Understanding Military Culture and the Role of Art in Healing

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Areas for Support

Overcoming Stigma

Perhaps the best way to talk about stigma is to start by addressing the elephant in the room. Post-traumatic stress disorder (PTSD or PTS as we will refer to it) is widely associated with service in the Post 9/11 and Vietnam eras. It is openly discussed among civilian populations due to news, literature, and media coverage. While increasing awareness of PTS can encourage individuals to seek treatment and support, it can also be an alienating topic that widens the military-civilian divide. Whereas civilians associate PTS with military service, veterans often feel stereotyped or judged by that assumption. The different ways that veterans and civilians approach this topic is a perfect case study for stigma and how we can work towards overcoming it. Physical and emotional health is highly tied to adequate performance and feelings of self-worth in the military & veteran community. Many service members adopt a power through mentality about their health that carries over into civilian life. Back home, family members and friends can be confused or frustrated by a veterans' reluctance to seek care. This combination of avoidance, pressure from society to be normal or healthy, and fear about what it means to have a diagnosis makes it more difficult to ask for help. Let's consider an example.

> Charlene is a Navy veteran who left the service and is now attending classes at her local college. Her photography professor assigns a group project. Charlene's classmates are excited that she is a veteran and decide their project should focus on "portraits of veterans with mental health issues" with the idea that it will help fight stigma. Charlene feels like her classmates are expecting her be the expert on this subject and doesn't like the negative wording they are using. Why do they need to focus on veterans with issues instead of talking about good experiences? Charlene had positive experiences when seeking mental health treatment during her service, and also doesn't feel like this defines her identity as a veteran. Sensing her discomfort, her group asks if this topic is too difficult for her because of her service. One person asks if she has PTSD or experienced Military Sexual Trauma (MST). Charlene now feels like her peers view her as broken, and she is frustrated that they made assumptions without first asking about her service experience. Her classmates can tell she is angry, and in turn, they also feel uncomfortable. While Charlene is flattered that her classmates show an interest in veterans, she doesn't feel comfortable speaking up because she's worried they will think she has a diagnosis, or is just some angry veteran.

How do we interrupt this negative cycle? **We can begin by engaging in conversations about health and wellness without assigning judgment and worth to an individual's ability.** The next sections will cover basic information about common health challenges associated with military service. It is important for us to be educated on these topics because it challenges misunderstandings and stereotypes. It is also important to understand that these topics do not solely define an individual's experience.

Post-Traumatic Stress Disorder

For the purposes of this primer, and to minimize stigma, we drop the D in PTSD and refer to the condition as Post Traumatic Stress or PTS. The reason for this is that even in the treatment community, many clinicians adopt this terminology in order to depathologize the after effects of trauma exposure. Veterans, first responders, and anyone with a trauma history generally feels more validated and understood when treated as though their reaction, and the post-traumatic symptoms they experience, are normal reactions in response to abnormal circumstances.

When looking at resiliency factors as well as risk factors, the history of the individual plays a significant role. In "Once a Warrior, Always a Warrior" Charles Hoge explains, "One reason that [PTS] develops in some individuals and not in others is that there are differences in resiliency, or the ability to bounce back after adversity. For example, individuals who suffered abuse or neglect as a child, or who have close family members with mental health problems or alcoholism, may be more susceptible after a traumatic event. Genetic factors are also likely to be important in susceptibility to developing [PTS] (though we have a long way to go in fully understanding this). However, individual differences in resilience are probably not the main factor in the war zone. The higher the frequency or intensity of combat – and particularly, the more personal the trauma is – the higher the likelihood of developing [PTS]. Combat is a great equalizer."

We are all influenced by our histories and experiences. If you reflect on your own timeline of significant events, chances are some of them were challenging. People with PTS often do one of two things— 1. They try to separate their military traumas and experiences from who they are and their identity. Or, 2. They immerse into the "PTS identity" and fall under its label and all that goes with it. Some veterans wear the military hat with pride, while others choose not to self-identify. One veteran, when explaining his reasoning behind not identifying himself, stated that after service he became a psychiatric patient, a DWI offender, and a criminal. He was proud of his military experience. Although the trauma he experienced in the service was partly what led to his mental health issues, drinking, and drug use, his veteran identity was still one part of himself he felt pride in. To quote this anonymous veteran, **"I don't self-identify because I can't be both. I can't be a psych patient, a law breaker, and a veteran all at the same time. They need to stay separate."**

When examining PTS, we have to also consider veterans' identities in terms of their conditioning into service. As referenced in the last section, certain survival skills that are trained and conditioned in service members no longer serve veterans when back home. Treating PTS is just as much about deconditioning as it is about trauma processing and return to self. In Indigenous and tribal cultures, when warriors returned from battle there were rituals focused around homecoming such as warrior circles, firepits and cleansing ceremonies. In general our society and culture is less in tune with these existential, spiritual and ritualistic-based practices. With

that, we have to consider what a veteran's deconditioning might look like and oftentimes this falls into their recovery process from PTS.

When looking at the best ways to support someone experiencing PTS, remember that the act of listening can go a long way. Most veterans return home with stories to tell and they may not know who, what, when, where, or how to recount their experiences. In "On Combat" Lt. Col. David Grossman writes a whole chapter on what to say to a returning veteran. He starts it off by stating, "There are three very important gifts that we personally, and collectively as a society, can give to these returning veterans. They are understanding, affirmation, and support." Keep this in mind throughout this section and later as we explore why the arts are so powerful in healing.

Now let's look at PTS on a cellular level. When a person is exposed to extended periods of stress or trauma their brain responds by activating its stress center, the amygdala, which is responsible for fight or flight, adrenaline release, instinct, survival and response to threat or danger. The brain functions in a compensatory manner, meaning that when certain areas are activated other areas decrease function. The prefrontal cortex actually lessens its functionality when the amygdala is activated. The prefrontal cortex is responsible for memory, reasoning, rational thinking and emotional regulation. This is important to know when working with the military & veteran community as oftentimes someone with PTS may respond to a situation in a heightened or triggered manner rooted in a neurochemical response. This is also the reason why many people self-medicate to soothe this process in an attempt to lower and deactivate the stress response. Survivors of trauma may have much higher thresholds for crisis situations (due to desensitization) while at the same time, much lower thresholds for immediate triggers (due to brain chemistry). This, among other dualities, may present as a challenge in terms of supporting a veteran in need.

Characteristics and symptoms of PTS worth noting include:

- Hyperarousal: irritability, heightened sensitivity, agitation, elevated emotional response.
- Hypervigilance: constantly on guard, cautious, in tune with surroundings, alert.
- Sleep Disturbances: nightmares, insomnia.
- Intrusive Memories: intense vivid memories of traumatic events and feelings related to them, flashbacks to traumatic memories.
- Emotional Dysregulation: mood instability, and difficulty managing emotions.
- Anxiety: can be chronic anxiety and/or acute, in the form of panic attacks.
- Emotional Detachment: numbing, emotional constriction, distance, avoidance.
- Altered Belief System: values and beliefs questioned, sometimes disrupted .
- Self-Doubt and Self-Loathing: questioning self, turning blame inward, self-destructive patterns.
- Apathy: less interest, care, or concern for hobbies, passions, goals, and activities.
- Hopelessness About Self and Future: despair, shame, and uncertainty.
- Difficulty Focusing: concentration issues.

For many, PTS is a biological reaction, an emotional response, a psychological condition, an identity crisis and a spiritual wound that in turn affects interpersonal functioning. It affects all life areas. When we look on the other end in exploring post traumatic growth, healing in all life areas must be cultivated.

Traumatic Brain Injury

Traumatic Brain Injury (TBI) occurs when an external force injures the head and brain and is classified based on the severity of the force, the duration of time the person was unconscious following the injury (if at all), the area of the brain that was damaged, and the amount of prior injuries to the brain (if any). TBIs range from mild, to moderate, to severe depending on these circumstances. Someone can experience a TBI even when direct contact is not made with the head, i.e. with whiplash or a nearby explosion. When someone experiences a TBI, their brain function is altered, thereby affecting emotional functioning and behaviors. Common symptoms of TBI include diminished cognitive functioning, memory impairment, impulsivity, mood instability, confusion, detachment and difficulty with sustained attention.

TBIs are considered the signature wound of the Post 9/11 era due to the use of improvised explosive devices in combat, as well as advances in medical interventions that aid in keeping service members alive, albeit with injuries. Research points to a significant correlation between TBI and PTS— prevalence of traumatic brain injuries increases one's vulnerability and risk to developing PTS.

TBIs can occur independently of, or in conjunction with PTS. A TBI is typically tested for with a neuropsychiatric evaluation, as well as brain imaging. There is a significant overlap in symptoms of both PTS and TBI, although the treatments vary greatly, so it is important to diagnostically determine as early as possible whether a person has one of these conditions or both, and if both, the severity level of each. Treatment for moderate to severe TBI typically includes a combination of medication, neuropsychiatric rehabilitation, and cognitive rehabilitation therapy. Although treatment for both PTS and TBI do show effectiveness, oftentimes these conditions are not 100% treatable, leaving lingering effects for the individual and their families.

Moral Injury

The Moral Injury Project at Syracuse University defines Moral Injury (MI) as "The damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct." Similar to TBI and PTS, MI can occur in conjunction with or independent from other conditions. There is also an overlap in symptoms between MI and PTS such as anxiety, depression, anger, sadness, sleep disturbance and emotional detachment. However, MI is more centered around guilt, regret and grief. MI can be a result of action, inaction, mere involvement, or bearing witness to events that go against one's belief system.

Signs of MI include taking inventory of one's values, spiritual or existential questioning, and language involving regret such as making statements like, 'I should have been able to stop the explosion' or 'why did I survive and she didn't?' and 'what if I had not been on leave while that disaster happened?' or 'what if we didn't bomb that village?' and 'I should have been there.' MI has a delayed onset, and can emerge months to years to decades after a precipitating event. MI is not yet a formal diagnosis, whereas conditions like PTS and TBI are diagnoses with specific clinical criteria, although there has been discussion of it becoming one. The spiritual struggles faced by those that have MI can be difficult for the individual to explain, thereby making it even harder for that person to seek help. **It is generally more difficult for people to find words that describe deeply rooted inner conflicts.** Layer this with the veteran civilian divide, stigma, shame, loss of camaraderie, possible PTS and TBI, guilt, loss and fragmented memories and this equates to great potential for silent suffering. Subgroups who may be at greater risk or susceptibility to developing MI include veterans who are LGBTQ, women, survivors of MST, those who have not deployed, are legally involved, or struggle with addiction, Vietnam era veterans, minorities, those who have missed milestones or losses in their families while overseas and those with trauma histories or who have PTS or a TBI.

For some, it's easier not to look at their own MI. Out of this avoidance spawns counterproductive ways to manage these feelings such as isolation, withdrawal, drug or alcohol use, emotional detachment, constant busyness and thrill seeking patterns. For some, it's not even a conscious choice to avoid their MI but rather a way of living that has become comfortable and normal to that person. Many veterans who have MI simply accept it, and the thought of a life without this wound seems foreign to them.

Some terminology you may hear that is peripherally connected to the concepts of PTS and MI are Soldier's heart, shell shock, and survivor's guilt. They all refer to the impact that combat exposure has on an individual's physical, emotional, spiritual, and psychological health. Survivor's guilt in particular refers to the guilt that a veteran carries related to the loss of a brother or sister in arms, coupled with the feeling that it should have been them instead.