jessica Geary, Finance Manager
 Division: Legislative Affairs Agency
 Approved By: Pam Varni, Executive Director
 Agency: Legislative Affairs Agency

Phone: (907)465-6626
 Date: 03/14/2016 11:55 AM
 Date: 03/14/2016

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version:	CSHJR 30(MLV)
Fiscal Note Number:	2
(H) Publish Date:	3/23/2016

Identifier: HJR030-MVA-OVA-03-12-16
Title: POST-TRAUMATIC STRESS INJURY
Sponsor: HERRON
Requester: House Special Committee on MVA

Department: Department of Military and Veterans' Affairs
Appropriation: Military and Veterans' Affairs
Allocation: Office of the Commissioner
OMB Component Number: 414

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates					
			FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
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Estimated SUPPLEMENTAL (FY2016) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By:	Ronald G. Clarke	Phone:	(907)428-6007
Division:	Office of the Commissioner	Date:	03/12/2016 08:30 PM
Approved By:	Robert A.K. Doehl, Deputy Commissioner	Date:	03/12/16
Agency:	Department of Military and Veterans' Affairs		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2016 LEGISLATIVE SESSION

Analysis

HJR 30 states the Alaska State Legislature believes the term "post-traumatic stress disorder" should be universally changed to "post-traumatic stress injury." It urges the American Psychiatric Association (APA) to change the term "post-traumatic stress disorder" to "post-traumatic stress injury" in the next revision of the Diagnostic and Statistical Manual of Mental Disorders, and encourages the Governor to support using the the term "post-traumatic stress injury" instead of "post-traumatic stress disorder."

HJR 30 is intended to 1) bring greater public awareness to the plight of people suffering from post-traumatic stress injuries, 2) encourage both the public and service providers to recognize and reject the stigma associated with terminology describing a medical condition as a disorder rather than an injury caused by an external source or event, 3) encourage the Alaska Departments of Military and Veterans' Affairs and Health and Social Services and agencies nationwide to continue educating service members and veterans, victims of abuse, crime, and natural disaster, their families, and the public about the causes, symptoms, and possible treatment of post-traumatic stress injuries, and 4) support the nationwide effort now under way to change the convention of referring to post-traumatic stress from a disorder to an injury in order to increase awareness, remove the stigma, and help more Americans get the help they need to recover from post-traumatic stress injuries.

The Alaska Department of Military and Veterans' Affairs applauds any effort to raise public awareness of post-traumatic stress injuries in both military and civilian populations, and welcomes broader understanding of their causes, effects, and treatments. While it is conceivable and even desirable more sufferers of post-traumatic stress injuries would seek treatment as a result of the passage of this bill, the Department's Office of Veterans' Affairs anticipates no measurable increase in service demand. OVA personnel and Veteran Service Officers assist tens of thousands of veterans each year and are equipped to address whatever case load increase might result. Further, unless and until the APA, medical providers, and federal and state administrators adopt the naming convention of "post-traumatic stress injury," medical diagnoses and treatment will continue to be prescribed and carried out under existing terminology, and there will be no effect on anyone seeking, receiving, or providing treatment under the old terminology. Consequently, the Department anticipates no fiscal impacts from the passage of this bill.



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER

**Department of Military and
Veterans Affairs**

Office of the Commissioner

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JBER, AK 99505-0800
Main: 907.428.6003
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March 7, 2016

The Honorable Bob Herron
Alaska State Legislature
406 Alaska State Capitol
Juneau, AK 99801

Dear Representative Herron:

Thank you for introducing House Joint Resolution 30 encouraging use of the term "Post-Traumatic Stress Injury" instead of "Post-Traumatic Stress Disorder." We support this and, indeed, any effort to increase awareness of psychological injuries in all their forms, especially the emotional trauma of military combat.

As you correctly note in your resolution, combat veterans and other military service members often struggle with post-traumatic stress, sometimes for decades. The personal, familial, and societal costs of allowing these injuries to go untreated can be enormous, in both human and economic terms. It is in Alaska's greater interest to help Soldiers, veterans, and others confront and surmount psychological injuries; understanding they are indeed injuries and not individual shortcomings is a significant step toward bettering our collective mental health.

As your Resolution points out, we have seen significant advances in the prevention, diagnosis, and treatment of Post-Traumatic Stress Injuries, yet many sufferers remain reluctant to seek assistance. People seeking treatment for mental health challenges are too often seen as personally responsible for their conditions. This discourages people from asking for help, especially those from a military culture that expects strength, self-reliance, and resilience, even in the face of the violent chaos of military combat.

The stigma attached to the term "Post-Traumatic Stress Disorder" carries the implication the person suffering is at fault or somehow inadequate to deal with the aftermath of an externally applied injury. We appreciate your Resolution's intent to dispel that notion and eliminate the stigma of psychological injuries caused by external events. Your resolution is an important step toward recognizing and diminishing the long-standing injustice of this inaccurate and outdated term.

Please let us know how we may assist you in passing HJR 30 through the Alaska State Legislature.

Sincerely,

A handwritten signature in cursive script that reads "Laurel J. Hummel".

Laurel J. Hummel
Brigadier General, Alaska National Guard, and
Commissioner, Alaska Department of Military and Veterans' Affairs



March 11, 2016

Representative Bob Herron
Alaska House of Representatives
State Capitol
Juneau, AK 99801

RE: HJR 30 – Post-Traumatic Stress Injury Resolution

Dear Representative Herron,

Please accept our sincere gratitude for your efforts in the fight to overcome the public stigma and discrimination associated with post-traumatic stress, and help bring honor and parity to all those who have been wounded in action against an enemy of the United States. With the number of service members and veterans, as well as their families now suffering from invisible wounds and their unwarranted consequences, the importance of your efforts here cannot be overstated.

In the end the fight against stigma is a war of words and the more voices to be heard, the larger the arsenal. The presentation of HJR 30 legitimately makes Alaska a pioneer in this resolve. Only fitting from the state whose motto is *North to the Future*.

Respectfully,

A handwritten signature in black ink, appearing to read "T Mahany".

Thomas Mahany
Executive Director
Honor for ALL

April 7, 2016

Commissioners Hummel and Doehl:

I am the Executive Director of Honor for ALL, a non-profit 501(c)3 organization dedicated to establishing visible honor for invisible wounds. I write today to inform you of and ask for your help in our efforts to establish a recurrent national day of recognition when we can honor, without exception, all our wounded.

In 2015, the United States Senate, House of Representatives and 8 individual states presented resolutions and/or proclamations designating 27 June as Post-traumatic Stress Awareness Day. Some still standing with the word disorder, but many making the progression to Post-traumatic Stress *Injury* Awareness Day. I can report to you that at present 37 of the 50 states are now on board to present PTSI Awareness Day resolutions and/or proclamations for 2016. One of these is the state of Alaska thanks to the efforts of Representatives Herron and Tuck on the legislative resolution side.

By introducing the word "injury" in lieu of "disorder" in the designation, it our intention is to effectively diminish the stigma associated with invisible wounds and their perception as mental illness. We believe the use of the word disorder conveys a negative image which can discourage some from seeking care and others from caring. Its use in this instance also assails the sense of honor that should accompany any wound received by a service member in action against an enemy of the United States. It is not our intention to eliminate any established clinical language, only to offer a kinder, more honorable civic term. Precedent for such a dual name allowance is documented in DSM-5 under §300.23 - *Social Anxiety Disorder, Social Phobia*. One diagnosis with two allowable names. No difference in criteria, eligibility or benefits.

With your help we can overcome this deplorable stigma and better ensure our service members and veterans embrace their invisible wounds in a timely, confident manner, ultimately saving lives and preserving families.

For addition information, please contact me directly via return email or by phone 248 224 4875.

Thank you for your consideration,

Thomas Mahany

Executive Director



Honor for ALL

Visible Honor for Invisible Wounds



DART CENTER FOR JOURNALISM & TRAUMA

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Home > Resources > PTSD is "PTSD"

PTSD is "PTSD"

September 19, 2012 by Matthew Friedman, M.D., Ph.D.

Changing the name of PTSD won't eliminate stigma or make sufferers more likely to seek treatment.

[Note: This article represents the opinion of the author alone. It does not, in any way, reflect official policy or opinions of the American Psychiatric Association (APA), the US Department of Veterans Affairs or the Department's National Center for Posttraumatic Stress Disorder (PTSD).]

I don't believe the American Psychiatric Association (APA) should change the name Post-Traumatic Stress Disorder (PTSD) to Posttraumatic Stress Injury (PTSI) because I don't believe that such a change will make a significant difference with regard to stigma or make sufferers more likely to seek treatment. I further believe that Canada's military has come up with the right solution: classification of post-traumatic stress as an Operational Stress Injury (OSI). This policy effectively addresses any stigma-related problems without changing the PTSD diagnostic label. In other words, we can have it both ways: keep the PTSD diagnostic term and have it regarded as an injury.

Why does it matter? First, let's consider the term "injury," which is a sufficient description for many purposes. But if I'm the clinician who is asked to treat an "arm injury," I must know more. Is it a bone fracture, a puncture wound, a serious abrasion or a scratch? If it's a fracture, what bone was broken? Is it a compound fracture or a Greenstick fracture, and so on? Do we need antibiotics? Should a tetanus shot be given? In other words "injury" may be a sufficient description for an after-action report following a specific military mission. But it is much too imprecise for medical diagnosis and the reason we need an accurate diagnosis is to be able to provide the needed treatment.

What was so remarkable when PTSD was first introduced in 1980 was the recognition that the specific nature of the traumatic stress didn't seem to matter. Whether it was combat, rape, child abuse, surviving the Nazi Holocaust – the symptoms were the same: traumatic nightmares, avoidant behavior, hypervigilance, etc. PTSD was PTSD. Thirty-two years of research have fortified the robustness and importance of the original DSM-III diagnosis. The basic construct – that overwhelming stress can produce a consistent pattern of profound and enduring changes in brain function, cognition, emotions and behavior has stood the test

of time.

PTSD is PTSD: Abnormalities in brain function, neurobiological reactivity and psychological mechanisms observed in combat veterans apply equally to rape victims or motor vehicle accident survivors with PTSD. PTSD is PTSD: treatments originally developed for female rape victims rank among our most effective treatments for service members with PTSD.

Changing the name to PTSI in an attempt to reduce stigma among soldiers would reverse years of research and suggest that PTSI is something entirely different.

I don't think the change would reduce stigma and improve treatment-seeking behavior. PTSI would still be included in APA's Diagnostic and Statistical Manual, alongside all the other mental disorders. Service members with PTSI might still be relieved of certain assignments, such as going out on patrols that might further expose them to combat trauma. Service members with PTSI would still know their wounds are invisible. They'd still know that they weren't eligible for a Purple Heart even though their combat-related disability might be permanent and life-changing, whereas many Purple Heart recipients recover from their physical wounds completely and go on without any chronic impairment.

The argument for PTSI is that an injury is a physical wound whereas a disorder isn't. So the "I" would indicate an honorable injury whereas the "D" connotes a dishonorable disorder. But that is simply inaccurate. A disorder, whether PTSD or depression, reflects a disturbance in the biological, as well as the psychological or developmental processes underlying mental function. We know from abundant research that PTSD is clearly associated with biological alterations, especially in brain function. So is depression. According to this logic, we should call depression suffered in the war zone a "major depressive injury" to split it off from other depressive episodes.

There is also the matter of appropriate research and evaluation. There needs to be strong empirical evidence to support any changes from past diagnoses. And, to my knowledge, there is no scientific evidence that changing the name of any disorder will produce the desired changes in terms of stigma reduction and increased treatment-seeking behavior.

Rather than debating what to call this disability, we should be considering how to substantially and meaningfully reduce stigma so that service members with PTSD will come forward for treatment. We already know that affected military personnel recognize that they are not the man or woman they had been before the onset of their deployment-related PTSD. We don't have to convince them that there is something wrong.

What we have to do is: 1) help them understand what is wrong – is it PTSD or something else; 2) help them understand that this is a treatable condition; and 3) help create an environment through military and social policy that will reduce barriers to seeking treatment. I think the real challenge is changing the environment.

The US is making substantial progress via social media platforms, public health campaigns,

and through collaborative partnerships between the Department of Veterans Affairs and the Department of Defense as well as community organizations. There is still much more work that needs to be done in this country. We need to do a better job through public education and risk communication, to increase awareness about our very effective treatments for PTSD. We should look at what has been accomplished by the Canadian military as an example of how major changes in official policy regarding PTSD can make a substantive difference in reducing stigma and increasing treatment seeking without changing the medical diagnosis PTSD. In short, I believe we can accomplish even more.

In Canada, PTSD is classified as an Operational Stress Injury (OSI), along with other injuries to any part of the body sustained in combat. Those with an OSI are eligible for Canada's Sacrifice Medal, the equivalent to America's Purple Heart, whereas Americans with war-related PTSD are not eligible for this honorable recognition. The cornerstone of the OSI model involves many levels of peer support from colleagues who have developed PTSD or some other mental disorder in the line of dangerous combat duty. In Canada, there is widespread public education for service members, their families and the general public, which includes a very active speakers bureau where service members or veterans with PTSD spread the word about the program and their own personal experiences. This education program also includes a specific educational effort directed towards military leaders: generals and colonels at the company and battalion level down to Non-Commissioned Officers at the platoon level. This is crucial because the enlightened behavior of military leaders is a key positive influence on attitudes towards mental health and stigma reduction. There is no wrong door. Any Canadian service member with an OSI due to PTSD will find his or her way to the OSI social support network.

I believe there are many actions being taken, and many more that need to be taken to reduce the stigma of PTSD among service members so they will request effective treatments. I believe reducing the stigma is precisely where we should direct our collective focus because the likelihood of success is much greater than can be realistically expected from calling PTSD something else.

[PTSD & Mental Health](#) [Featured Articles](#) [PTSD](#) [Traumatic Brain Injury \(TBI\)](#) [PTSI](#) [Special Report](#)



Matthew Friedman, M.D., Ph.D.

Executive Director, National Center for PTSD

Matt Friedman is currently Executive Director of the U.S. Department of Veterans Affairs National Center for Post-Traumatic Stress Disorder (PTSD), and Professor of Psychiatry and of Pharmacology at Dartmouth Medical School.

He has worked with PTSD patients as a clinician and researcher for more than 30 years and has published extensively on stress and PTSD, biological psychiatry, psychopharmacology, and clinical outcome studies on

depression, anxiety, schizophrenia, and chemical dependency. He has written or co-edited 15 books and monographs, 52 book chapters and 93 peer reviewed articles in scientific journals. Listed in The Best Doctors in America, he is a Distinguished Fellow of the American Psychiatric Association, past-president of the International Society for Traumatic Stress Studies (ISTSS), chair of the Scientific Advisory Board of the Anxiety Disorders Association of America (ADAA), and has served on many VA and NIMH research, education and policy committees.

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Home › Resources › An Injury, Not A Disorder

An Injury, Not A Disorder

September 19, 2012 by Frank Ochberg

Post-Traumatic Stress Disorder has been an accepted diagnosis since 1980. It's time for clinicians to adopt a new name - Post-Traumatic Stress Injury - that is more accurate, hopeful and honorable.

Post-Traumatic Stress Disorder – PTSD – has been an accepted diagnosis since 1980. And that's a good thing. So why is it now making controversial headlines? Why are some clinicians like myself – along with a wide range of veterans' advocates, women's groups and others – arguing for changing the name of the diagnosis, PTSD, to PTISI – for Post-traumatic Stress Injury?

In large part this argument has been inspired by retired General Peter Chiarelli, the former Vice Chief of Staff of the U.S. Army. After two tours in Iraq, Gen. Chiarelli grew alarmed by rising suicide rates in the Army. He reviewed every case, and came to the conclusion that many service men and women hate the term "disorder," and suffer in silence rather than endure that label. "For a soldier who sees the kinds of things soldiers see and experience on the battlefield today, to tell them what they're experiencing is a disorder does a tremendous disservice," he has said. "It's not a disorder. It's an injury."

Jonathan Shay, MD, PhD – whose pioneering studies of veterans earned him a MacArthur Fellowship – and I agreed with Gen. Chiarelli. We wrote to the American Psychiatric Association President, John Oldham, MD, on April 7, 2012, proposing that the new edition of the Diagnostic and Statistical Manual, currently under review, adopt the PTISI name. We wrote that there is a crisis of suicide, stigma, and misunderstanding affecting young veterans. Anything that helps them seek help is worth consideration. We then argued that the name affects civilian survivors of trauma as well – crime victims, women who are raped and battered, and others who develop the syndrome. Finally, we explained how the injury model applies to the history, theory and treatment of this condition.

(That includes journalists who cover war and have high rates of PTSD. We believe journalists, too, are injured on the job and are more like the physically wounded than the chronically mentally ill.)

Since April, this new language has received endorsements of this proposal from a wide spectrum of individuals, some of whom speak for veterans groups, some for women's issues, and others who represent organizations that advocate for the needs of traumatized populations.

Women who survive rape, incest and battering plead with the APA for recognition of their dignity. They ask the APA to keep the basic concept behind Post-Traumatic Stress Disorder intact, but to improve the name to a phrase that they find more accurate, hopeful and honorable.

Many endorsers are men and women who have received a PTSD diagnosis, who are grateful for the help they have received, but who ask the APA, on their behalf, to re-name the condition an injury. They tell us that they will feel less stigmatized. But they also explain how the concept of an injury, rather than a disorder, does justice to their experience. Once they were whole. Then they were shattered. When their counselors, employers, friends and loved ones behaved as though they were survivors of injuries, with lingering wounds, they could heal. When they felt like mental patients and were treated as persons with pre-existing weakness, they could not heal.

Among those who share this concern are longtime leaders in understanding the impact of violence – including a previous director of National Institutes of Mental Health, Bertram S Brown, MD, MPH; the founding president of the International Society for Traumatic Stress Studies, Charles Figley, PhD; leading feminists such as Gloria Steinem; several authors of books documenting their traumatic struggles, and military and VA mental health professionals.

Jonathan Shay and I shared these letters of endorsement with the APA. We hope those who have the power to name psychiatric syndromes will eventually be persuaded, whether or not the change is adopted for this version of the DSM.

To date, we have heard the following arguments against a name change from members of the DSM-5 committee:

- A name change will make no difference;
- There are far more important ways to combat stigma;
- Disorder is a term in the DSM and it is clearly defined in ways that apply to the reality of PTSD;
- The U.S. Department of Defense can use any name it likes – the Canadian military, for instance, refer to Operational Stress Injury. The DOD, not the APA, should change names;
- The Purple Heart will confer honor and recognize psychological injury. Let's work on that for PTSD received under eligible conditions;

- PTSD has genetic elements and changing the name could reduce emphasis on biological etiology and biological remedy.

In response to the six arguments we hear from the DSM-5 committee members, we offer these observations:

- A name change will make a difference to the hundred-plus people whose letters have been submitted to the APA and to the thousands they have heard from directly on the issue. People who are labeled "disordered" tell us why being labeled PTSD would improve their lives. This is evidence that should be acknowledged, whether or not it means that more will come forward to seek treatment.
- Certainly there may be other important ways to combat stigma. Let's work on all of those. Let's also realize that an APA name change will signal something very positive to those who look to us for leadership. It will mean, "We take this seriously. We listen to our patients. We join the movement to speak with respect about those who have invisible wounds."
- The APA, in the DSM, has defined disorder in ways that apply to PTSD. We agree. But PTSD is at least equally applicable as a label. We have diagnoses in the DSM that use names other than disorder. Because "disorder" seems innocuous to those who write the DSM, we should not deny evidence that the term is degrading to so many who carry the label.
- Canada's military and veterans agencies did change the titles of their clinics to "Operational Stress Injury" services and they did find that a successful move. Take that as evidence that names and titles do matter. Instead of simply saying "let DOD change" (a change that would do nothing for traumatized civilians), use the Canadian experience of beneficial name change to move us forward, not to hold us back.
- The Purple Heart will confer honor, and when the APA changes PTSD to PTSD, the fight for the Purple Heart will be far easier to win. We base this conclusion on soundings we have taken in the US and Canada. Canada does have a Sacrifice Medal for PTSD, stemming from military service under carefully defined circumstances. But the Pentagon needs more ammunition to change the rules for a Purple Heart. Leaders have told us that PTSD will be critical.
- Biological psychiatrists have no reason to fear that a name change to PTSD will inhibit research on genetic factors. There are constitutional factors at play in determining who becomes injured after exposure to traumatic events, and who has difficulty recovering. There is biological vulnerability and biological resilience. The scientific community will have just as much impetus to conduct research and treatment studies on ways to prevent and ameliorate the injury after PTSD is renamed PTSD.

There is another concern we must address. Some actually believe that we who advocate a

name change are motivated by a desire to reduce benefits because we are associated with the military or the government. This is a red herring. Changing the name to injury is motivated by a conviction that there are many who deserve help, including benefits, and they closet themselves due to stigma and fear. The APA will change the elements of the diagnosis as outlined in DSM-5 drafts. These changes are of far more consequence than a name change to third-party payers who may seek an excuse to limit resources.

Indeed, if the APA changes the name to PTSD, all of us must make it clear that we are doing this because our patients, our potential patients, and their advocates have convinced us that this is accurate and honorable and hopeful. But we are NOT suggesting that the consequences of traumatic stress are any less significant, painful, and capable of creating disability. In fact, we believe a name change will help protect benefits by securing broader public awareness and support for those who suffer from the signature psychological injury of war, violence and human cruelty.

In sum, PTSD is a better term than PTSD. It is accurate. It does justice to the condition. It is preferred by those who contend with the condition. The APA would bring credit to itself and respect to its patients by adopting this improvement in diagnostic terminology.

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Frank Ochberg

Frank Ochberg, M.D. is a founding board member of the International Society for Traumatic Stress Studies and recipient of their highest honor, the Lifetime Achievement Award. He edited the first text on treatment of post-traumatic stress disorder (PTSD), and served on the committee that defined PTSD. Ochberg founded and secured the funding for the Dart Center for Journalism and Trauma, served as its first chairman and now is chairman emeritus of the Center. He helps journalists understand traumatic stress and he helps traumatic stress experts understand journalists.

He was associate director of the National Institute of Mental Health and director of the Michigan Mental Health Department. At Michigan State University, he is clinical professor of psychiatry, formerly adjunct professor of criminal justice, and adjunct professor of journalism.

Ochberg developed, with colleagues, the National Center for Critical Incident Analysis, Global Youth Connect (a young persons' human-rights organization), Gift From Within (a charity for persons with PTSD), and the Committee for Community Awareness and Protection (responding to serial-killer threats). For the latter activity, he is the first physician to receive the Law Enforcement Medal of the Sons of the American Revolution. As a Red Cross volunteer, Ochberg has helped families at sites of earthquakes, floods, fires and aircraft disasters. He represents the Dart Foundation and directs their support of victimization programs around the world.

Provided by Rep. Herron to HJR 30 in SSTA




The *Ripple Effect* of PTS

Children of servicemembers can feel the impact of their parent's post-traumatic stress.

By Don Vaughan

Illustration by Marina Munn



NAVY CHIEF PETTY OFFICER JASON MILLER OF LISBON, WIS., served three tours in Iraq as an explosive ordnance disposal (EOD) technician, one of the most stressful and dangerous jobs in the military. Over the course of his service, he lost several buddies to enemy bombs and was blown up a couple of times himself, resulting in hearing loss and traumatic brain injury.

Miller also developed post-traumatic stress (PTS), though it took a while for him to realize it. During visits home between deployments, all he could think about was returning to Iraq, and he often found himself feeling anxious and irritable. Miller's PTS had a detrimental effect on his relationship with his young daughters, the second of whom was born just two weeks before his second tour.

"When I returned home, she had colic and would continually cry for no reason," Miller says. "I couldn't stand to be in the same room with her. When you can't even hold your own child or tolerate the sound of her crying, there's something wrong."

Other times, Miller says, he simply checked out. "I was present [with my children] physically, but not mentally," he explains. Miller recalls one incident in which his daughters were taking a bath and pouring cups of water on the floor at his feet. "It didn't even faze me," he says. "I was a million miles away." As a result of his emotional issues,

Miller says, his older daughter began pulling away emotionally and remains somewhat distant today.

When he started waking up feeling angry and required more and more alcohol to fall asleep at night, Miller knew he needed help. Through an Air Force psychiatrist, he tried a number of therapeutic modalities and found cognitive processing therapy, which requires him to write about his most traumatic events over and over, to be most effective.

At around the same time, Miller's parent command stepped in, pulling him from EOD and instructing him to work on getting better. Miller retired from the Navy in 2013 after 16 years of service.

Though he still experiences symptoms of PTS, Miller says things are much better for both him and his family. Miller continues to journal as needed and published a book about his experiences in Iraq and afterward titled *The Coffin*. (See "Related Resources," facing page.)

"Cognitive processing therapy is a way to help suppress the anxiety," he

says. "I still become anxious, but now I know how to deal with it. And that has definitely helped my relationship with my kids."

A common issue

Miller is far from alone in his struggles with PTS. The National Center for PTSD estimates that between 11 and 20 percent of veterans who served in operations Enduring Freedom and Iraqi Freedom will experience related symptoms in any given year, and the condition affects a significant number of Gulf War and Vietnam veterans as well.

The most commonly reported problems associated with PTS include intrusive memories or nightmares of a traumatic event, feelings such as numbing or guilt, and symptoms of hyperarousal, such as hypervigilance, irritability, and sleep problems. Understandably, these symptoms can have far-reaching effects on a veteran's children, mental health experts note.

Dr. John A. Fairbank, a psychologist and codirector of the UCLA-

Duke University National Center for Child Traumatic Stress, has been studying the effects of trauma on children for decades. In the 1980s, he was part of a study that interviewed Vietnam veterans and their spouses.

"We took a look at how the children were doing from the spouse's perspective," Fairbank explains. "We compared the families of veterans who had PTSD with the families of veterans who did not, and not surprisingly, we found higher rates of reported problems among the children whose veteran parents had war-related PTSD. There was a significant difference."

According to the American Academy of Experts in Traumatic Stress, a parent's PTS can influence a child in numerous ways, depending on age and other factors. The three most typical patterns among children are

- the overidentified child, who experiences secondary traumatization and might experience some of the same symptoms as the veteran parent;
- the rescuer, who assumes the adult role to compensate for the parent's difficulties; and
- the emotionally uninvolved child, who receives little emotional support from the parent.

These children are more prone to depression, anxiety, and difficulties at school.

How parents express symptoms of PTS can influence the relationship they have with their children, notes Dr. Paula Schnurr, a psychologist and executive director of the National Center for PTSD.

"One of the symptoms of PTSD is feeling numb or cut off from the world," Schnurr explains. "The extent to which that is communicated to a child can have the particularly negative effect of distancing the child from the parent. The child may feel unloved or less connected to the parent in that circumstance. And that is children across all age ranges."

However, people vary in the extent to which they feel numbing or how they communicate, Schnurr adds.

"I've had clinicians tell me about parents who can communicate with their children but not anyone else," Schnurr says. "Their children touch them differently. So it's not a foregone conclusion that someone who comes back with numbing is going to be unable to communicate love or have feelings for a child."

Consequences of anger

Another common problem is anger, Schnurr notes. "Fortunately, many people with PTSD don't display significantly angry behaviors, but if they do, I think there are obvious problems that can emerge," she reports. "In extreme cases, anger can really challenge the parent/child relationship."

Young people can respond to a parent's PTS symptoms in a wide variety of ways, experts report. Among toddlers, this might include regression, such as when a toilet-trained child suddenly refuses to use the toilet, or engaging in frequent tantrums. Older children might engage in potentially dangerous behaviors, such as getting into fights, participating in risky activities, or using alcohol or drugs.

"Some children really try to behave," says Schnurr. "They overattribute their ability to control the situation, so they stay out of mom or dad's way or try to prevent mom or dad from getting angry. They may also remove themselves from the situation. Children may also act out because they are angry themselves. In more extreme cases, they may have trouble with school work and general acting-out behavior."

Living in a household with an emotionally distraught parent can have an adverse effect on a child's overall quality of life, observes Fairbank. Sometimes the effects are indirect. For example, a child might do poorly in school because he or she is kept awake

Related Resources

■ *Why Is Dad So Mad?* (Tall Tale Press, 2015) by 1st Sgt. Seth Kastle, USA (Ret)

■ FOCUS: Family Resilience Training for Military Families (www.focusproject.org)

■ Free guides for supporting children from military families (for parents, teachers, and others) from Teachers College Press (www.tcpspress.com/militaryfamiliesoffer.html)

■ Parenting for Servicemembers and Veterans free online course (www.veterantraining.va.gov/parenting)

■ *The Coffin* (War Writers' Campaign Inc., 2015) by Jason Miller

at night by the affected parent's pacing or because the child is concerned about the parent and can't concentrate. Similarly, if a parent is frequently angry or irritable, the child might be reluctant to invite friends over to visit, resulting in social isolation. "There are lots of ways these things can affect children's functioning within the family, within school, and with peers and friends," confirms Fairbank.

Longitudinal analysis

In an effort to better understand how PTS affects young people in childhood and later in life, Fairbank is working with the Millennium Cohort Family Study, which has collected information from nearly 10,000 military families, including active duty servicemembers and veterans.

"The Millennium Cohort Family Study is specifically designed as a



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longitudinal study, and we hope to follow these families for 21 years," Fairbank notes. "This project will allow us to look at the impact of PTSD and other significant war-related health and mental health conditions and see how the children in the families are doing."

There is research in other areas of trauma, Fairbank says, which suggests that when children are exposed to trauma at a younger age, the impact tends to be more complex. "It has a broader range of outcomes, the younger the person is at the time they are exposed to the trauma," Fairbank says. "But what we don't know at this point is how the age of the child relates to the parent's war-related PTSD. We hope to find that out through our research."

According to Dr. Ron Avi Astor, a psychologist and the Lenore Steinfeld and William S. Wood Professor of School Behavioral Health at the University of Southern California in Los Angeles, two of the most important factors that can influence how a parent's trauma will affect the rest of the family are family communication skills and outside support systems.

"From our work, we see it's not the PTSD alone or even the experience of war alone that determines the outcome of a child or family," Astor explains. "While the military parent is away, the other parent may struggle with the organization of the household. If they have good support, it's a nonissue. If they have bad support, it can be disastrous. If you add PTSD on top of that, without a lot of strong social support, I think that makes things even more difficult."

Being a parent with PTS can be extremely difficult. But help is available for those who seek it.

"If you believe you have a problem, reach out," advises Miller. "When you figure out that you have dug yourself into a hole, you have to climb out of it and live in the real

world. Essentially, what I was doing was hiding from the reality that I had PTSD for a long time. You have to face it and not let it define you. You have to make sure you are in control of it."

Fairbank recommends a resiliency-based resource known as Project FOCUS. (See "Related Resources.") "It is really focused on talking about deployments before they happen and upon return, as well as all of the issues that affect children, spouses, and servicemembers," Fairbank says. "It does it in a very family-focused way."

Early prep is helpful

Advanced preparation for a military parent's deployment and return, and the issues that might pop up afterward, also can be beneficial, says Astor. "The more the family can prepare psychologically, socially, and emotionally and speak openly about it, the better, depending on the age of the child," he explains. "Families also need to situate themselves in a strong, caring and supportive family and community setting."

The VA is there to help, says Schnurr. It provides a variety of family services, including education, consultation, and marriage and family counseling, for immediate family and caregivers. Additionally, many support programs are in place, including a parenting self-help Web-based course (see "Related Resources") tailored to the needs of veterans and active duty servicemembers facing mental health and reintegration challenges.

The VA also has partnered with the UCLA Welcome Back Veterans Family Resilience Center and the Military Child Education Coalition on pilots of clinic-based parenting education initiatives. **MO**

— **Don Vaughan** is a freelance writer from North Carolina. His last article for *Military Officer* was "TBI Prognosis," March 2016.