Psychotherapist, Author, and Vietnam War Veteran Dr. John L. Hart responds to Michael Savage's Views on PTSD

John L. Hart, Ph.D. author of There Will Be Killing

Everyone is entitled to express their opinion here in America, even radio shock jocks of all stripes and flavors, and that includes Michael Savage. Mr. Savage has a popular radio talk show that I have admittedly never listened to but he recently made a lot of waves over the air after ranting, "I am so sick and tired of everyone with their complaints about PTSD, depression. Everyone wants their hand held, and a check—a government check. What are you, the only generation that had PTSD? The only generation that's depressed? I'm sick of it. I can't take the celebration of weakness and depression . . ." And so on.

I gather that Mr. Savage has a reputation for doing a lot of ranting and expressing opinions that a certain segment of the population is inclined to agree with. Good for him and them. It's America. We get to do that. It's one of our basic freedoms that we should never take for granted, particularly since so many of those freedoms have been bought at a heavy cost to our men and women in uniform.

As a forty-year practicing psychotherapist and a veteran of the Vietnam War who has also struggled with PTSD symptoms, I personally and professionally disagree with Mr. Savage's assessment of this Anxiety Disorder. However, he does get points for further opening the dialog regarding PTSD, and I would like to expand that to the debilitating effects it can have on those who live with its sufferers.

It is relatively easy to identify symptoms and then make a quick list of the effects of trauma on young women and men in war. It is NOT easy to sit three feet away from that same traumatized individual and hear their breathing become increasingly rapid and shallow as their diaphragm constricts, see the raw fear and agitation growing on their face, hear the tremor of anxiety in their voice as their throat muscles tighten; to smell their sweat and taste their horror, listen to their sobs, sometimes escalating into shrieks and screams.

What I have just described is a session that can occur between a mental health practitioner and a patient who has been exposed to violent physical/mental/emotional traumas. This could happen in a war zone, or, sometimes, as close as home.

One of the greatest challenges most of us face as therapists is the ability to strike a balance between empathy and self-preservation in order to do our jobs and continue to help those who need us. This is equally true for those who aren't necessarily mental health professionals but find themselves in a similar role requiring compassion, active listening skills, and doing their best to deliver sound advice to a loved one who is no longer on steady ground themselves.

For those of you in that position, as well as anyone who is simply curious about the extraordinary workings of the mind, I would like to introduce you to what is known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). This is the diagnostic bible for mental health practitioners—and of course I am very happy to provide a copy to Mr. Savage upon request. The DSM Manual has gone through several incarnations (we are now up to DSM-5) and I'll spare you a history lesson on it, but let's say someone you care about has been exhibiting certain signs and symptoms that didn't just pass or

indicate a blip in behavior (we all have those). No, this is something that feels a little scary because they've been struggling for at least a month, and you've begun to wonder if it could be what we now call Post Traumatic Stress Disorder—a diagnosis that wasn't in the textbooks until 1980. So, when Mr. Savage brings up the generational gaps of response to war trauma, he does have a point that has much to do with advancements in research and education.

While I would never recommend anyone make a mental health diagnosis unless they are a qualified professional, I would like to offer an abbreviated excerpt from the latest DSM that a professional would use as a basis for identifying this particular Anxiety Disorder (Warning: this is excerpted from an academic journal; scroll past the next page if you want to skip school):

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on wakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

With Delayed Onset: if onset of symptoms is at least six months after the stressor

And there you have the clinical criteria for a diagnosis of PTSD. Identifying signs and symptoms with the assistance of an academic text, however, essentially whittles it down to nothing but reading words on paper. The real work occurs in a room alone with a patient or with a group of patients. And that is very, very different.

Let's go back to our earlier session: Three feet away from the traumatized person you're actively listening to as they relive what caused their PTSD. They take you back to the time and setting where they experienced the trauma. You are both immersed in a seething cauldron of fear and shock and terror and

pain. You and they may be experiencing vivid images of the events that they are describing: unbelievable atrocities most of us would never encounter outside a murder mystery or psychological thriller that might include torture, deprivation, mutilation, and worse. These horrible things have seared themselves in their memory. And now yours. You and they will now continue to live the images of those experiences again, and again, and again.

This is not simply words in a book and lists of symptoms on a piece of paper. If Mr. Savage could experience a session like this, or more to the point experience first-hand the kind of trauma leading to such a session, I daresay he would be singing a different tune.

For several years I was a member of the clinical faculty for Basic Clinical Training at the National Child Advocacy Center in Huntsville, Alabama. The training was for new child psychiatrists, clinical psychologists and counselors from various disciplines who were planning to have a career working with children who have been physically, emotionally, and/or sexually traumatized. I greatly admired these people who were taking their advanced training into a field of work that was somewhat like a war zone. Indeed, recent brain research has shown that the brains and nervous systems of traumatized children and young combat veterans experience some similar changes due to long-term stress. What we found over time was that the brains and nervous systems of the care givers working in this field also experienced changes. Whereas “combat fatigue” was an accepted given for soldiers, “compassion fatigue” for caregivers is a newer realization just now beginning to be fully acknowledged and respectfully accepted as a form of emotional trauma itself.

What became evident after looking deeper into the career paths of people entering the field of child trauma treatment was that the work took a quick toll on the therapists. Many of the therapists, after long years of dedicated study, would leave the field soon after they started. Those that stayed would find it taking a toll on their own wellbeing, their physical health and their own families suffering as a result. They were experiencing what we now call secondary trauma after repeated exposure.

During the Basic Clinical Training week we inserted something we called Caring for the Caregivers as an essential part of the training. Not only did we want to do as much as we could to train them in how to do the work with the children, we wanted to be able to give them some direction in how to care for themselves in order to mitigate and minimize the secondary trauma so that they would be able to continue to do the work.

Sometimes simple stories get a lasting lesson across easier than professional jargon. The following is a real story that those advanced students easily understood and told me later they would often remember:

Patches, Rags, and Starlight, were three of our best child therapists. They were pretty old and not very pretty. They all had a lot of scars and each weighed over 1200 pounds. They all had a history of being abused themselves and had been rescued from different farms and ranches around New Mexico and brought to the ranch near the University. There they had been rehabilitated by a gifted “horse whisperer.” After their rehabilitation they became “therapists” in the equestrian therapy program for children and young adolescents who had been physically, mentally, and/or sexually abused. These were really tough-to-reach kids. They were hurt and mistrusting. The doors to their feelings and emotions

were scarred and locked up tight to protect them. Traditional talk therapy in a room was slow and often not very successful. Interestingly, Patches, Rags, Starlight, and their fellow horse colleagues were a lot better at reaching the kids than we were. The kids could see the scars on the horses' bodies and knew what they had been through. It was remarkable to see how the kids could understand that being tough, hard, mean, or abusive was not the way to go with these horses. That talking straight to the horse, giving the horse good directions and being steady, calm, reliable, and gentle, worked wonders. It was truly touching and poignant to see a hard-core kid who always had a scowl on their face, gently and lovingly groom and brush and care for "their" horse. They could learn to tell their horse their story, what they had also lived through, and they could learn to trust and rely on their horse, to open their heart, expose their own gentle vulnerability to their horse.

That was the work the horses did . . . and it was not easy. In fact, what we learned was that about every six months, give or take depending on the individual horse, the horse—let's say Patches—began to burn out. The work was taking a toll. Patches would become jumpy, anxious, stressed. Patches needed care for being the caregiver. Patches would be sent out to pasture to just enjoy being a horse with the herd. Sleeping, eating, running around. NO work. NO kids. Just good, positive horse stuff.

The stories of Patches, Rags, and Starlight made an impression on the doctors. They realized that after doing just so much work with the kids, they too were burning out. They too needed some time out in the pasture. The pasture being whatever or wherever provided solace and restoration for them individually.

You too might be a caregiver, or know someone who is. You or they might be going through the trauma of caring for a loved one, a returning soldier, a parent with dementia, a child with a long-term chronic illness. If so, then slowly burning out and needing replenishment, just like Patches, is inevitable.

It's important to take time to think about how you replenish, how you restore, how to nurture yourself. Be as kind to yourself as you are to others. Get yourself out to pasture.

As for Mr. Savage, it takes a lot of mental and emotional energy to get whipped into a verbal frenzy. The same advice can only benefit him as well.

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