The Intimacy of Trauma

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Abstract: Posttraumatic stress disorder (PTSD) is a serious problem for the military and for social workers involved with such clients. Clinical impressions have made it increasingly clear that soldiers serving in combat may experience harmful personal consequences for mental health and well-being. The research in this field focuses primarily on the presence of posttraumatic stress disorder and traumatic brain injury and their respective taxonomies. What is often lost is the stories of these men and women and the intimacy issues that each of us faces on the journey from deployment to reintegration. The following article represents an open discussion from the author's perspective on war and some tales from psychotherapy that illustrate the challenges to warriors, warrior families and practitioners alike.

Keywords: trauma; PTSD; TBI; combat trauma; reintegration; subthreshold PTSD

Imagine this scene. You are a soldier who has been successful for many years. You have been able to negotiate your way through life-threatening situations. You have exhibited restraint when feeling threatened. You followed rules, despite the fact that rules of engagement (ROE) are often different than what your training and your instincts tell you. You must exhibit restraint and at times remain unresponsive in the midst of violence and chaos. You have shown maturity and been rewarded with commendations for your competence and leadership on the battlefield.

Now imagine you come home. All you want to do is rejoin the real world and participate in the most mundane tasks. For example, I returned from Iraq after 364 days and wanted to help. My family of four had become a “threesome” and my wife did a spectacular job mitigating the impact of my absence. Being sensitive to the new rules my wife imposed on the household, I did not want to get in the way. Yet coming home made me feel like a third wheel and useless. I felt incompetent. So I asked to rejoin the family in subtle ways, such as running errands. On one occasion my wife asked me to go to the bank where we lived in Germany. She asked me to convert some US dollars to Euros so we could celebrate my return and our reunion. I sprang into action as if this task was really important and went to the bank on post. This benign event would normally be unremarkable. There I stood in a long line in the bank because it was “payday activities” day waiting for my turn with the teller. My wife met me at the bank and was surprised I was still waiting to make my transaction. As we stood in line, she began to tug at my sleeve, telling me I needed to calm down and relax. I was perplexed by her suggestion because I thought I was simply standing in line waiting for my turn. Truth be told, I felt like the people in line were like mindless robots going about their business like worker ants, while our men and women were on the battlefield risking their lives. I shrugged off her comment and whispered, “I'm just waiting for the teller.” She reiterated her request and added, “You really need to calm down! You are making people nervous!” I quietly stated again with my teeth clenched together that I was just waiting my turn. Next thing I knew, two military police officers (MPs) had me by each arm and escorted me out of the bank. Confused, embarrassed, and angry, I managed to get to my car without making the scene worse. When I got in the car, I sped out the gate of the base and my mood became very intense. My wife tried to calm me down and reached over to soothe me. When she touched me, it was as if battery acid had been poured on my arm. I threw her hand off of me, swore expletives at my family, and nearly put the car off the road. I braked the car hard and pulled off into the shoulder. I threatened to leave them all not only on the side of the road, but for good. It was not a father-of-the-year moment. I now knew I had a problem and I needed help. Perhaps this restraint I mentioned comes at a cost, perhaps regarding locus of control. To this day, I do not know exactly what I did in that bank to cause the interaction with the MPs. My wife observed that I did not do anything inappropriate or say anything. She also noted I was present and not somewhere else as if I were dissociative. She simply observed that I had an

intensity about me that made people nervous.

When reconsidering this situation, many things come to mind. Do all soldiers who return have PTSD or are there subthreshold or subtle issues that we all come back with (Yarvis, 2008)? All I know is I was 42, I had been in the US Army over 20 years, I have a PhD, and had researched, spoken about and written about PTSD and it did not mean a damn thing. I was in trouble and so was my marriage potentially. I think about the soldier who is 26 years old and deployed four times and is married to another soldier who has deployed two times. I'm a social worker who thinks about this stuff every day and it did not matter. So what about that soldier who kicks in doors during four deployments and never thinks about this stuff? How do providers help them and help them see what's going on?

I will say this carefully. Perhaps it is easier if you lose a limb. Do not misunderstand me. I would not trade places with someone who has sacrificed a part of their body. However, if you lose a leg it is obvious. You lose a leg and your appearance automatically solicits support to you. You lose a leg and providers assume you are not happy about it and assume there are co-morbid psychiatric issues. You lose a leg and you are treated like a rock star, rightfully so! However, when you lose your marbles and the grey cells in your head get mushed together, it is very hard to describe, very hard to solicit support. You may not know it is happening to you. I am reminded of that officer I was in the bank that fateful day that drove me into therapy. However, if it were not for the therapy I might not be married today, have a career or even be alive today.

To place this in another context, I used to teach special education. I worked with adults that had intellectual and mental health challenges. Some of these adults appeared normal, while others physically appeared to have these challenges because of Down Syndrome or some other physical difference. One of my duties as a special educator was to integrate my clients into their communities. So, I would take clients to buy their sundries at a local pharmacy. When I brought the individual with Down Syndrome into the pharmacy and the staff saw them struggling to locate the deodorant, for example, they were often asked if they needed help or shown what aisle the deodorant was in. However, when the normal looking individual, with equally profound intellectual challenges as their Down Syndrome counterpart, became confused or even asked for help, the pharmacy staff would treat them as if they were stupid or a bother. The fear and sense of incompetence that individual felt was palpable at moments like that. Sometimes our normal looking soldiers are made to feel stupid or no longer of value by their units that once embraced them. These are the same feelings our psychologically wounded warriors feel amidst the mundane tasks of reintegration when their issues begin to surface after they redeploy from combat.

Social workers and other providers can be critical interventionists for our psychologically wounded warriors. However, these care providers can only take patients as far as they can go intellectually, emotionally and spiritually. Even when we are not struggling personally, we often rely most on our training and the diagnostic yardsticks or taxonomies that come with the DSM-5 or ICD-10. We miss the subtleties of reintegration and focus on the pathology. If you remember nothing else from reading this article, remember to step out of the pathology and look at the process or “see the forest through the trees.”

The following are two tales or cases that illustrate this point. One is personal and the other is right out of my case files. First, most of us are familiar with PTSD. We understand that the major clusters are exposure to a life-threatening event or perceived exposure, avoidance, numbing and re-experiencing. We know through meta-analyses of research across populations with different types of trauma that re-experiencing, if observed, is most predictive of developing the full disorder if left untreated (Yarvis, 2008). What are not often discussed in the scholarly literature are the subtle symptoms associated with PTSD, such as guilt, sleeplessness, anger, and loss of sense of one's competence and confidence. When soldiers experience these symptoms, they may not think there is a problem and others will not necessarily associate them with a disorder (Yarvis, 2013). For example, I felt guilty about not being present for my family for 364 days of the most recent military-induced family separation. These 364 days were in addition to the some 1400 other

days I had spent away over the years. I did not know I felt guilty at first. I just knew I had not been there for my family and that I wanted to make up for lost time. One way this manifested itself was quite benign and I would have not brought this example into therapy, claiming it was a sign there was something wrong with me. We lived in Germany when I deployed to Iraq. My children lived among and went to school with German children. In Germany, German children learn to ride their bicycles at a very young age. It seems as if they are issued a bicycle at birth. At three years old, my daughter was cognizant of the fact that all her classmates knew how to ride their bikes and was embarrassed that she had not learned to ride her bike yet. I was close to taking the training wheels off when I left for Iraq and this task was one of the few things my wife did not get done while I was deployed. Like many fathers, that was ok with me because I fantasized about letting go of the bike and watching my child ride off into the sunset for the first time. So as if I was on a mission from G-d himself, I was determined to teach my children to ride their bikes upon my return. I was like a drill instructor barking, “G-d dammit pedal faster!” while my daughter cried and refused to ride under the pressure. Indeed I scared her. Meanwhile my antics were in full view of the women in my neighborhood whose husbands were all still deployed. I heard one lady exclaim, “Well looky here, the little social worker's family isn't so perfect now.” But it was as if, if I could just teach my kid to ride her bike, one year's worth of guilt could be swept away. The case only deepened the reintegration gap between my family and me and cut more deeply into my fragile and weakening sense of competence.

One's sense of competence is also impacted by the effects of traumatic brain injury (TBI), one of the signature injuries of the Global War on Terror (GWOT). Most mild cases abate and people return to their baseline functioning levels. With help, many moderate cases successfully achieve a high level of functioning and severe cases make significant improvements restoring neurocognitive pathways. However, experiencing a TBI can erode at one's confidence and self-image as a warrior. Most soldiers do not understand the etiology of TBI. And for clinicians, deciphering the nosological boundary between PTSD and TBI remains challenging because the disorders share many symptoms. The key for warriors with these co-morbid conditions is to address the warriors' perceived support rather than relying solely on the fact that they received support. There is good research that perceived support matters more in psychological recovery than received support (Norris & Kaniasty, 1996). The key with TBI is two-fold: (1) remembering that deciphering the nosological boundary between PTSD and TBI is difficult, and (2) that combating perceptions or TBI-myths held by soldiers about their TBI can erode at their confidence in themselves and the treatment systems around them (Brainline, 2014).

I mentioned the 26-year-old dual-military couple. The wife of the couple and young Army Specialist (E-4) came to see me. She had recently re-deployed from her second deployment and felt she might have PTSD, based on her husband's behavior and PTSD and TBI diagnoses after his four deployments. The two had barely seen each other over that eight years of marriage and had two babies along the way, both conceived during brief R & R visits during two of their deployments. They were struggling to be a couple and family and had much to readjust to.

When I asked her why she presented for therapy, she began to yell (which she continued to do in my direction for most of the session) loudly and cry. She opened with “My marriage is fucked.” Like most therapists I asked what “F'd” means (to her) because the range of meanings could go from rape to standing in a long line at a bank. She screamed, “We are getting a divorce because he's cheating on me.” All attempts to slow her down and calm/soothe her failed, adding to my own sense of incompetence. Finally when I got her to describe what happened, she told me that he has PTSD and she thinks she does too. She was worried about his recent heavy drinking and asked him to stop. It is important to pause for a moment. Many returning soldiers turn to alcohol to sleep and soothe themselves after the appearance of these very confusing subtle psychological symptoms. I was not a drinker at all and found that within three months nearly all the alcohol in my home, that was nearly all given to me as gifts, was gone and I was replacing it for the first time. So her husband was doing something similar. She begged him to stop drinking immediately and he complied. However, her husband now lacked his primary coping

mechanism and began to pace the home anxiously all night for days on end. Without sleep, he became more and more irritable. The mood culminated in a fight and the couple went to bed angry. This fight added to the fog of reintegration. They were in love but showed no love, did not laugh, did not have sex, and did not touch. Feeling remorse, my patient went to reach over to her husband and apologize but he was not there in bed. She grew worried and got up to search the house for him and caught him masturbating to pornography. As soon as she said the "M" word, she became bright red and said "Can we talk about this?" I nodded and she proceeded to tell me that she turned the corner and caught him masturbating to porn. She yelled at him and embarrassed her husband, who responded like a 15-year-old caught with his father's Penthouse Magazine, and stated words no spouse ever wants to hear, "I want a divorce!" She yelled at me stating, "This is why my marriage is f'd, you dumbass!"

Each subsequent question I asked was met with more hostility. Finally, I tried to get at whether masturbation and use of pornography was normal for them. I am not in the judgment business as a social worker, rather the risk management business. So, while I believe using porn reduces women or men to objects or their genitals and that using it behind their partner's back is a form of infidelity, I had to determine what is normal for them. Therefore, masturbation was normal for them. They did it together as part of their normal sexual activity. They also bought pornography together and used it privately and openly as an adjunct to their intimacy. She exclaimed, "But he did it without me and wants a divorce and must be cheating!" Her conclusion, although reasonable, represented cognitive distortions on her part brought about by her anxiety and depressive symptoms.

I asked her why her husband might masturbate? She remained heated and yelled, "Because he is cheating, you asshole!" My discomfort was exceptionally high. I persisted. I asked her about their history. They dated throughout high school, were honest and open, and truly in love. They enlisted together and despite their separations had never been unfaithful. So when infidelity was ruled out as a likely possibility I asked her the question again, "Why might he masturbate?" She grew frustrated with me. I changed tactics. I asked her about her two- and four-year-old children. I asked her if she ever noticed her children touching themselves. She angrily said, "They are NOT sexual!" I replied that I knew that and asked then why they might do it. She concluded because it simply feels good. And what happens when it feels good, I asked? She replied, "Oh, I guess it soothes them." I told her she was correct and then proceeded back to questions about her husband. I posed to her why might her husband who has just come home, cannot sleep, cannot drink, cannot communicate with or have sex with his wife, masturbate? She said, "Ok, I see your point…it soothes him." I instructed her to approach perhaps with an apology and talk to him about what happened. Two weeks later, she presented that they were doing "great" and joked, "If you can talk about masturbation, then you can talk about anything!"

The moral of the story is step out of the pathology and look at the process. If I did not allow the foul language or the discussion, I would have lost her or alienated her. Had I been overtly uncomfortable, I could have easily hid in the PTSD discussion and missed the real concern. Most soldiers have concerns about intimacy and feeling competent. They think how could I exist in combat and not be able to negotiate my role as a father, mother, lover, parent, etc. (Yarvis and Beder, 2011).

I remember rounding at the U.S. Naval Hospital in Bethesda with medical students. We visited with a 19-year-old Marine with bilateral amputation who lost his legs in Afghanistan, only a few weeks into his nine-month deployment. He was surrounded by his parents and his young bride. He was remarkably open to the medical questions and upbeat, still displaying the machismo of a combat infantryman. We left the room and I asked the young medical students what they missed, after a detailed medical examination. The medical students shrugged and stood silent. I asked the group why none of them asked about the marine's sexual activity or concerns. One of the medical students quipped, as if social workers just did not get it, "He's not thinking about that…he just lost his legs!" I countered with he is 19 and his newly minted bride is sitting at his side. Not only are they thinking about sex, but it is likely the elephant in his small hospital room. So I directed us back into the room and asked the marine and his family if we could ask

a few more questions. The marine graciously allowed us and sat up as straight as he could to face the officers in his room once again. I asked him did he have any concerns about sex. Before the marine could answer, his parents joked, those two love birds are likely sneaking into the bathroom to come up with new ways “to do it.” The couple blushed and the marine politely asked for some privacy with us and dismissed his wife and parents for a moment. He then began to express that he was not worried about the loss of his legs. He said he would fight until he could walk again someday, but that his biggest fear was that his wife would leave him if he could not find a way to have intimacy with her again. And he thanked us because in his weeks of hospitalization no one had asked him about this concern and it was his number one fear. We must learn to overcome our own discomfort to be effective clinicians in the process of helping warriors return home to functional lives.

The coming home process is a winding river, but it is often the clinician who is on the banks of the river, preventing it from flooding over for the warrior. Many warriors and family members have bi-polar feelings around the coming home process. We want to hold our families at a distance (perhaps to protect them) and pull them close because we have longed for intimacy. Another personal experience illustrates this notion of polarity. I was evacuated from theater (MEDEVAC’d) for nothing as impressive as injury sustained in combat, but because I may have suffered a heart attack. Apart from the fear of what was going on with my body, I felt guilt about being on a plane full of heroes. After I was cleared by the cardiologist in Germany, my wife, not unlike the marine previously, inquired about the possibility of being intimate since we had been apart for over 8 months. The doctor said, “Don't kill him.” The doctor offered to “help” us and stated I can spread out your follow-up appointments so the two of you can have some time together. However, all I was thinking about (and feeling guilty about) was returning to duty. And then before I could ask the doctor about returning immediately to duty in Iraq, my wife cut the doctor off mid-sentence and said, “You need to get him the f@#$ out of here!” I was relieved and horrified by her comments at the same time. I wanted desperately to be with my family. If asked while I was downrange, I would have given back all of my combat pay for a hug on each of my kids and wife. However, I also felt a strong sense of duty and there was a pull to complete my mission and return home properly with my unit. My wife felt the same. She wanted to hold me close and be intimate, but did not want to shed the thick skin she put on during our separation, only to have me taken from her again. These bi-polar feelings are very confusing. And one could also argue that there are negative psychological consequences to not completing one's duty in addition to these confusing bi-polar feelings. Of course we want to be with our families and our families want us to be with them, but we all want to serve (Yarvis and Landers, 2012).

When I came home for good I was asked to lead most of my unit's reintegration briefings and I also counseled many of my colleagues on and off the record about their family concerns. Like many, my homecoming was celebrated. But when the parades and celebrations ceased, reality set in. We had been apart for a very long time. I am fiercely proud of my marriage and the openness my wife and I have achieved, but deployments highlight the slightest fissure or insecurity in a marriage. Although there were no issues of infidelity, those questions came from my wife and from me to her. In addition to the difficult ideas circling in my head, I was not sleeping and was edgy and angry, although I was not mad at anyone or anything. I think the notion of being “keyed-up” is very real. Even without trauma, if a soldier works 20 hour days for a year, he or she cannot simply turn that physical vigilance off. My wife and children were scared and scared of me. All of these things led to some long nights, where we all sat with the loudness of the silence on some very long nights worrying, ruminating, and perseverating on a thought or distortion of a thought.

Therapists have to be able to discuss the most intimate of things. I pride myself on being able to do this personally and professionally as does my wife. One day after the fog of celebrations was long over, she said some powerful words, “I've thought about leaving you.” Pause for a moment and imagine the first thing that comes to mind when you hear words like that. My reaction was did she cheat? Of course I felt terrible that my best friend felt this way and that I had something to do with it. I also was angry with the U.S. Army for doing this

to us. Of course it was our choice to serve, but that did not matter at the time. The conversation evolved to “Am I a terrible wife for having those feelings?” Relief took over my body and I shared that I had similar thoughts, because who would want to put their life partner through such a thing. We complimented each other and our marriage for having the ability to remain so open. It was then that the journey of my real homecoming began, moving from trauma to intimacy.

At the end of that critical and intimate moment, I knew I still had a lot of work to do (it would be over three years to do the heavy lifting). I told her at the end of the conversation that I loved her and I believed her. I rationally knew my wife was this amazing and loving person whose loyalty was as ironclad as my own. But I told her that I cannot sleep and I will likely sit up all night with those painful words etched in my forehead and become paranoid with the words “I thought about leaving you” playing like a broken record, over and over again in my head. To my wife's credit she said, “You bring it on and I will reassure you as often as you need to ask me.” So I took her up on this and it lasted three months. Of course this behavior of mine was wearing her down and hurtful too because it suggested I did not really trust her. So one night she grew tired and reached her limit to pain with all of this and dragged me by the arm to her night table drawer. She angrily pointed to her drawer and showed me 21 batteries. Those batteries were the monument to her fidelity. While this falls in the realm of “too much information," it is a superb reminder that the journey home is not just about what we saw in combat or what we did. The journey is also about very VERY intimate things. Latex ‘boyfriends’ were new to us and we had to talk about it, but being able to talk about these things requires great maturity, safety and the ability to communicate without shaming your lover. It is intimacy that trumps all. I will reiterate, what about that 26-year-old couple who never thinks about these things nor could talk about these things even before combat? As a therapist it never ceases to amaze me how couples can engage in very intimate acts but not talk about the acts themselves or what they want from their partner. In combat we say complacency kills and we demand a kind of intimacy that leads to trust and cohesion in ways that are hard to describe to an outsider. But we do not demand that avoidance of complacency from our partners and family members.

Combat is also intimate. But what is functionally adaptive for combat may not work functionally in one's living room. These adaptations also contribute to the bi-polar emotions we feel. My wife and I demand openness. Nothing is taboo and no topic is off limits. However, do we want to share the evils we have been a witness to? “Why would I burden the people I love most with these things?” is likely what most soldiers ask themselves when withholding their war-induced trauma spectrum experiences from their loved ones. The soldier must consider that if they deploy again, they must consider these withholdings as means of not causing further or deeper worry for their families. However, withholding goes against the openness rule and fuels the cognitive distortions that something must be wrong or we would be open. Yes of course soldiers want to unburden themselves and be intimate with those they love, but they also want to protect those most dear to them. And there are some things that many soldiers feel only another soldier could understand. However, those relationships with other soldiers do create space between lovers. Do I really want to tell my children that I saw dead children when they ask me innocently was Iraq fun? Do I really want to tell my wife I thought I was never going to see her again on a number of occasions? The answer is both yes and no (Coll, Weiss, & Yarvis, 2011).

What is adaptive for combat is not always adaptive for home. In combat we know that “loose lips sink ships” and that maintaining operational security (OPSEC) is critical to mission and protecting American lives. At home this behavior might be seen as being secretive and dishonest. In combat we keep our weapons with us at all times to always be ready. At home we feel naked without them and unsafe, and with them we are potentially an accidental danger to others. In combat we target aggression and at home we must be passive, not aggressive. In combat we drive quickly and avoid obstacles and debris that could be hiding an IED, at home one can endanger other drivers and one's own passengers by driving “recklessly” or too aggressively. These are some examples where it is difficult to go from being tactical to practical. And there is that loudness of the silence. No one is

saying anything and many trauma victims call this a "conspiracy of silence" which victims feel re-traumatizes them (Danieli, 1998). How does one live with the sights, and the sounds, and the smells and the pain?" Who could possibly understand what I've seen, what I've done, what I could not effect? These are painful questions and they are not often captured in active thoughts. They may be unconscious and subtle concerns gnawing away at ones confidence, sense of purpose and self.

To many warriors, the most frightening and humiliating reactions to combat and operational stress often affects processes associated with memory, which impacts sense of competency and self. The experience of trauma can leave the soldier with absent or incomplete conscious memory of important events and/or lead to re-experiencing symptoms known often as "flashbacks." Sights, smells, and sounds can unexpectedly and abruptly cause the warrior to re-live sensory experiences associated with traumatic events and emotions, or intrusive memories. They can cause fear and confusion in the warrior and their family. A soldier can begin to become numb or avoid the stimuli or triggers associated with the previously benign stimuli that triggered the responses they experience. Without an understanding of the way the brain stores memory in trauma and within the strangling hold of silence, warriors conclude that if they "block out" these feelings and memories, perhaps with alcohol or other substances or simply avoiding stimuli, that they must be making up these experiences and that they have lost control of themselves. The gaps in memory, re-experiencing, dissociation, and nightmares for the soldier are proof that they are incompetent or crazy, when in reality they are normal responses, chemically, physically, and emotionally to trauma. These responses are designed to protect us.

To reiterate, it is harder to describe and solicit support for oneself when your marbles get rolled around than if you sustain physical injury. And if months later you do not even know what is happening to you. Automatic reactions, physical reactions, and response generalization can increase over time without intervention. Viktor Frankl (1961, p. 122) states, "Between stimulus and response there is a space. In that space is our freedom and the power to choose our response. In our response lies our growth and our freedom." Therein is the soldier's opportunity for restoration of control.

All of us in the helping professions who work with warriors and their families have a passion for helping them find solutions that are causing them concern, restore harmony among them and return the warrior to duty. Understanding military culture and the warrior's reality are key. Soldiers in therapy, like many of us, confront death and their mortality, locus of control issues, aloneness, and the restoration of meaning of life. However grim or intimate these topics might seem, they contain the answers to restoration of safety and control, wisdom and redemption, and healing and forgiveness. What we need to relate to the warriors in our care is that it is possible to heal soul wounds. It is possible to feel safe. It is possible to confront the truths of their lives and harness the power they have in their existence in the service of change and posttraumatic growth.

To the warrior the most obvious concerns relate to life and death. To adapt to the reality of death, we devise ways to bargain with it and escape it. Soldiers must do what most elderly people do later in life. They must put death out of their minds and turn it into something positive. They do not become complacent, but they distract themselves with something meaningful in the present. As therapists, by slowing down their combat experiences we can find the meaning we all seek. For example, a corporal tells me in session that he was in Sadr City, Iraq. He tells me "There I was, wearing the flag of the United States on my right shoulder, all the best thinking went into the creation of our great nation and America is a force for freedom, and it didn't mean a damn thing." He was describing observing Al Qaeda-supported militia kill children within his line of sight and there was nothing he could do. But when we slowed it down and he observed that perhaps the children in those beladiyahs or neighborhoods, where he patrolled, had perhaps even a few more months or years of life because he and his platoon mates were there, he felt the shame lifted. He was ashamed to have been given a bronze star medal because he believed he could have done more for all of the children he encountered, but now the medal had turned into a symbol of pride because he realized he had done the something he could do.

Now the corporal understood his nightmares about observing death simply as failed dreams rather than his failures. His nightmares were symptoms of his anxiety and guilt, not reflections of him as a man, as a husband, as a father or as a warrior. In his dissociative moments he split off from his family and his reality and most of all from the terror associated with his own mortality and death. This process is invisible and confusing, but in Sadr City his normal psychological machinery that protected him failed as he reached his limit to pain and his death anxiety or posttraumatic anxiety broke through. But he needed to see that the world was no safer before Sadr City and that he had the capacity before and after to restore that machinery, improve its functioning and focus on living his life again in a meaningful way. This is his journey and in some ways it is my journey because it is every warrior's journey. Each of us must negotiate these experiences in our own way. For the sick, dying, or soldier in combat we get a closer gaze at death, but often those who gaze at death and survive have a stronger pull to life.

I owe a great deal of debt to my wife, children, extended family, fellow soldiers, and valued colleagues for teaching me and allowing me to teach and counsel others on how to avoid existential isolation, loneliness and for helping me to break the conspiracy of silence.

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