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USE OF NARRATIVE TO PROMOTE ALTERNATIVE TREATMENT METHODS FOR POST TRAUMATIC STRESS DISORDER AND MILD TRAUMATIC BRAIN INJURY: A SEMI-SELF-PORTRAIT

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Storytelling serves to communicate, in a non-threatening way, new ideas that can inspire people to action. When done well, a story will draw readers in and help them create a reality where there is no division between the version of the storyteller and the reader. It is when the two stories become one in the reader's mind that the greatest chance exists for change and action.

In telling my story it is my desire to enable action not only by those suffering the effects of mild Traumatic Brain Injury or Post Traumatic Stress, but by those who love, live, work with or supervise them. My story is meant to help overcome the cultural bias that prevents one from seeking mental health assistance and to dispel the assumption of heresy with regard to alternative treatment modalities. By exposing my own pain and learning, both physical and mental, I hope to show others a pathway out of the false reality the brain can create in its self-defense.

Knowledge is only useful to those willing and able to learn.

Haas (2002), in Denning (2005, p. 193)

According to Stephen Denning (2005), "An appropriately told story can achieve what the rigors of analysis cannot: communicate a strange new idea easily and naturally and get people into enthusiastic action" (p. xii). Although I do not think my ideas strange or new, I do want to communicate them through my story in order to impel others to action.

My argument is, first, that there are alternative methods available to treat the emotional pain and physical pain of Post Traumatic Stress Disorder (PTSD) and Mild Traumatic Brain Injury (mTBI), challenges that are afflicting Veterans of the wars in Afghanistan and Iraq; and, second, that more important than the treatment method itself is receiving treatment in the first place. The action I seek is to get people into treatment. By telling my own story, I hope that Soldiers, Sailors, Airmen and Marines suffering with the emotional and physical pain of PTSD and mTBI will overcome their fears, confusions and biases in order to seek treatment. For their families I want my story to inspire hope, hope that things can be better, by providing them useful knowledge about the signs and symptoms of PTSD and mTBI as well as alternate forms of treatment. For leaders and other professionals, I hope to open their minds to a different way of thinking about those who suffer from the effects of PTSD and mTBI.

To accomplish this I apply the narrative techniques described by Denning (2005) in his book *The Leader's Guide to Storytelling: Mastering the Art and Discipline of Business Narrative*. I present a story designed to motivate people to act directly and to get those needing treatment into treatment; to establish my own credibility by sharing my expierence; and to share the knowledge that I have acquired on PTSD, mTBI, and various treatment methodologies.

The storytelling techinque is useful and important to these missions for several reasons. Studies in social pyschology show that information is more quickly and accurately remembered when it is first presented in the form of a story, particulary one that is intrinsically appealing (Denning, 2005, p.2). One may think that developing a story is easy and that telling it is easier still; initially I did. I assure you, however, this is not the case. Take, for instance, a story designed to motivate an audience to action.

It is hard enough to craft a true story that has a clear purpose; a single protagonist who embodies the change idea; the provision of an alternative; elimination of non-essential details; and a happy ending (Denning, 2005). What is much harder to grasp is that in the end it is not my story that makes you take action, it is your story. During the process of reading or listening to my story there is a point in time when it can become your story. According to Professor Janet Greco (personal communication), "The listener fills in the speaker's narrative with his or her own particulars." It is the listener's story that is crucial, because it is the listener's story that springs the listener into a new future (Denning, 2005, pp. 52-64), "one in which he or she can take the role of protagonist" (Greco, personal communication). I offer my story first and foremost to help those who are suffering breach the obstacles to treatment and second to dispel the perception of heresy that surrounds the use of alternative forms of treatment due to health care professionals less familiar with their use.

My Story - All the King's Men

My world came crashing down around me on February 19, 2009. I was on the telephone with the Commanding General when I suddenly and uncontrollably began to sob. I remember suffering the feeling that I experienced during overseas engagements: fast heart rate, shallow rapid breathing, the hot flash and trembling, as the adrenaline flooded my system. What was different this time was that I was not engaged in combat and I could not grab hold of it as I had done so many times in theater. I had lost personal control and had an overwhelming feeling of being lost. I remember the General asking what was wrong, and my reply, "I don't know. I feel like I am shaking apart but my hands are steady. It is like I am outside myself looking in." What I didn't know then is that when the call ended, he called my Command Sergeant Major, who arrived in my office in minutes. The Sergeant Major

stayed there until the General came down about an hour later to remove me from the office.

I had been spiraling downward since receiving the first of several concussions in Afghanistan in 2006. Upon returning home in late February 2007, I often woke up feeling like I had a hangover, even when I had not had any alcohol. I would suffer from a headache that lasted days, accompanied by ringing in my ears (sometimes so loud I could not hear myself think) and light sensitivity. I couldn't fall asleep, so I would drink to relax. I was short-tempered, irritable, and angry. At times I would forget what I was talking about in mid sentence or repeat myself several times. I isolated myself from friends and family, determined to snap myself out of whatever it was that was bothering me. I felt I just needed time to deal with it, but eventually it all became too much, and in late summer of 2008, I finally went to a physician for help.

I was sent for an MRI, CAT-scan, audiology examination, eye examination, and finally ended up with a neurologist. I was diagnosed with migraines and given two sample drugs to take, with a return visit scheduled in a month. The drugs did nothing to prevent or reduce the headaches, light-sensitivity, or ringing in my ears. On the follow-up I was given a different drug, one that I took daily to prevent and reduce the headaches. The drug, I was told, would cause some confusion when I initially began to take it. I was told not to worry, as it should not interfere with my ability to work. On medication day three (a Wednesday) I showed up at work unkempt, with no nametags or rank on my uniform and unable to remember how I had gotten there. I knew I had driven, but did not remember the trip. By the end of the day the medication had worn off, the headache was back, and I drove home.

The Saturday after that, February 19th, I was awakened at 0345 by the phone ringing. I was informed of a combat casualty in Iraq and that we needed to initiate the notification and assistance process. I am told that I was initially disoriented and then abrasive. I remember trying to go back to sleep and having my first ever flashback of an engagement with Taliban forces. By 0500 I was unable to sleep so showered and dressed for work. I stopped for breakfast at an all-night diner and was at the office before 0700. On the inside I was racing at warp speed but on the outside the world was moving terribly slowly. At around 0800 I was on the telephone with the Commanding General, as recounted, when my world came crashing down.

A little more than an hour later I was discussing with the General my plan to seek treatment so that he would be assured that I was committed to getting better. The reality was that there was no more denying I was injured; I finally realized I had sustained an invisible wound and I would need help from a mental health provider in order to heal. As I look back to that day, I am thankful that whatever triggered my brain to overload my emotional and physical receptors did not cause me to harm myself or anyone else.

I was lucky enough to be in the Tricare Prime Remote System, so my medical provider was a civilian, and her referral for mental health went unchallenged by Tricare. I was then provided a list of about seven providers. I called the closest three and waited, making an appointment with the first one to call me back, The Quiet Mind Foundation.

Showing up at a psychologist's office for the first time was uncomfortable in numerous ways, but in the days, weeks, and months that followed, I learned many things about my friends, my family, and myself. Now, after a year of treatment, I look back and wonder why I did not do it sooner. I have fewer headaches, am sleeping better, and have restored cognitive ability. I no longer avoid being with family and friends, and more importantly, they no longer avoid me.

My Mission

I sent a copy of my working draft of this story to several military friends and associates. I received feedback from two people almost immediately. The first, said it was a "little scary" to read my tale. (I had, through previous conversation, inspired this person to seek treatment.) The second, a spouse of a Soldier, told me: "I really enjoyed your paper it is good [sic] that someone is trying to make a change because everything you said is very true. Trust me I live with it every day and its [sic] very hard, because he won't go get help." By describing my symptoms they had turned my story into their story.

My intent is to get those who suffer silently to identify the symptoms, reject the pain of suffering, and embrace the joy of treatment. Based on the limited feedback I have, I think I am headed in the right direction. Only time, and numerous telling of this story, will determine if I am successful. I am battling against the lingering perception among service men and women that seeking treatment will reflect negatively on them.

Definitions and Research

When we MEDEVAC a Soldier from the battlefield with a visible wound, we give him a medal and call him a hero. It is not the same for the countless Soldiers, Sailors, Airmen and Marines who return home with PTSD, whether or not caused by or in conjunction with mTBI because PTSD is classified as an illness not an injury:

> Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood.
>
> People with PTSD experience three different kinds of symptoms. The first set of symptoms involves reliving the trauma in some way such as becoming upset when confronted with a traumatic reminder or thinking about the trauma when you are trying to do something else. The second set of symptoms involves either staying away from places or people that remind you of the trauma, isolating from other people, or feeling numb. The third set of symptoms includes things such as feeling on guard, irritable, or startling easily [Hamblen, 2010 p.1].

This classification may be part of the barrier to treatment. A study of Soldiers (Hamblen, 2010) returning home from Iraq found that only 40% of service members with mental problems said they would get help. In many cases this was due to the Soldiers' fears about what others would think and how it could hurt their military careers. I believe strongly that if PTSD is redefined as an injury, then Soldiers and others will more likely treat it as an injury. Such relabeling will not only promote the seeking of treatment for those suffering but also may serve to remove the stigma attached to sufferers and make treatment acceptable within the military community. This change in nomenclature may seem overly simple, but unless we do it, we will never know.

Mild Traumatic Brain Injury (mTBI) is different from PTSD in that it is a physical injury to the brain and is defined as follows:

> A physiological disruption of brain function as a result of a traumatic event as manifested by at least one of the following: alteration of mental state, loss of consciousness (LOC), loss of memory or focal neurological deficit, that may or may not be transient; but where the severity of the injury does not exceed the following: post-traumatic amnesia (PTA) for greater than 24 hours, after the first 30 minutes Glasgow Coma Score (GCS) 13 - 15, and loss of consciousness is less than 30 minutes. Generally the terms mTBI and concussion are used interchangeably [American Congress of Rehabilitation Medicine, 1993, pp.86-87].

This cumbersome definition shows why most people do not know what a concussion is! In truth, the chances are if you strike your head and are momentarily disoriented, you have suffered an injury significant enough to cause concussion.

A concussion is actually not defined by a physical injury but by a loss of brain function that is induced by trauma (Academy of Neurology, 1997) It would seem to me that trauma, whether emotional or physical, would cause similar electro-chemical reactions in the brain. A study conducted at Emory University in 2004 has had success in indentifying areas of the brain physically affected by PTSD as well as success with treatment by Selective Serotonin Reuptake

Inhibitors (SSRIs) (Bremner, 2002). Work continues at Emory and elsewhere to understand the brain's reaction to the electro-chemical response of emotional trauma. Why then do we have a double standard, classifying PTSD as an illness?

If we do consider PTSD purely as a disorder of the mind, then centuries of cultural bias weigh us down in attempts to treat it among those who are and still wish to be seen as brave, strong, and competent. As a culture we have a negative mind set towards mental illness for several reasons. First, before the age of enlightenment, mental illness was looked upon as possession by the devil. Second, during the mid-to-late 1800s, gentlemen of culture were being cloistered away in back rooms of mental hospitals around the world, suffering the late-term effects of syphilitic insanity, referred to at the time as "the pox" -- Italian, French, or English depending on country of origin (Seligman, 1995). Society came to associate the mental condition with the character flaw of being with women of ill repute. Even after science proved the cause of the disease was an invading microorganism, society did not let go of this puritanical view. PTSD is not the result of a character flaw or of having low moral values. Trauma, be it physical or emotional, causes a reaction in the brain that alters it from the norm.

I am certain that, like me, many Soldiers do not consider getting their "bell rung" a serious brain injury. It is. What is more frightening is that several such lifetime incidents have the potential to lead to serious health issues. The long-term health effects of multiple concussions are further complicated by the frequency at which they occur. Some of the best data available on concussions are coming out of organized sports, specifically American football (see for example, Guskiewicz, McCrea, Marshall, Cantu, Randolph, Barr, Onate & Kelly, 2003).

As noted by Green, Strange, and Brock (2002), "Cognitive scientists have discovered that we turn experiences – both our own and those of others – into stories to help us remember them and communicate them effectively" (pp. 292-294).

One of the best stories I found on the subject of mTBI is *Head Games: Football's Concussion Crisis* (Nowinski & Ventura, 2007), which I expect will help me in my quest to inspire action in members of the military. Much like the professional football organization, our government is having a crisis in coming to terms with mTBI. The number of afflicted Veterans continues to rise with each rotation of forces home from Afghanistan or Iraq. Being too slow to recognize long-term effects, or to implement treatment, is having a significant impact on the quality of life for those afflicted. Self-medication is leading to an increase in drug and alcohol abuse, which in turn is causing an up-tick in the number of adverse separations from service for disciplinary reasons.

Nowinski and Ventura and I share a common purpose when it comes to mTBI and our desire to educate the community, help prevent injury and promote treatment. Their story is very powerful. While reading for my research, my method of note taking is to use Post-It™ notes. Upon finishing the first chapter of *Head Games*, my note was: "This is me in 2008!" Nowinski and Ventura's story had become my story, solidifying my acceptance of Denning's principles on storytelling. I was not reading about football players, I was reading about me, and the information jumped from the page and into my brain.

One of the more significant pieces of research is on the long-term effects of multiple concussions: "Players who had suffered three concussions in their lifetime had more than three times the rate of clinically diagnosed depression and five times the rate of mild cognitive impairment, also known as pre-Alzheimer's disease" (Nowinski & Ventura, 2007, p. 8).

The US government is also continuing to study PTSD and mTBI. In a six-year study of 181,093 Veterans conducted from a California VA hospital (Jaffe, Vittinghoff, Lindquist, Barnes, Covinsky, Neylan, Kluse & Marmar, 2009, p. 104), researchers found that Veterans with PTSD were twice as likely to develop dementia compared to Veterans without PTSD. The researchers are calling for further studies to determine the link between PTSD and dementia in an effort to decrease risks to Veterans.

Treatment Options

Early on in my psychological treatment I identified seven concussive occurrences in my lifetime. These did not include my multiple exposures to the concussive effects from over-pressurization of an explosive blast. The discovery of the long-term effects *scared the hell out of me*. I needed to know what I could do to *prevent this from happening to me*!

The process of treatment for my PTSD and mTBI are part of the answer and has involved three methodologies. First was the discussion therapy, second was exercise, and third was Far Infrared (1072nm) Light Stimulation Therapy. There are also two additional alternative treatments, Acupuncture and Quantitative Electroencephalography (qEEG) Biofeedback.

Discussion therapy was not what I imagined it to be. Part of my aversion to psychotherapy is that I envisioned a Freudian-looking therapist sitting over me, taking copious notes, while I lie on the couch answering questions about childhood. I was relieved to find that this was not the case at all. What it is for me is having my own private tutor to help me re-learn me. I learned to open my mind and accept that as a human being I am a system of mind and body. What affects my mind most likely affects my body and vice versa. By discussing with me what I think and what I feel, my therapist has guided me on a journey of techniques to interpret and counter thoughts that generate negative emotion and energy.

I was told that my brain had diminished ability to cross-lateralize information between the left and right hemispheres. This information caused an "aha" moment when I looked back at what the drug I had been prescribed in February was intended to do: in addition to use as a migraine treatment, it is also used to control seizures from epilepsy and to treat bipolar disorder. Treatment for these ailments is to restrict the brain's flow of information across part of the brain called the corpus callosum, the neural pathway between the hemispheres. The medication further complicated what was already happening within my brain. The chemically induced shunt of the corpus callosum trapped me within my right hemisphere. Unable to balance between my hemispheres, the emotion came pouring out during that fateful phone call with the General. In therapy, by using a series of motor skill movements, I caused my brain to relearn simultaneous use of both hemispheres. The exercise came from the book *Edu-K* (Dennison & Dennison, 1987).

The third treatment method involved wearing a headband that uses infrared light to monitor blood flow in the brain while watching a movie or listening to music on the computer. Dementia studies have indicated that the use of low power Far Infrared (1072nm) can improve cognitive ability in about four weeks of use, ten minutes per day, by stimulating brain cells to repair themselves (University of Sunderland Press Release, 2008). Trials are currently underway, and this seems to be a promising new technology, one whose benefits I personally experienced. I remember at about the six-week mark of my therapy realizing that I could hear myself think, something I had been unable to do for quite some time. This was the first of many milestones to come over the course of the year.

Another treatment that I have not used but intend to is Quantitative Electroencephalography (qEEG) biofeedback. This therapy has derived from the diagnostic tool of the EEG used to monitor electrical brainwave patterns. As with infrared light therapy, I will be subjected to auditory or visual stimulation in an effort to retrain my brain via the monitoring of electrical impulses. Studies show that most individuals with mTBI improve on neuropsychological tests as a result of this therapy (Thatcher, Walker, Gerson, & Geisler, 1989, p. 105).

Another alternative treatment method is acupuncture. I use traditional Chinese acu-puncture with my therapist, who is originally from China where she was educated and practiced for more than a decade before immigrating to the United States. At the first visit Dr. Liu devised a plan to insert the needles at key points to relive the emotional and physical stresses on my body. Cheng (1987) noted that, "According to traditional Chinese medicine, acupuncture points are situated on meridians along which qi (a 'life energy') flows" (p. 35). My practitioner agreed: "Qi is like a river. When it flows uninterrupted it flows smoothly; when it is blocked it flows quickly, like water over rocks at the rapids" (Liu, personal communication). By inserting the needles in

positions along the meridians, Dr. Liu is working to insure my qi flows smoothly. I am experiencing an inner calm as well as pain relief from herniated discs in my cervical and thoracic regions. It works, and I urge others to try it and to be encouraged by over three millennia of Chinese practice of this procedure!

Time and further studies by the medical and psychological communities will continue to validate procedures I have mentioned, as well as discover new and more effective treatment methodologies. I have hope that results of the research will significantly reduce my risk over time for depression and pre-Alzheimer's dementia.

Summary

The road to successful recovery begins with the decision and action to seek treatment. This applies equally to those suffering from PTSD and mTBI as well as to those family members who support us. Help is not far away. For Soldiers, Sailors, Airmen, and Marines it is as easy as going to "sick call." The chain of command is another avenue, as is the Chaplain. Military OneSource (Military OneSource, 2010), through a webpage and toll free number, can assist in locating a provider, and also keeps the treatment confidential. If reading this paper has struck a nerve, and you are a Veteran of war, I encourage you to seek help. Don't miss out on the great things life has to offer by living in a daze trying to control things, that in the end, you cannot.

For family members, in addition to the chain of command, Chaplain, and Military OneSource, referrals are available from primary care providers. Don't forget, if the situation is life and death dependent, 911 is the fastest way to receive immediate assistance. I encourage those who need help not to be afraid to reach out. In our fast-paced world we often do not recognize that someone is in need. By reaching out, the sufferer can hopefully teach us the signs of trouble and allow us to help others sooner.

I encourage those of you in leadership positions not to ignore the problem signs we are all trained to recognize. I also encourage you, once you recognize the need, not to allow the Soldier, Sailor, Airman, or Marine talk you out of his or her need for help. There comes a time when a leader must make the hard decisions and take charge.

My failure to control me did not occur because I wasn't smart enough or strong enough. I failed to control me because I did not have the proper tools in my toolbox. Once my brain was *out of whack*, I no longer knew what was best for me. Despite my friends and family who prodded me, I was able to rationalize away all their concerns with my warped sense of what was right for me. I believe, as Master Uguay said, "There are no accidents" (Osborne & Stevenson, 2008). I also believe that what happens does so for a reason. That reason may not always be clear in the moment, but we should not let that dissuade us from taking action.

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