Emily:  I'm Emily Kumler and this is Empowered Health. My father and both of my grandfathers fought in wars. I was raised in a family where we were taught to respect the military and to honor those who had served. And today, Memorial Day 2019, we're going to spend some time honoring people who have also given a lot to the service of this country though they're not veterans. They're a group that goes largely unrecognized, but from my perspective deserves the respect, support, and attention of those who have served in combat. They are the loved ones of vets who have died by suicide. Every hour a veteran in the United States commit suicide.[1] Each of those people as girlfriend, wife, partner, parents, and many leave behind children trying to understand what happened and what went so horribly wrong. Their experience is one of complex grief riddled with guilt and confusion. Yet as a country we are neglectful in honoring them and we as a country hardly spend any time at all thinking about the consequences of our overseas actions on the families back at home. For example, did you know that in 2016 America dropped 26,171 bombs in seven different countries[2]. Seven countries. Did you even know we were at war in seven countries? Well, that affects a lot of people and unfortunately under president Trump, the civilian casualties overseas have also skyrocketed.[3] What does that mean? That means that our men and women who are serving over there are faced with all kinds of complexities that feel quite different as you'll hear later in the episode than in past wars. We've also learned in researching this episode that the battlefield is quite different.[4] Whereas in the past there used to be safe spaces where doctors, accountants, the administrative teams, the suppliers would be kept off of the front lines. That's no longer true. In the wars we're fighting today, there is no safe place. So our men and women are coming home pretty traumatized from these kinds of changes in warfare and yet their training doesn't provide them with the psychological understanding that it's normal, that they're traumatized, that actually it would be more abnormal if they faced that kind of situation and weren't traumatized. And what we're going to talk about today is both the trauma that is experienced and how one organization in Boston is trying to help those vets as well as their significant others who are often faced with traumatic situations here at home trying to save their loved ones and break the stigma that goes along with this kind of trauma. And then very often are the ones who find the bodies of their loved ones after they have died, which is a particular kind of trauma. And it feels very much echoed in the experiences of our service members who overseas are also having to deal with caring for, collecting, cleaning up the bodies of their comrades. So today I hope this episode will honor those women who are trying to pick up the pieces after they have traumatically lost a loved one. And I also hope that this episode is helpful to anybody whose lost somebody in a traumatic way. We're going to hear some of the ways that the Home Base[5] program is caring for these women

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[1] https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf *every 72 minutes to be exact

[2] https://nationalinterest.org/blog/the-buzz/scary-fact-america-dropped-26171-bombs-7-countries-2016-18961

[3] https://aoav.org.uk/explosiveviolence/explosive-violence-monitor-2017/

[4] https://www.armyupress.army.mil/Journals/Military-Review/English-Edition-Archives/July-August-2017/Perkins-Multi-Domain-Battle/

[5] http://Home Base.org/

and for the vets. And we're also going to hear first up from a person who kind of came up with the idea for the program and recognize the need in a very personal way.

Kim Ruocco: So my name is Kim Ruocco[6]. I am vice president of suicide prevention and postvention for the Tragedy Assistance Program for Survivors[7]. I'm a clinical social worker and also I am the surviving spouse of major John Ruocco who died by suicide in 2005.

Emily: And my understanding is that John had been home for a few months.

Kim Ruocco: Yes

Emily: And so can you talk a little bit about what that was like for him to return for those three months and then sort of how this has led you on this path?

Kim Ruocco: You know, my husband had about in six months in Iraq. He was an attack helicopter pilot for the Marine Corps. He flew 75 combat missions in Iraq and came back from there in November of 2004. You know, he had been in the Marine Corps for almost 15 years. Had had three tours that, you know, some of them were included combat and others did not. But over the years had experienced a lot of exposure to trauma and loss within the Marine Corps in training accidents and other things he experienced. So when he went to Iraq this last time, he came back and a lot of things had happened while he was away. His unit that he was attached to in Pennsylvania had been moved to California and our family had just bought a house in Massachusetts. So he was now, you know, attached to a unit all the way across the country. His civilian job that he had been training for, to fly with the commercial airlines, did not go through when he didn't get the job. And when he returned, he had a re-emergence of depression and anxiety and grief that was kind of unresolved from all his other years within the Marine Corps. At the time like so many military families, we were not able to really be together and really help him transition back home because now he was connected to this unit that was on the west coast. So we really only saw him Thanksgiving and Christmas between the time he returned from Iraq and when he died in February. So I knew, you know, he was suffering but a lot of our conversations about his suffering were by phone, you know, and I couldn't see him in person. And like many service members who are suffering, you know, they have good moments and they have bad moments and you hold onto those good moments and hope that that they can push through. I had seen my husband pushed through depression and get to the other side about 10 years earlier when you had had a major depression following the loss of many of his peers in military aircraft crashes. So I was hopeful that he would also get through this period, you know, and like most military spouses, you know, are cheering him on, trying to support him. But at the same time during that period I was really encouraging him to go to behavioral health. And to tell them that he was, he was having trouble. He was resistant to that. He had never gone to behavioral health in all the years in the Marine Corps. He feared that he went to tell anybody about his

[6] https://www.taps.org/kimruocco
[7] https://www.taps.org/

suffering that they would see him differently, view him differently, that he was afraid that they would think that he just didn't want to redeploy cause that unit was scheduled to redeploy in March of that year, he was a leader within the unit. And so he also worried that people wouldn't think he could lead. All of these things, you know, were part of the culture of the Marine Corps and unfortunately he didn't have any role models that really showed him that you could get help for your mental and still be promoted and still be a good leader and come back even stronger than others. So, he actually died February of 2005. We had had a conversation that day, where I was really worried about him. He did not watch the Superbowl game where his team was playing in the Superbowl. And it was kind of a final straw for me because knowing that he was feeling so badly that he couldn't get out of bed to watch the Superbowl with his friends, I just knew he had to be really bad. You know, and I said to him that's it, John, you know, you've got to get help. It doesn't matter whether even your career is gone or things change. If you're feeling so badly that you can't get out of bed and can't go to the game, this is bad. He did promise me on that phone call that he would go to behavioral health. I asked him directly too on that call, because I do have a clinical background. I said, are you feeling so badly that you're thinking about suicide? Is that coming into your brain? And he said to me, I would never do that to you and the boys. Our boys were eight and ten years old at the time. And this I find from survivors that I talked to you now, or is it pretty common thing that sometimes if they're asked about suicide, many times they say, I would never do that to the family. I could never do that. But in reality, you know, when their brain takes over and they get that darkness, even though they meet at the time when they say that, they can't hold onto that, that promise. And that was the case with John. Like I look back on that time and I literally feel like I was watching somebody die of like a terminal disease. And I watched instead of proactively took them someplace, right. That he wasn't able to really make those decisions about whether you needed help or her or not anymore. And I really should have gone in there and grabbed him and taken him to help. But that's only on the look back. Right? Cause now I know how it ended. So what I tell spouses now and other people is, is when you first start having signs that people are struggling, you can get help really easily then without it impacting your career or the way you look people look at you. I mean there's easy counseling for grief, for communication, for marriage that that will not impact your career, won't go on your record, that can help you resolve things really early on. My husband had multiple losses in the air wing of buddies, you know, and there was no space for grief or for processing that or for dealing with the anxiety of getting back in the cockpit after your buddies had just died in the cockpit. Right. So what I tell military families is take advantage of those times when you can go the counseling before your loved one has become so sick that going to the doctor, you know, is gonna really change things. And so one of the things that I've, that I read about you having said was that that first year after you've lost somebody in your family is really sort of about redefining your future and redefining sort of your sense of family and self and all these other things. Can you talk a little bit about that? It was really an overwhelming feeling when my husband first died to the point where it felt like our family had burned to the ground. Right? And then I had to rebuild it because it's not the future that I ever thought. And now it was complicated with all kinds of other emotions and issues that I never thought I'd have to deal with. You know talking to the children about why their debt, they had died this way. How did their hero who made it home from a combat zone then take his own life?

The spiritual questions I had about it, the how to talk about it in public, how to, you know, get our family roles back to a place where they were appropriate. Because you know, my kids and everyone in the line at the funeral told my eight and ten year old little boys "you're the man of the house now, take care of your mom." So there was a lot of things that I had to kind of navigate and kind of fix so we had a healthy foundation to rebuild on. I've since now developed a best practice, three phase model for other survivors so that they have a roadmap on how to do this. Because for me, at first I didn't trust my instincts and I was desperate for someone to give me a roadmap. And a lot of the advice I got was not good advice. As a suicide loss survivors, we often don't trust our instincts, at least at first because our loved one has literally died on our watch. That's what it feels like.

Emily: So what are some examples of bad advice? I feel like it might be helpful to just say what wasn't helpful

Kim Ruocco: At the scene of my husband's death, I made it there right after he died. And so it's a crime scene when they're, when a suicide happens. So first responders came, right? They sent a priest, they sent somebody identified as a trauma specialist. They had detectives and they had police officers. And so my, as a mom, my first thing that I was worried about that I was really freaking out about was what do I tell my children and how do I tell my children. I was asking everyone in the room, what am I gonna tell my kids? How am I tell my kids this? What do I tell them? And the advice I got was very bad and really damaging. The priest looked at me and said, you know what the Catholic Church thinks about suicide and I [said] actually I don't. I grew up Methodist. My husband was a very devout Catholic and he said, well, that it's a sin.

Kim Ruocco: I said, you're telling me that I'm supposed to not only tell my kids that their dad is dead, but that is in hell? Is that what you're telling me? And he just looked at me, you know. I have since learned that that's not the teaching of the Catholic Church.[8] That that was something that's old school in order to try to prevent suicide. There's still a lot of that out there and suicide loss survivors are still given that message sometimes very early on.

Emily: What is that message, that message is basically don't talk about it? I mean like what are you supposed to do with that? I don't even understand how somebody could say that to you and think they're being helpful.

Kim Ruocco: I think, you know, that he just didn't know what else to say.

Emily: Wow.

Kim Ruocco: He was just caught off guard. Additionally, the trauma specialist told me that my children were too young to understand suicide and so that I should tell them that he died in an accident. Which I did. So I then was flying home from California to Massachusetts to be with my

[8] https://bulldogcatholic.org/the-church-and-suicide/

children. And in my head I'm thinking, I can't take them to the church, which we go to every Sunday, they had grown up in the Catholic church, had gone to mass every Sunday with their dad now, something that was so valuable to them, a big part of their support system, I had to protect them from. I also was starting my journey on a lie with my children. And so I [?] thinking, I've got to keep anyone from telling them the truth. How am I going to keep them from finding out? How am I going to, you know, how, what if they do find out? They're gonna know I lied to them. So all of those things were very dangerous and very made it even more difficult for me to start this over again.

Emily: And exhausting.

Kim Ruocco: And exhausting and scary. You know, my instinct at the time was I gotta get home and recluse myself. I gotta grab my children, get to my house, lock the doors, pull down the shades and protect them from the world. You know, and that's traditionally what a lot of suicide loss survivors have done because there's so much stigma and judgment and bad messaging and fears that they will often, if they can't find the right support, will go and recluse themselves. And that's when there's trouble because these are now families that are increased risk for suicide, mental health issues, addiction issues[9]. And you have them reclusing themselves without support, you're now in danger of losing additional people in that family. You know, 50% of our family members are either witnessing the death or finding a loved one's body. And so think about the trauma of.

Emily: Well, and having to continue live there, right? I mean that would also be traumatic.

Kim Ruocco: And having to clean up, you know, [...] don't even think about this but some families end up cleaning up, you know, after their loved one's death in the family home. So the amount of trauma that is associated with suicide in our military families is incredible. So that's, you know, that is part of this stabilization is identifying which families have had that kind of trauma. How can we help them? And that was one of our biggest challenges in our model was figuring out– we can do all the other things right. We can help them talk to the children, we can help them with their spirituality, we can help them rebuild the family and roles. We could help them find peer support. We can help them understand why people die by suicide so they could not feel like it was their fault. But what we really had challenges with was the traumatic piece.

Emily: Kim realized that the solution of these problems, the problem of trauma, actually lay with someone she knew personally, that she'd known her whole life.

Kim Ruocco: General Hammond[10] and I are friends for, you know, feels like our whole life. And you know, it's interesting, we've gone this parallel path where he went in the military, I was a military spouse and we've kept in touch over the years. And then after my husband died and I

[9] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html
[10] https://mghcme.org/faculty/faculty-detail/brigadier_general_ret_jack_hammond

started this program with TAPS and we built this protocol, you know, him and I had a meeting to try and talk about kind of what my organization was doing with his organization was doing when he first started at Home Base. And I said, you know, Jack, the hardest thing for me is this trauma piece. You know, we've got a really good model that moves survivors from stabilizing them, all these specific issues, integrating grief into their life and really finding post-traumatic growth. And we're seeing huge, you know, recovery and huge support for families who are moving through our model with the exception of those who have the trauma. And he said, tell me more about that. And I started to talk about these families that I was seeing who had witnessed the death or found their loved ones and how difficult it was to get trauma care in the communities across the country. There's just not good trauma specialists, especially in rural areas across the country[11]. And he said, I think I can help. And he started to tell me about the intensive clinical program that he was doing for veterans. And he asked me, do you think that would help with these spouses? I said, absolutely. So, you know, he immediately thought about what they were doing for veterans and we started talking about how that might transfer to family members.

Emily: I mean, it feels like almost a perfect parallel, right? I mean, these are both sort of like extreme PTSD situations. When I first heard about it, I was really interested in the fact that like, you know, I always like things that sort of in retrospect seems so helpful and logical, but then you kind of wonder like why dIdn't we think of this a long time ago? I know.

Kim Ruocco: Well, you know, there's so many things in this journey for me, that are like divine intervention, right? That they just all fall into place and you're like, wow, something else is guiding this. Right? I mean, what are the chances that two of us had the ability to pull this together in such a beautiful way? You know? And he had the program, I had the people.

Emily: And so have you been a part of any of the groups that have gone to Home Base?

Kim Ruocco: Yes. So, I have a team of what we call peer professionals. So, our peer professionals are clinicians who are also loss survivors. So Dr. Carla Stumpf-Patton[12] is our psychologist who oversees our ICP group. She stays with them for the entire two weeks. But I come in, you know, a couple times during the two weeks to meet with the survivors, to talk with them, you know, to do a little peer-to-peer support as well.

Emily: Well, I'm sure there is something incredibly powerful about you being able to talk about your experience and help them heal in a way that they can sort of look at you now and see that you've progressed and that that's a possibility because there's something so phenomenal about getting people who have experienced the same kind of thing together. What was that like the first time you were able to do that?

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[11] https://www.ajpmonline.org/article/S0749-3797(18)30005-9/fulltext
[12] https://www.taps.org/about/staff-grid/carla-stumpf-patton/

Kim Ruocco: The first time I felt hope was when I went to a suicide loss survivor peer group in my local area before I went to TAPS. That was the first little inkling of hope. And then when I went to TAPS, there wasn't a suicide program yet. So I had to build it. And as people started coming, it was really rewarding for me to meet other spouses, other parents, other siblings who had had similar losses. But for the clinical program, the interesting part about this is so Dr. Carla Stumpf-Patton who comes up with the families and also Jennifer Burns[13], both of them are spouses who lost their husbands to suicide, right? So they are providing the peer-to-peer support for this contingent of spouses who have lost their husbands to suicide or boyfriends or fiancees. We do the peer support on both ends of these ICPs.

Kim Ruocco: The incredible thing is, is that when we first bring them together, most of those women have never met somebody else whose husband died by suicide and they found them or witnessed the death. This is usually the first time. We bring them together in Boston. We support them, we go with them, we're there for them. We introduced them with one another and they are for the first time realizing they're not alone and that this didn't only happen to them and what they've been experiencing is not, they're not crazy. It's normal for what they were exposed to. And so they create this own peer group within a peer group. Right? And we know from best practice in peer-to-peer support is the closer you can match people by their greatest struggle, the more impactful that peer-to peer relationship will be.

Kim Ruocco: So now we've matched them on all different kinds of levels, right? Everything from their both spouses, they're both military spouses. They all lost a husband as suicide. They all witnessed or found the bodies of their loved ones. And we also, you know, try to connect them for, you know, spouses who have children, spouses who don't have children. So that, you know, they can deal with the children's issues. The cool thing about it too is then when these groups graduate, so when the first ICP group graduates, they then are warmly coming back to TAPS for peer-to-peer support. They continue that connection as a peer group and as the new graduates of the ICPs are coming in, we introduced them to the graduates as beacons of hope, right? So the ones that are graduated and now doing really well say to the new ones, you know what?

Kim Ruocco: We went through the ICP. It's really helped us, it's changed our life. We're now functioning. I'm now a better mom. I'm now a better sister. I'm now able to get a job, I'm now able to sleep. And they give them hope and then when they graduate they join the other group. And so we have this growing peer group that going forward are able to connect on all the challenges of having trauma, of having children, of being a military spouse who have lost a loved one to suicide. The new groups when they graduate, we have a call with the older groups like to just talk about what's it like to go back home after having two weeks to just focus on yourself and now you got to go home and take care of your children and try to incorporate the coping skills and incorporate what you've learned. And so this growing peer group is also a beautiful offset of this intense two weeks that they're also getting through Home Base.

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[13] https://www.taps.org/about/staff-grid/jennifer-burns/

Emily: Well, I mean I imagine that it's almost like you're giving them permission to just be themselves in a complete way. Whereas in the outside world they're trying to navigate based on all kinds of environmental factors. You know, like you were saying protecting your children or trying to keep this sort of story quiet or you know, and in that space it seems they really have permission to just be.

Kim Ruocco: Absolutely. And you know, a lot of them were carrying around secrets that were very dangerous. A lot of them were having thoughts of suicide themselves. A lot of them were feeling like they were not good parents or not able to take care of their children. They were considering, you know, giving their children to other family members to take care of. Things like that, that are very dark and very scary that they never had shared anywhere else. And now they have this, you know, this whole peer group that understands that, understands those struggles and can support them in overcoming them. And they also have clinical treatment that have taught them coping skills and ways of dealing with those feelings and those emotions when they come up. So we're really saving lives here, not just improving them. We're really saving lives.

Emily: Well, and I would imagine the effect on the family unit too. Like whether it's the children or the, you know, other people that are part of the extended family that benefit from seeing that nucleus restored in some way.

Kim Ruocco: Hopefully, you know, they're able to teach what they've learned to their children, right? Because they're modeling it. They're modeling what to do when they're feeling anxiety, what to do whenever they're having flashbacks. They're modeling, you know, meditation and mindfulness and, and good coping. It can only improve that whole family system.

Emily: I thought it was particularly interesting when Kim mentioned that she started working on this, on her own through TAPS and recognized that the one problem she really couldn't help with was the trauma piece, but that she happened to have a connection to somebody who was working with vets on that specific piece of the puzzle. And she happened to have gone to high school with Brigadier General Jack Hammond, who's the head of the Home Base program in Boston. And before becoming the executive director of Home Base, he had served a 30 year military career in the army with multiple deployments in Iraq and Afghanistan, which gave him firsthand experience on these kinds of issues, both the front lines of the battlefield as well as the struggles of coming home and dealing with post traumatic stress, which he's very open about. And I think that his experience in both of those forums has made him an incredible leader. And you'll hear when we talked to him, he has an openness about the way he talks about his experiences, which is really refreshing to me. So I can imagine how it felt or how it feels when he's working with these groups of vets who come through Home Base. And it's no wonder that this program has had so much success. And it also seems to such logical sense that Kim mentioned to him that she was working with all these wives and girlfriends, significant others who really needed the same kind of therapy that the vets were getting at Home Base, but that

there was no program in the country that was properly treating them. So he's going to tell us a little bit about why his new mission might be his most important one yet.

General Hammond: With 18 or 19 veterans killing themselves in VA parking lots in the last year[14], that's a vote of no confidence. And so Home Base was really developed to help fill a gap. Folks that wouldn't go to the VA, folks that couldn't go to the VA because of discharge status.[15] The VA's working on that now out of accept those men and women, we're realizing that many of the bad conduct discharges some of these post 9/11 veterans were getting were based on mental health injuries[16] they sustained during their first tour, second tour, maybe third tour. And then suddenly they had an alcohol problem that made them a misconduct problem and they got a bad conduct discharge.

Emily: That feels so incredibly unfair, doesn't it?

General Hammond: It does. But I've got to tell you, if you think of the circumstances, you can see how it happens. So having been on both sides of the equation, I get it. So if you're a young 26 year old captain in the army and you're responsible for the lives of 200 people and you're getting ready to ship out to Iraq or Afghanistan and you've got a sergeant that's showing up drunk. Your choices are take action against him, take him with you or have him sign paperwork and he gets basically a general discharge. And from the soldier's perspective they're so sick of it, they just say, so I sign this paper and I'm out. Yeah, sure. Great. And they don't think of the longterm consequences. The captain is worried about the 199 soldiers. It's not that he doesn't care about that one guy, it's just he doesn't have time because he's getting ready to go to combat.

Emily: No and I think obviously that's the right decision to make in the aftermath of it all. Right? Then what? Then where do they go?

General Hammond: So since then it's come to light that their are a lot of these going on because the units were going to war for year coming home for a year going back and when you come home for that year, you spend two months kind of unwinding, another couple months resetting and then all of a sudden you get into the train up cycle for the next deployment, so you stay alive for the next deployment.

Emily: There were also a lot of people who came home thought they were done right and then were called up sort of unexpectedly.

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[14] https://www.washingtonpost.com/news/national/wp/2019/02/07/feature/the-parking-lot-suicides/?utm_term=.d26926769f3f

[15] https://www.va.gov/health-care/eligibility/

[16] https://www.gao.gov/products/GAO-17-260

General Hammond: Stop loss[17], you name it. Or they went into the reserves and they got pulled back up.

Emily: Does that still happen? I mean, that was a big story.

General Hammond: It's not as common because we don't have so many people deployed. [18] And so as you can imagine, when we had 150,000 in Iraq, we had another 50,000 in Afghanistan that's 200,000 people a year that are deployed. And so there's somebody who just came home, somebody's who there, and somebody who's getting ready to go. As you're hitting that cycle, the Marine Corps is a relatively small organization. I think there's in the combined active and reserve marines, I think there's about 300,000. The army carries the lion's share of it because between the army, the army guard and the army reserve, there's 1.1 million. We're the largest land based force in the world.

Emily: And you're an army man?

General Hammond: I'm an army guy. And the marines are great. It's just they are a smaller force. The army was doing 12 to 15 month deployments[19]. The marines were doing seven to eight months deployments[20], the air force was doing four to six month deployments[21] and the navy really wasn't there because these are two landlocked countries.

Emily: Yeah.

General Hammond: By 2008, 9, you started seeing more navy guys fill noncritical army positions or big base positions because we just ran out of people. And all these men and women, if you go back and look at five, six deployments, special operations folks,15[22]. So that's why we saw a spike and we're still seeing this spike in suicides with active duty members. So last year, the suicide rate for actively serving members in the conventional forces was up 20%[23]

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[17] https://www.thebalancecareers.com/military-stop-loss-3345246

[18] https://www.dmdc.osd.mil/appj/dwp/rest/download?fileName=DMDC_Website_Location_Report_1903.xlsx&groupName=milRegionCountry - Deployment as of March 2019

[19] https://www.nytimes.com/2007/04/12/world/middleeast/12military.html

[20] https://www.militarytimes.com/2013/12/04/8-month-deployments-become-the-new-norm/

[21] https://www.airforcetimes.com/news/your-air-force/2016/03/29/air-force-deployment-tempo-brings-new-kinds-of-strains/

[22] https://www.theatlantic.com/international/archive/2011/10/for-elite-us-troops-wars-end-will-only-mean-more-fighting/247309/

[23] https://www.dspo.mil/Portals/113/Documents/02%20TAB%20A%20-%20QSR%20CY2018%203rd%20Qtr-%20FINAL.pdf?ver=2019-01-10-114556-633

over the year before. And in the special operations community it was up 300%[24]. Just think of that. Think of any other job you have, because it's a job, where you had a 300% increase in suicides in your company. Right? It's staggering.

Emily: What do you make of that

General Hammond: 15 deployments

Emily: So there is this sort of, you know, I don't know if it's a fallacy or exactly what to call it, but it seems like a misnomer or confusion about PTSD[25]. And I think there is this, the criticism is sort of like, well, you know, people are more sensitive today, right? Or there's like more of this, like why are we seeing more of this? Is it something about the actual warfare in the Middle East? Is it about the instability of coming and going so much, not knowing where you're going to be in a, you know, six month period? Or is it about our culture having changed in some way? And I feel like I would love for you to just sort of address that head on.

General Hammond: Sure. I see it. I hear it. So when I first got here, I would talk to a lot of older guys and veterans. I just met with a guy about an hour ago, a World War II veteran Marine Corps, and he went through Bougainville[26], Iwo Jima[27]. He fought in all those battles. He's 94. He's doing okay, but he's carried around PTSD for the last 70 years. Most of those guys that went through those horrific battles didn't know what it was, because they didn't talk about it. And it really wasn't diagnosed as an injury until the mid-eighties.

Emily: Because it was more just sort of like, those are your war wounds, suck it up,

General Hammond: Suck it up. And frankly any talk of that would be talk of almost cowardice. You know, unmanly, you name all the things that you could say, but I guarantee you when I talked to the old World War II guys, they'll say, what's the deal with all these young kids and all this PTSD? And so I'll ask them, how do you at night? And they'll laugh and they say, I haven't slept since the war. And I'll say, okay, and how's your drinking? They'll say, great, as long as I got booze, and how's your marriage? And they'll say, which one? And so I'll explain to them that they had PTSD, they probably do– still do. And that our goal is that these young men and women will sleep again, that they won't be drinking themselves to sleep every night

Emily: But it's treatable?

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[24] https://www.cnn.com/2019/02/02/politics/socom-military-suicide-spike-2018/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+rss%2Fcnn_latest+%28RSS%3A+CNN+-+Most+Recent%29

[25] https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

[26] https://warfarehistorynetwork.com/daily/battling-for-bougainville/

[27] https://www.history.com/topics/world-war-ii/battle-of-iwo-jima

General Hammond: It's treatable. And that's the key. If you can come in to get care, we can help you.

Emily: We're really gonna focus on this program that you guys are doing for the wives of soldiers who have committed suicide.

Emily: Yup.

Emily: And that program came about, it sounds like from a conversation with you and Kim. Yeah, exactly. Tell me a little bit about that conversation and what, how you sort of made this all happen.

General Hammond: Sure. So, Kim and I went to high school together.

Emily: Okay.

Emily: And she reached out and was explaining her concern. She works for an organization called TAPS, Tragedy Assistance Program for survivor. They've been around since the nineties. They take care of all military families that have lost somebody, whether it's to training or war. So they were a good partner for a lot of reasons. Sometimes the gold star designation can make things a little unclear. And just to give you an example, if a service member is killed in action, they're a gold star member. If a service member–

Emily: And their family is also then right?

General Hammond: They become a gold star family[28].

Emily: Which means their benefits and all that stuff are extended to them?

General Hammond: There are not a lot of benefits,I think that's a bit of a misnomer.

Emily: Yeah, no, explain this, please.

General Hammond: But if somebody dies in just a vehicle accident in Iraq, their family is a gold star family. If it happens three days after they come home and they're at Fort Hood, they're not. If somebody dies, you know, in a suicide situation in Kuwait, that's a gold star family. If it happens three days later, it's not. So it's a challenge because, all of our families–

Emily: What is the reason for that distinction?

[28] https://www.army.mil/goldstar/

General Hammond: They created the legislation, the law based on, I think it was probably World War II and they were really doing something special for the killed in action versus a training accident.

Emily: But even suicide over there.

General Hammond: Yes. So don't forget back in the forties, they probably didn't tell the family it was suicide.

Emily: Yeah. Okay.

General Hammond: So it really, because it's such a stigma that somebody died.
Emily: Right.

General Hammond: And I can guarantee you they would have covered that up and just said he died. Nobody wanted to spare the family any embarrassment or grief.

Emily: Right. So it's just an archaic law essentially that's not been updated properly.

General Hammond: Yeah.

Emily: So the family whose not the gold star family. What happens then?

General Hammond: We call them family of fallen. So in all these situations, there's not much that happens. So if your service member dies while on active duty, there's a grief benefit of about a hundred thousand dollars. And there's service member's group life insurance, which is about $400,000.[29]

Emily: What about medical benefits or anything like that for the family? If they were getting them through the service member?

General Hammond: So I believe they still get TRICARE[30], which is an insurance program that's fair to good. But the challenge is there's still nowhere to go because when it comes to these injuries, and that's really the key. You can have any kind of insurance you want, if you can't access care specifically tailored for what your problem is– this is complex grief. This is complex trauma. You don't see anything more complex than this.

General Hammond: And that's one of the reasons Kim reached out. They don't have a clinical program that's dedicated to focus on their injuries. So I can give you an example. My wife was looking for some help during my first set of deployments because we shipped out for six

[29] https://download.militaryonesource.mil/12038/MOS/ResourceGuides/A-Survivors-Guide-To-Benefits.pdf
[30] https://www.tricare.mil/

months. It got extended to a year, then it got extended to 18 months. And a lot went on and she needed some help. And so she reached out to TRICARE and said, you know, I need a mental health appointment. And they said are you suicidal. She said no. She said it'd be about a six month wait.

Emily: Yikes.

General Hammond: So she said he'll be home by then and everything will be fine.

Emily: Not Helpful.

General Hammond: Not Helpful. Well, so that's TRICARE. So that's TRICARE for anybody on mental health. Number one, there's a national shortage, so there's a national shortage of health mental health care providers. But deeper than that is the challenge of qualified mental health providers. So what we see across the board, and that's one of the challenges in mental health, it's the worst reimbursed field of medicine[31]. Because of that, less people go into it and because the reimbursables is so bad, people don't do extra things to become more accredited because there's no payback on that. So to give you an example, evidence-based care[32] is the cornerstone to solving these problems. Most clinicians aren't trained in evidence based care. Why? Because once you have a license, you don't need it to legally treat people.

Emily: Meaning you're just seeing one off patients basically and not–

General Hammond: So a good mental health provider might see marriage counseling, may see food issues, may see trauma issues, divorces, you name it, they're fully licensed to treat any of that. But I would tell you, you know, when you're monkeying around in someone's head that have complex issues that's like having your pediatrician do surgery. In a pinch could they do it? Probably. Do you want them doing it? Probably not. I'd rather have a neurosurgeon. So anyway, if you take it, if you look at how do you get certified, you have to go to a place like Mass General and it would cost you probably around $10,000. When you're done you can't charge any more for being certified. So there's no incentive to go spend the time, money, and aggravation to get qualified in this because most of them are generalists. You know what I mean? There's not a big market, but just trauma. So you probably couldn't make us solid career if that's all you treated. So you're going to be treating a broad spectrum.

Emily: Yeah, but that to me does feel like maybe that's the role of the government in all of this, right? Like if the VA paid for tons of people to get this kind of training so that they could go back to their local facilities.

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[31] https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

[32] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2349778/pdf/bmj00524-0009.pdf

General Hammond: No, so you're onto something there. And so that's something we're doing now.

Emily: Okay, great idea.

General Hammond: But the challenge is who pays for it? And so that really is a, it is a business of government. And so we did get $1 million from the state last year to do just that.

Emily: How long does that last?

General Hammond: A year

Emily: But I mean lke how many people do you get trained through?

General Hammond: So we trained 75 clinicians[33] across outlying areas of Massachusetts that don't have access to care right here. And we trained another couple hundred first responders and veteran service agents to identify people with these injuries to then connect them to care. So that's going to be an ongoing thing we're hoping to partner with the state on because the turnover and the number of people that need to be trained so high.

Emily: Right.

General Hammond: It's a pretty, I don't want to say, well it's a selfless thing on our part because we don't take the money and then use in our clinic. We take the money to train doctors outside of here to treat people outside of here. And to create capacity. And those same people can treat anybody in the general public now that has trauma-based injury, rapes, assaults, car accidents. 5% of the general population has PTS based on all crimes and accidents.[34] It's more prevalent in the military for obvious reasons. But if you had a car wreck and you were trying to get somebody for the trauma care because you were affected, you know, there was a fatal, right. You would have the same opportunity to have no access to care as a veteran would. Do you know what I mean?

Emily: Yeah.

General Hammond: And there's a big difference between seeing a good therapist and a good therapist that has evidenced based treatment as in the toolbox.

Emily: And so when you say evidence based treatment, can you talk a little bit about what that means?

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[33] http://Home Base.org/education-training/training-institute/
[34] http://www.ptsdunited.org/ptsd-statistics-2/ - *Approximately 8%

General Hammond: Sure. The gold standard right now is prolonged exposure therapy or cognitive processing therapy. And there's a great deal of training that gives the clinician the skills to deliver that therapy. So when we train these 75 docs, they come here for two days and then we work with them for six months and they send recordings of their sessions, then they get feedback and then they send more recordings. So it's a very labor intensive process because they want to make sure that they've mastered the techniques and they can give them feedback. So you didn't really address that right on this one. Here's a better way to approach it than you did so that they can deliver it effectively.

Emily: And they're learning. I mean, that's an incredible training program.

General Hammond: It's an incredible training opportunity and Mass General's a teaching hospital. So it's right within our wheelhouse. And as you probably know, all of our clinical team have appointments at both MGH and Harvard. So this is what they do in general. And so it's just an extension of the Mass General medical school, Harvard Medical School, Mass General Hospital. And so if you have a really good therapist without those skills, they're delivering aspirin, it can manage the symptoms, it can lower your temperature and manage the pain. Most people with these trauma based injuries need penicillin. They need an antidote, they need a cure. Aspirin doesn't do it and that's why you hear about somebody that's been in therapy for years and they're not getting any better.

Emily: As General Hammond explained. Part of what makes Home Base so special is its partnership with Mass General Hospital, which is perhaps one of the best hospitals in the world and is sort of ground zero for this understanding of complex grief. The woman who is the head of the family program, which is the one that deals specifically with these women and significant others who have lost vets is Dr. Ohye[35]. And she's going to explain a little bit about the methodology of the program that she runs for these women. And I think it's important to mention that this program is exclusively funded by private donations and those private donations are going to run out after two more sessions. So two more groups of women will be admitted and then the funding will be over. So if anybody listening feels compelled to give money, I would say this is certainly a worthy cause that is looking for donations. Dr. Ohye is going to explain that part of what makes her work so special is not just the research side of it. She's also on the faculty at Harvard Medical School and they are tracking all of the results of how people are doing and how successful the program is, which she'll explain. But it's also just the sense of bringing these women together who have been so isolated. And there's sort of a unique blend between trauma and isolation that on the counter side when you bring people together and allow them to share in this pain that they've experienced, it heals them and transforms them in a way that you probably just can't do in any other environment. Here she is.

Dr. Bonnie Ohye: Well, I've been the head of family programs, let's see, for almost 10 years now. And since the mission around family care has been such a central part of Home Base,

[35] https://mghcme.org/faculty/faculty-detail/bonnie_ohye

when it became obvious that there was this very hidden group of family members that were really suffering and struggling post their loss, it became a really natural invitation for me to pull together the resources that allowed this program to take shape.

Emily: So I know you guys refer to the process as complex grief[36]. Can you explain a little bit about what that is?

Dr. Bonnie Ohye: Sure. So the concept of complicated grief is a relatively new concept and has been formalized within the diagnostic and statistical manual in psychiatry. It's characterized by prolong persistent memories, longing, grief for the deceased, in such a way that it impedes an ability to reengage with life, develop future goals, accomplish things that were going on at the time of the death that the survivor has abandoned in an effort to try and reestablish equilibrium in her life. So it's a process of trying to get the person unstuck from their position of being profoundly absorbed in the longing and mourning process.

Emily: And you do that through sort of storytelling it sounds like?

Dr. Bonnie Ohye: Well, there is a central part of the process that involves that. There's also an effort to make a safe environment so that the survivors can both feel understood about their loss, but also encouraged very gently to look into the future, to look into the future in a way that reflects the goals and the values that they want to live their lives by. So it's not merely telling a story, but it's sort of allowing them to reawaken parts of themselves that had been overcome by the loss in their grief.

Emily: And that must be partly just giving them permission as a group of people who have experienced a similar thing.

Dr. Bonnie Ohye: Absolutely. Absolutely.

Emily: Can you talk a little bit about how you're measuring success of this program? I know it's still very new, but...

Dr. Bonnie Ohye: So, as a program with an academic medical center, we have been very conscientious about making sure that we evaluate the symptom picture of each of the patients before they arrive as part of the process that allows us to know what they are struggling with in a way that will support matching our treatment program to what the most need. We evaluate their symptom picture, their level of functioning, symptoms of depression, anxiety, PTSD. Their general sense of enthusiasm for life whether they're sleeping well or not, and evaluate those very same things at the end of the program as well as in three months and 12 months after they've been discharged from the program.

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[36] https://www.mayoclinic.org/diseases-conditions/complicated-grief/symptoms-causes/syc-20360374

Emily: And how is all that going?

Dr. Bonnie Ohye: It's going very well. Very well. The outcomes are very stable both at the end of the treatment as well as a year later. Recovery is sustained over that period of time, which is pretty remarkable for a clinical intervention. We also have reports directly with survivors that have been through a treatment program who share with us their sense that the program really allowed them to reclaim themselves and to fashion a life and a set of new goals and aspirations that pull them forward rather than the experience of having been really mired in their loss.

Emily: I mean, just from a sort of empathetic perspective, it's so hard to imagine. I mean, when I first heard about, you know, what you all were working on here, I was really struck by this idea that like you fall in love with somebody, you have this idea of what your life is going to be like. They leave for a period of time and they come back and sometimes they're quite different than the person that you remembered.

Dr. Bonnie Ohye: Right.

Emily: And then you realize that they're sad and sick and you can't help them.

Dr. Bonnie Ohye: Right.

Emily: And that that sort of sense of wanting to fix things becomes unresolved forever when they're gone. And so, you know, just if there's anybody who's listening or who has experienced something like this, are there any points that you make with these groups of women that you feel like would be important for us to communicate in a sort of more broadcasting way about ways to think about this in a slightly different way or to change that perspective?

Dr. Bonnie Ohye: Well, we try very hard to communicate to all of the program participants that we appreciate how much shame, guilt, anger, remorse, sense of rejection and lack of resolution they are living with day to day, sometimes minute to minute and that they don't have to live with that if they seek out treatment

Emily: And it's a two week, women come for two weeks and everything is paid for while they're here. And in that two week period of time you're really having a profound impact. I mean that sounds like such a short period of time, but it's an intensive programs.

Dr. Bonnie Ohye: It's very intensive. We provide 61 hours of clinical treatment in either individual modalities or group modalities in those two weeks and that doesn't count the weekend. So it's very intensive both from the perspective of the clinicians that deliver the care, but more striking, it's very intensive for the participants as well. They really work hard and they're really engaged and their commitment to their own health is really what allows them to be as successful as they are in the treatment program.

Emily: And then when they go home, do you set them up with follow up care from there?

Dr. Bonnie Ohye: Often we begin that process before they arrive. Because we know that having a strong therapeutic support network when they go back home is essential to maintaining their progress and furthering their recovery. So I'm often on the phone with candidates before saying "well, I noticed that you don't have this in place. Why don't we try and put that together with your permission?" And so we work really hard up front to make sure that we have confidence in the providers that the patients return home.

Emily: So do you have any kind of general idea in the country of how much this is needed? I mean, you guys are servicing a small number of women as much as you can, but what is the demand?

Dr. Bonnie Ohye: Well, if we look at the statistic about 20 veterans committing suicide daily [37] and that rate is 22% higher than the civilian rate[38]. And we consider that at least every one of those veterans has one or two family members. It's a very large number. Only two of the 24 women that we've treated here did not have children. So we're talking probably about two to three children per patient as well. So if we look at the impact on the whole family system, it's really quite significant.

Emily: Are there things that you've noticed that have been surprising to you in one way or another that people get out of the program that are sort of, I mean, nothing is really separated probably, but things that you weren't necessarily designing for but that have been added benefits?

Dr. Bonnie Ohye: I think the most striking thing is the joy that these women recover in life as they leave the program. The transformation is pretty remarkable. I do think that that's a function of the quality of treatment that we offer and the quality of the entire treatment program. But it's also that they have the benefit of [being] connected with one another. And one of our objectives is to cultivate that peer connection in a very, very profound way. The isolation that they've experienced is very profound and it prevents them from feeling entitled to the good things in life. And to be happy again. So to see them recover that sense that they can own and embrace happiness, it's just very moving all the time. Every single time

Emily: When these soldiers are coming home and they're killing themselves and their wives or girlfriends or mothers and fathers, brothers, I mean anybody who's sort of in their circle of love and you know, family or whatever, they're all suffering. And I think as a country, we are sort of negligent to the impact that that has had in a really direct way because of the patriotism of the individual who went to serve. And so I'm sort of interested in how can we tell this story in a way

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[37] https://www.mentalhealth.va.gov/suicide_prevention/data.asp
[38] https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf

that allows people to realize there's an exponential crisis that happens when somebody comes home and they're suffering. Because it's not just them, it's their family, it's their friends. It's all of these other sort of extensions of that. And so in terms of the program that you guys are running here for the widows, you're offering similar kinds of behavioral, sort of like cognitive therapy[39]. All of this stuff for them that allows them to then heal and go back to their families and communities and sort of not start over again. I don't like that expression at all, but heal in a way while they're here.

General Hammond: The challenge is getting folks to be able to come in her because many times unless the service member came home with a catastrophic injury or they were killed, there really isn't a trauma piece to it. I think the principal injury most of them have is stress, anxiety and maybe some depression. So again, the two week program wouldn't be a good fit for them, but we have other programs that we currently run for them. So the challenge we had was this other group, this group that was associated with TAPS is straight up trauma. The age of these women was 28 to 34. They had kids and everyone that's come here so far either saw the suicide or walked in and found the body. That's profound trauma. It's so many different levels. There may have been some domestic abuse going on because of the mental health injuries of the person that took their life.

General Hammond: So they might've been at some level happy, they're gone and then they felt guilty about being happy. They were mad that that person chose death over their family. So it's anger, sadness–

Emily: Unresolved feelings across the board.
General Hammond: But all tangled up in a way that the average person just can't comprehend or deal with. And so they were some of the most injured people I've seen and that's why we're focused– it's triage. They're the most injured of that subset and we're starting with them. As we move forward, we'll open the aperture a bit, but we only have limited resources. And if we lose one veteran every hour. There's a lot of suicides out there we got to deal with. We are looking at an extended weekend program Thursday, Friday, Saturday, Sunday where we can compress a whole bunch of mental health care, a full course of individual treatment into a long weekend. And give some wraparound care in that period as best we can because some folks can't take two weeks.

Emily: Right.

General Hammond: And some folks don't need two weeks, but they need more than one hour a week for 10 weeks.

Emily: Well and the specialized care, I mean, I would imagine since that's not readily everywhere.

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[39] https://www.cognitivetherapynyc.com/What-Is-Cognitive-Therapy.aspx

General Hammond: Well, It's not available. And if you do go, it's probably $250 an hour.

Emily: Right.

General Hammond: And if you can't afford it, it doesn't matter if it's available, it's not accessible. And so we know that through these programs that we do, when we compress them like this. First of all, it doesn't matter where they live, they only have to come in once and go home once and they get all the treatment done at one time. So we have a 95% completion rate in our two week program with veterans. A hundred percent completion rate in the two week program for our survivor spouses. Traditional mental health care is about a 30% completion rate.

Emily: Wow.

General Hammond: So if you only do 30% of a treatment, what's the chances of getting better?

Emily: Right. I also think that there's something so profound about the idea of bringing them together and having that shared experience that they then leaving friends and it's a support group and all of that. I would imagine.

General Hammond: So when we designed it, there were two options because we have three other partners now who replicated this and at one site they have a rolling admission and we considered that because we thought we might be able to really see more people. It'd be a little easier to manage. But we decided to go with the cohort model where they all start and finish together, 12 people. I am so happy that we chose that because I see the bonds at develop amongst these groups. We build a team and this team is forever Intertwined. They create a closed Facebook page just for those ten people, 12 people. And when they're having a bad day, they can message the other folks, let them know about it, and they have the ability to respond back without having to tell the whole story. They already know why you having a bad day. They know it's June 5th, your alive day is June 5th. You're dealing with a lot of unresolved, you know, you've got some guilt feeling bad because you lost some friends that day. You don't have to tell you a story to them. You say, hey, I'm having a bad day. It's my anniversary.

Emily: Right.

General Hammond: They can speak in shorthand and then they can get nine people who are their friends really jumping in and helping them a bit.

Emily: This episode served as a reminder to me of the deep human spirit that lives within all of us that wants to connect and feel like they're part of something and really wants permission to feel both sadness and happiness. And it also was a big reminder that we are fighting wars and

that when you go to the supermarket or you're enjoying the baseball game, it's really important to sort of think about those who are sacrificing so much in the name of this country. And whether you agree or not with the foreign policy, we have to all together as humans support each other in moments of trauma and in loss. And I think for me personally, this made me really want to get involved and try to help more in these kinds of situations and with people who have suffered loss sort of in isolation and in silence. So I hope that this was a reminder to all of you too. And that it wasn't, you know, sort of a depressing episode, but rather one of there is so much ability to heal and when we deny ourselves that chance, whether it's a soldier who has suffered trauma and sort of assumes that that's his war wounds that he has to live with forever or whether it's the wife of somebody who has, you know, witnessed somebody who she loved go off to war and come back a different person and isn't able to help him or you know, sort of rescue him in a way, which I'm sure is the, you know, unconscious conscious thing that we all want for our loved ones that we together as a civilization have a duty to help each other. So Happy Memorial Day. I hope this was thoughtful and made you all want to get involved.[40] Thanks. I'm Emily Kumler and that was Empowered Health. Thanks for joining us. Don't forget to check out our website at empoweredhealthshow.com for all the show notes, links to everything that was mentioned in the episode, as well as a chance to sign up for our newsletter and get some extra fun tidbits. See you next week.

**RESOURCES:**

- Contact the National Suicide Prevention Lifeline: Call 1-800-273-TALK (1-800-273-8255) or use the online Lifeline Crisis Chat
- Veterans Crisis Line: A free, anonymous, confidential resource that's available to any Service member or Veteran in crisis.
- TAPS Helpline: 800-959-8277
- Donate to Home Base
- For Practitioners: Register for WEBINAR: SUICIDE, GRIEF AND TRAUMA - SUPPORTING VETERANS AND FAMILIES OF THE FALLEN Presented by the TAPS Institute for Hope and Healing.

[40] http://Home Base.org/contribute/donate/