This is Study Guide 2 of Florida Course 5L - DV

Note from CEU By Net: Your now have the essential background on what drives the disruptive and frightening symptoms accompanying post-deployment PTSD - such as flashbacks, the 'freeze reaction', runaway heart rate, dissociative reactions, 'shut down', failure to distinguish 'then' from 'now', and taking refuge from those symptoms in drugs and alcohol (SUDs). You now understand what forces have led to anger management isssues, rage reactions, paranoia, conflict leading to domestic violence, etc.. Now it's time to choose the treatment approaches to use.

Finding Balance

Chapter 7. Choosing Treatment Practices

> Fully effective treatment may require a strategically staged, multi-modal treatment approach. On the one hand, a treatment approach that emphasizes cognitive reorientation to the present, while disregarding past trauma, may insufficiently address the reliving of the trauma in images, feelings, or behavior. On the other hand, a treatment approach that focuses prematurely on exploration of the past may exacerbate, rather than relieve intrusive affective and somatic symptoms. With appropriate timing, however, different treatment modalities might well be employed in complementary fashion.
>
> —van der Kolk and Pelcovitz (Clinical applications of the Structured Interview for Disorders of Extreme Stress (SIDES). *NC-PTSD Quarterly,* p. 24)

Given that many or most readers of this Guide will be clinicians in the substance use disorder (SUD) treatment field, their need or opportunity for choosing trauma-specific treatment practices is likely to vary widely. In many cases it will be most important to provide trauma-informed services in general, and to choose SUD treatment approaches and practices that respect the complexity that trauma brings to the recovery process. In other cases SUD clinicians will be working closely with trauma specialists. In some cases, SUD professionals may be the only sources of help that veterans see.

It is beyond the current scope of this Guide to describe the treatment interventions available for post-deployment stress effects—and far beyond that scope to recommend one practice over the other. However, this chapter does provide a very brief, very general overview of some things that civilian clinicians might want to consider in planning or refining their approach toward working with veterans. It includes four sections and two pull-out pages:

- Identifying Trauma-Related Assessment Instruments
    - Suicide Risk Assessment With the SAFE-T Card
- Choosing Safe and Appropriate Treatment Interventions
- Using Symptoms and Neurobiology in Considering Treatment Practices
    - Table: Using Symptoms and Neurobiology in Considering Treatment Practices
- Additional Considerations in Treatment Planning

Future updates to this chapter may provide more information on specific practices, including treatment planning practices, and links to sources of further information and training.

Identifying Trauma-Related Assessment Instruments

While the Military has developed systems for evaluating Service Members' readiness for return to duty, the question of readiness for return to civilian life is a bit less clear. The Armed Forces have implemented universal screening processes in their primary care settings to try to reduce stigma and make it easier for veterans who need services to seek them. Civilian clinicians in SUD treatment and mental health can also do their part, by becoming familiar with the instruments used to identify and diagnose the range of post-deployment stress effects.

Begin With an Assessment of Strengths: The weight of contemporary knowledge of trauma is overwhelming. As young as our collective understanding of this subject is, experts have managed to put together exhaustive lists of symptoms, signs, and gut-wrenching experiences in the theater of war. All of this information is essential, but even the most compassionate assessment process can drive the stigma and shame deeper into the veteran's heart, without ever intending that consequence.

The fields of mental health and substance use disorders have learned the hard way that a focus on the problem must be well balanced—and even preceded—by a focus on the individual's strengths, resources, and resilience. In recovery-based approaches toward the care of SUDs, clinicians and recovery mentors alike are learning to begin the assessment process with an inventory of strengths and resources, also called "recovery capital" (Granfield and Cloud, 1999) The collection of this information is then used to feed the treatment planning process, and to help remind clients of the equally overwhelming reality of recovery (White, Kurtz, and Sanders, 2006; White, 2007).

Screening and Assessment Instruments: The Department of Veterans Affairs (VA) National Center for Posttraumatic Stress Disorder (NCPTSD) has on its web site (www.ncptsd.va.gov) a wide variety of trauma screening instruments, trauma exposure

measures (to identify traumatic events experienced), and PTSD measures (to identify symptoms related to those events).

These instruments vary widely in terms of the time it takes to administer them, length, complexity, thoroughness, sophistication, measurement of symptom severity/frequency, reading level, and cost. They also differ in terms of the range of trauma types screened for or assessed. It is important to find a balance between the desire for a manageable assessment process that is acceptable to the client with the need for accurate assessment of people whose symptoms may not always fit neatly into the restrictive diagnostic criteria laid out in the Diagnostic and Statistical Manual of Mental Disorders.

Even if war exposure is the factor that triggers the trauma, the history of earlier childhood trauma can influence the direction and course of post-trauma effects. So along with the traditional PTSD symptoms (fear, avoidance, hyperarousal), it is also important to assess challenges in emotion regulation, consciousness, relationships, and meaning/spirituality (Ford and Kidd, 1998).

If complex PTSD or DESNOS might be an issue, the SIDES scale can be used after a careful, developmentally based trauma history to capture information on the overall effects of trauma. The SIDES scale was developed based on seven categories of clinically relevant issues that were not included in PTSD diagnostic criteria, but were identified during the DSM-IV field trials for PTSD. Most of the symptoms listed in the SIDES are included in other DSM diagnoses, e.g., dissociative disorder, somatization disorder, various Axis II personality disorders, and as “associated features” under PTSD (van der Kolk and Pelcovitz, 1999).

The 27 diagnostic criteria addressed in the SIDES are organized in seven categories:

1. Alteration in regulation of affect and impulses
2. Alterations in attention or consciousness
3. Alteration in self-perception
4. Alterations in perception of the perpetrator
5. Alterations in relationships with others
6. Somatization
7. Alterations in systems of meaning (van der Kolk and Pelcovitz, 1999)

Global Assessment Processes: Friedman (2006) cautions that people diagnosed with PTSD have an 80-percent chance of meeting diagnostic criteria for at least one other psychiatric disorder. He recommends a wide-ranging assessment process that includes all of the following.

Risk and protective factors to assess:

- Risk of suicide
- Danger to others

- ongoing stressors
- Risky behaviors
- Personal characteristics
    - Coping skills
    - Ways of relating to others
    - Attachment
    - Shame
    - Sensitivity to stigma
    - Past trauma history
    - Motivation for treatment
- Social support
- Other psychiatric and medical disorders

Other issues to assess:

- Experience of stigma within the military
- National Guard or military reserve service
- Military sexual trauma
- Survival of serious injury

Choosing Safe and Appropriate Treatment Interventions

In an empowerment model, the client is a well informed partner in choosing treatment practices. However, the clinician first has to do the homework.

For the conscientious clinician, evaluating treatment approaches and practices to offer clients is often a bit of a juggling act—looking at the grounding of the practice in empirical evidence, cultural factors, the cost of the intervention, available training in the intervention, the time the intervention takes vs. the time available for treatment, the client's individual preferences, etc. The one consolation might be the evidence that the quality of the therapeutic relationship is far more important to treatment success than the choice of treatment practices (Hubble, Duncan, and Miller, 1999).

The choice of practices may be quite limited if you have only a limited number of sessions to spend with the veteran—either through the veteran's own preference or because resources are limited. Although post-trauma effects are complex and healing often requires time and effort, Psychotherapist and trauma specialist Lia Gaty reminds clinicians that they are not likely to be the end-point in a particular client's therapeutic journey.

Suicide Risk Assessment with the SAFE-T Card

The National Suicide Prevention Lifeline has developed an assessment card based on the American Psychiatric Association's Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. This The SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) card is available from the organization's web site, http://www.suicidepreventionlifeline.org/. Its content is reprinted below, with permission:

Risk factors:

- Current or past diagnoses: Mood disorders, psychotic disorders, alcohol or drug problems, personality disorders
- Key symptoms: Anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- suicidal behavior: History of prior suicide attempts, aborted suicide attempts, injury to self
- Family history: Suicide, attempts, Axis I diagnoses requiring hospitalization
- Precipitating factors: Triggering events leading to humiliation, shame, despair; ongoing medical illness
- Access to firearms

Protective factors:

- Internal: Ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- External: Responsibility to children or beloved pets, positive therapeutic relationships, social supports

Likelihood of suicide:

- Ideation: Frequency, intensity, duration (in past 48 hours, past month, and worst ever)
- Plan: Timing, location, lethality, availability, acts in preparation
- Behaviors: Past attempts, aborted attempts, rehearsals (e.g., tying noose, loading gun) as opposed to non-suicidal self injury

The same criteria can be used to assess the possibility of homicide, when this possibility is indicated. This assessment is particularly important with postpartum mothers, and in men with Axis II disorders or paranoia who are dealing with loss or humiliation.

PLEASE NOTE: The Veterans Suicide Prevention Hotline is 1-800-273-8255 (TALK). It is sponsored by the Department of Veterans Affairs and the Substance Abuse and Mental Health Services Administration.

Even if all you have time to do is help veterans establish some sense of empowerment and a few safety skills and resources, that is a significant step in the healing process. If you do it in a way that leaves them feeling good about coming back to you or seeking help elsewhere in the future, you have just improved their chances of recovery significantly.

Criteria for Choosing Approaches: In looking at evidence-based and promising practices to offer people with post-trauma effects, the clinician is often caught between:

- A traditional approach that advises only to use evidence-based practices that have been tested and used extensively with the specific population served and found to be safe and effective
- The growing use and acceptance of a number of promising approaches for which the body of evidence is still under development, including many somatic and somatosensory approaches designed to make it easier to integrate the body's procedural memories with narrative memory

Even a well documented technique like Eye Movement Desensitization and Reprocessing (EMDR, a model that combines cognitive and somatic techniques) is sometimes still the subject of debate, with many clinicians, clients, and studies reporting highly positive results, and detractors still casting doubt on the relevance of the somatic component (bi-lateral eye movement, tapping, or sound). It is necessary for clinicians to learn about the practices they are considering from multiple sources, including (and perhaps most important) a number of people who have been treated with those techniques.

There are also practices, most notably Dialectical Behavioral Therapy (DBT), that have been used and tested most often with complex trauma or DESNOS (Linehan et al., 2006). These practices have been tested on some cohorts of veterans who also present with DESNOS symptoms (David, Simpson, and Cotton, 2006; Koons et al., 2000).

Complicating all this is the fact that some of these practices look and sound simple, but still require extensive training and (in some cases) licensing. EMDR, for example, is not a technique, but an approach that begins with an extensive process of building safety and resources before addressing any traumatic material. A clinician who saw only the hand and eye movement, deciding to skip the costly training and simply use that technique, would be seriously jeopardizing the patient's well being (Ferentz, 2008).

Safety Considerations in Choosing Treatment Practices: Trauma is an area of great danger for the patient, and so an area in which safety is the first and most important consideration. A few safety considerations in choosing treatment practices:

- As mentioned earlier in this Guide, it is important not to mix veterans in with general population (civilian) therapy groups.

- SUD treatment providers need to work closely with trauma specialists to ensure that all steps are taken to stabilize both the trauma symptoms and recovery from substance use. Withdrawal from addictive substances can often trigger trauma symptoms, and trauma symptoms often lead to self-medication with alcohol and drugs.
- Do **not** use techniques that involve the recalling or re-experiencing of traumatic memories unless you are:
    - Well trained, supervised, and experienced in these technique
    - Ready to monitor and lower arousal levels when they start to escalate
    - Working with clients who have strong skills in managing their emotional responses
    - Certain that you will be able to bring to stability and containment before the session ends
- Once again, the emphasis is on building veterans' own skills in creating safety. If you use techniques that involve the recollection of traumatic memories:
    - Establish a firm foundation of safety and resources before you begin
    - Include ample training for the veteran in stopping or shutting down the process
    - Always progress slowly, giving the veteran practice in "toggling" back and forth between arousal and calming (Ferentz, 2008)
- For any work with trauma survivors, spend ample time, both on the establishment of safety before working on traumatic material, and on stabilization and containment of the traumatic material before ending the session.
- Monitor reactions to and effectiveness of any medications prescribed for the veteran, and take these medications' side effects into account in planning and carrying out interventions.

To gauge the level of arousal, an old mainstay in the field of trauma is the SUDS (Subjective Units of Disturbance Scale), designed by Joseph Wolpe, the developer of systematic desensitization. On a scale of zero to 10, (in which zero is neutral, no disturbance, and 10 is the worst level of disturbance the client can imagine), the client "rates" his or her disturbance at any given time.

It is essential that clinicians be trained in all the practices they use, and refer clients out for any other technologies they might need. Courtois (2006) strongly recommends the use of informed consent forms for any practice offered to and chosen by the client. These forms would describe the practice, its purposes, its characteristics, and the extent of the evidence base behind it. She also recommends that clinicians who are considering using practices that do not have a solid evidence base first consult their licensing regulations to see if they might face any challenges there.

Evaluating the Evidence Base: Even within the realm of practices with a solid evidence base, there are several cautions. If you are relying on the evidence, it is important to look at the studies in question and note:

- The sample size upon which the evidence is based
- The fidelity to treatment protocols that took place in that study
- The nature of the control group used (wait list vs. other treatments)
- The appropriateness of the population studied to your proposed use with veterans
- Whether or not these results can be generalized to this population—and to this individual veteran

Using Symptoms and Neurobiology in Considering Treatment Practices

The table on Page 87 lays out:

- Specific challenges (e.g., symptom clusters)
- The neurobiology beneath those challenges
- Strategies to address those neurobiological factors
- Examples of treatment approaches or practices that tend to help you carry out those strategies

Many veterans will have symptoms that appear on more than one line of this chart, and so they might benefit from more than one therapeutic intervention.

> **Please note:** The final column, "A Few Corresponding Practices," includes both evidence-based and promising practices that are designed to address the symptom clusters and challenges listed to their left. The inclusion of a practice in this column does not constitute a recommendation that this practice be used, in general, or in a specific case. That would be far beyond the scope of this document. By the same token, the omission of a practice from this column is not in any way meant to imply that this practice is not appropriate or effective.

You will notice that the chart does not mention medical interventions. Although medical interventions are sometimes necessary for stabilization, recommending specific medications would be beyond the scope of this site. The general advice is to coordinate with prescribing doctors and help monitor medication side effects and effectiveness.

The chart also does not mention the many self-help and self-care measures that are important for veterans, as they are for all of us. Some of those measures are mentioned in the final chapter, "Promoting Veterans' Recovery and Self-Care."

When you look at this chart, please remember that it is centered on the neurobiology of trauma—the brain, the stress systems, and the other parts of the body that carry the stress—and ways of addressing that central driving force. Although the chart does not address any of the other, equally important aspects of the human being—the mind, the heart, the spirit—it is definitely not meant to diminish the importance of these aspects. The aim is to get the body in line so the mind, heart, and spirit will have a more hospitable climate to live in, and a better chance to make their needs and wishes known.

Additional Considerations in Treatment Planning

A Multi-Modal Approach: As the table on Using Symptoms and Neurobiology in Considering Treatment Practices shows, veterans may experience many different "clusters" of symptoms. Clinicians who have the luxury of time will want to consider and use multiple approaches and practices, based on the veteran's symptoms, stage of recovery, and stage of readiness.

According to van der Kolk and Pelcovitz (1999), "Fully effective treatment may require a strategically staged, multi-modal treatment approach. On the one hand, a treatment approach that emphasizes cognitive reorientation to the present, while disregarding past trauma, may insufficiently address the reliving of the trauma in images, feelings, or behavior. On the other hand, a treatment approach that focuses prematurely on exploration of the past may exacerbate, rather than relieve intrusive affective and somatic symptoms. With appropriate timing, however, different treatment modalities might well be employed in complementary fashion. Thus, recognition of the complex nature of adaptation to traumatic life experiences may lead to further development of a more comprehensive treatment approach to trauma-based psychiatric disorders" (van der Kolk and Pelcovitz, 1999, p. 24).

Treatment Planning Resources from the National Center for PTSD: Although the evaluation and choice of trauma treatment practices is beyond the scope of this Guide, the Department of Veterans Affairs offers a guidelines document called *Management of Traumatic Stress* (2004), Washington, DC: VA/DoD Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense, December, 2003 (update targeted for 2006). It is available from the Department's Office of Quality and Performance Publication 10Q-CPG/PTSD-04, and available for download at http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm.

Table: Using Symptoms and Neurobiology in Considering Treatment Practices*

Challenges/Symptom Clusters	The Neurobiology	Strategies	A Few Corresponding Practices*
Post-deployment stress effects (in general)	The amygdala (primitive, unconscious emotional memory) is calling the shots	Learn to contact and enlist the help of the higher brain, including the prefrontal cortex (reason, logic, calm), anterior cingulate gyrus (relationship), insular cortex, and hippocampus (conscious memory)	Grounding in safety, Mindfulness training, cognitive/ behavioral skill training, affirmations (Siegel, 2007)
	Key higher brain structures (e.g., prefrontal cortex) are nurtured and activated through bonding and face-to-face contact (Schore, 2001)	Constructive face-to-face contact with trustworthy people	Building the therapeutic relationship, connecting with other veterans, harmonizing relationships with family and friends
	The amygdala is primarily concrete, and unable to grasp the more abstract kinds of thoughts and instructions that our logic would have us use in the healing process	Add concrete elements (images of shapes, sizes, sounds, smells, motion, etc.) to calming and safety instructions, and to skill building around stress and memories (always monitored and controlled)	Guided imagery (using the veteran's own chosen images), building a "safe place" in the imagination, placing traumatic information in a visualized "container" to maintain control, EMDR, careful use of somatic practices (Ferenz, 2008), art therapy, music therapy, dance (Scaer et al, 2008)
Fear, anxiety, irritation, anger, rage, sleeplessness, racing thoughts	The body has learned to respond to stress with hyperarousal of sympathetic processes and chemicals, and lacks enough GABA to promote calm or serotonin to help control impulses	Learn/practice ways of recognizing and labeling emotions, calming emotions, and slowing down in a controlled setting; clinician monitors arousal and provides coaching and support for the calming process	Grounding in safety, EMDR, self-soothing, Mindfulness, anger management, cognitive/behavioral therapy, careful use of exposure (great care in cases of DESNOS) (van der Kolk & Pelkovitz, 1999)
Responding to stress by "shutting down," numbing, avoidance, dissociation	The body has learned to respond to rising stress with parasympathetic chemicals, to avoid hyperarousal and maintain safety	Recognize this as a safety measure, improve motivation, develop concrete grounding in safety that will allow the veteran to take gradual steps toward recognizing and breaking out of dissociative patterns	Motivational interviewing, self-monitoring skills training, Mindfulness, careful use of somatic practices, great care in considering exposure therapy (which might bring on hyperarousal) (Danenburg, 1999)
Exhaustion, hopelessness, sense of helplessness, lack of arousal, depression, risk taking just to get some stimulation	Sympathetic arousal processes are worn out, both sympathetic chemical levels and serotonin levels are too low	Balance the stress system to gradually reintroduce sympathetic chemicals, promote clear thinking and higher serotonin levels, promote impulse control	Somatic practices, cognitive/behavioral therapy, Mindfulness, art therapy, music therapy, affirmations; focus on building appreciation, gratitude, and hope
Intrusive memories (images, sounds, smells, feelings, etc.), flashbacks, confusion between past and present events	Amygdala is bringing up fragments of unconscious traumatic memory, without any grounding in time or space from conscious narrative memories in the hippocampus	Safety measures and reminders for use during flashbacks and intrusive memories	Cue cards, self-soothing skills training, visualization, establishing a "safe place"
		Skills for distinguishing past from present and re-grounding in the "here and now"	Mindfulness, Focusing, cognitive skills training, visualization, art therapy
		Learn to integrate those memories with conscious narrative memories in the hippocampus	EMDR, narrative (with grounding in safety), careful use of exposure therapy (Ferenz, 2008)
Substance abuse or dependence	Alcohol or other drugs have served as self-medication, and (if dependent) convinced the brain they are necessary for survival	Keep trauma symptoms in mind in decisions to withdraw from alcohol/drugs. Allow the brain to stabilize in the absence of these substances	Motivational interviewing, motivational incentives, cognitive/behavioral therapy, SUD recovery-based approaches
Self-defeating thoughts	Prefrontal cortex is underactive, amygdala is influencing thoughts	Learn to question and replace self-defeating thoughts with constructive ones	Cognitive skills training, Mindfulness training, affirmations (Siegal, 2007)
Somatic conditions (e.g., unexplained tics, pains, numbness, tremors, etc.)	Energy of the freeze response is trapped in procedural memory in the brain	Release the stored energy through attention to the body, particularly in affected areas	Firm establishment of safety, followed by carefully used somatosensory practices
DESNOS symptoms (e.g., impulsivity, dependency, suicidal thoughts, delusions, rage, paranoia)	Amygdala is running the show, prefrontal cortex is underactive, development has been compromised	Provide safety, structure, clear boundaries, education/training in management of thoughts and emotions, focus on the present	Dialectical Behavioral Therapy (DBT), using EMDR only in later stages of recovery

These are practices you might look into. Their inclusion on this page does not constitute a recommendation of their use, in general, or with specific clients. No one should use any of these practices without: 1) a clear understanding of their uses and the evidence behind them and 2) ample training and (if required) licensing in the specific practice.

According to the National Center for PTSD's web site (www.ncptsd.va.gov), "the goal of that document is to promote effective management of acute stress responses (ASR) and acute stress disorder (ASD), early identification of probability of developing PTSD, and effective management of PTSD in primary care and mental health settings. It is presented in an algorithmic format that leads the reader through recognition of these conditions, makes recommendations for treatment and treatment objectives. The document also provides guidelines for determining whether or not recommendations and recommended treatment approaches are supported by the evidence." Among the resources in this document are guidelines for looking at the evidence behind the practices that are available.

The Importance of Strengths and Resources: One important hope is that the SUD treatment field's focus on recovery and strength-based treatment planning will inform and inspire treatment planning processes in services for veterans with post-deployment stress effects. Strength-based approaches are important for most people, but particularly important for veterans, who come from a culture that traditionally emphasizes strength and stigmatizes people with combat stress injuries.

Treatment plans should:

- Be custom-built for the individual veteran
- Be developed in a collaborative process between the veteran and the clinician
- Use language that the veteran finds relevant to his or her journey toward and through recovery
- List important strengths and resources—in the individual, the family, the community, and beyond—first identified in the assessment process, then updated as treatment progresses
- Center on the veteran's own goals for his or her treatment and recovery
- Detail approaches that use the identified strengths and resources to pursue the identified goals
- Include or intersect with the veteran's plans for ongoing recovery, re-balancing, and self-care (see Ideas for Recovery, Re-Balancing, and Self-Care)
- Be continually re-evaluated and improved as the veteran progresses through treatment, refining goals and finding new sources of strength, resilience, and resources

Chapter 8.

Ideas for Recovery, Re-balancing, and Self-care

> Veterans returning from Iraq and Afghanistan often show amazing courage and survival skills, not only in war but also at home.
>
> —Armstrong, Best, and Domenici (*Courage After Fire*, p. 34)

If helplessness is the hallmark of trauma, and empowerment is the antidote to helplessness, then the fact that so many sources offer suggestions for self-care and ongoing recovery is certainly a neon sign of hope. This chapter focuses on things that veterans can do to re-balance their stress systems. These suggestions reflect the helping professions' growing awareness of:

- The unbreakable connection between body, mind, spirit, and relationships
- The role that all of these play in trauma and recovery from trauma

A good clinician can enhance motivation, but the primary motivation for wellness and self-care will come from the veteran's own decision to take responsibility for putting his or her stress systems back in balance.

In the words of Jonathan Shay, "The essential first step that a veteran needs to take, which is a precondition of healing, is to establish his own safety, sobriety, and self-care. This is often a protracted struggle, and various means of assistance are available to support the veteran in accomplishing these things for himself" (Shay, 1994, p. 187).

The ideas presented on the following pages represent just a sample of ideas from a few of the many people who are addressing issues of trauma, trauma recovery, and self-care. Many of these ideas—breathing deeply, movement, relaxation, spiritual practices, and keeping in contact with other veterans, to name a few—seem to make each expert's short list.

These suggestions are organized according to their sources, to allow credit where credit is due—though these sources would undoubtedly pass the credit on to others, and particularly to those who have worked so hard to bring their lives back in balance.

- Suggestions From Three Presentations on Post-Deployment Stress Effects
- Suggestions From Books and Pamphlets for Veterans
  - Medea's Tips for Controlling Flooding
  - The Power of Common Responses to Combat Stress—and Suggestions for Getting Back in Balance

Suggestions From Three Presentations on Post-deployment Stress Effects

From ONE Freedom: These suggestions come from staff and consultants of ONE Freedom (Scaer et al., 2008), the Colorado-based not-for-profit organization (http://www.onefreedom.org) that provides education and training to veterans and their families.

- Deep, slow breathing, paying attention to the breath:
  - It is a way to "talk to the amygdala" and undo the effects of the freeze response (because deep breathing brings oxygen into the body, and awareness of breath brings us into an awareness of the body).
  - Breath is also something we can control.
  - Deep breathing helps regulate the heartbeat and heart rate variability (healthy differences in the heart rate between inhaling and exhaling).
  - Deep breathing is particularly important because we get most of our oxygen from the bottom of our lungs.
  - Controlling the "exhale" helps to regulate the stress system and slow down the arousal process.
- Attention-control exercises are important. We need to cultivate the inner observer, so we can observe our own thoughts, actions, and reactions. The observer (based in the higher brain) is an antidote to the automatic "reactor" driven by the amygdala.
- Mindfulness training/meditation helps cultivate the inner observer and activate the higher portions of the brain, so we have better control of the amygdala.
- Create a list of your top 10 peak experiences and visualize them in your mind.

- Generate an emotion, name it, and observe how you feel. Naming an emotion helps "downregulate" the amygdala, to bring it under control. "Name it and tame it."
- Think of appreciation as investment in your own strength. Appreciation changes the heart rate. Making a list of things you appreciate smoothes "heart rate variability."
- Rest is a lost art, and it brings us closer to where the memories are.
- Doing slow, deliberate exercises can help discharge some of the energy trapped in the body by the freeze response.
- Writing about our experiences helps us integrate our memories and understand the journey.

From Alison Lighthall: In a 2008 presentation, former Army Psychiatric Nurse Alison Lighthall offered a number of suggestions for self-care and re-balancing, including cutting down on (or quitting) caffeine. She has worked with many veterans whose anxiety problems vanished or grew much easier after they stopped having large quantities of caffeine. Lighthall also outlined a stress-management program she developed, called "Dynamic Stress Management." Components of that program include:

- Improving mental resiliency, so that fewer experiences in life trigger negative stress reactions
- Changing our thinking, so we are more likely to respond in constructive ways and less likely to respond in destructive ways
- Replacing the word "stress" with the more positive and empowering word "challenge"
- Remembering the positive impacts of stress, including:
    - Increased endurance
    - Enhanced physical strength
    - Alertness
    - Vigilance
    - Team cohesion
    - Increased faith in a higher power
    - A sense of purpose
    - Indifference to aches and pains
    - Heroism
    - Loyalty
- Remembering that balancing of the stress system requires "oscillation" (going back and forth) between stress (expenditure of energy) and rest (restoration of energy)
- Working toward balance by "changing it up"—following stillness with movement, noise with quiet, etc.

From Lia Gaty: In a 2008 presentation, psychotherapist and trauma specialist Lia Gaty offered the following suggestions for recovery and re-balancing:

- Face-to-face contact with someone you trust
- Yoga
- Meditation
- Breathing exercises (breathing deeply and slowly)
- Dancing vigorously and often (when you move in rhythmic ways that involve both the left and right sides of the body in turn, it helps balance the brain and integrate memories and experiences)
- Exercising vigorously, swimming
- Laughing hard with someone else
- Acupuncture, massage, tai chi
- Gardening
- Theatre
- Sports
- Visualization
- Focusing (a body-based self-therapy technique developed by Eugene T. Gendlin, PhD)
- Heart math (use of a device that helps in heart rate variability training)

Suggestions From Books and Pamphlets for Veterans

From *Courage After Fire:* In *Courage After Fire: Coping Strategies for Troops Returning from Iraq and Afghanistan and Their Families,* Armstrong, Best, and Domenici (2006) provide an entire book full of suggestions. A few are shown below:

Strength based exercises:

- Make a list of challenging experiences you've overcome in your life, and how you handle them
- Do the same for difficult situations during the war
- Make a lesson of moments of satisfaction, thrill, or humor during the war

Relaxation drills:

- Smooth breathing
- Imagining safety
- Muscle relaxation
- Simple outlets (what can I look at, listen to, smell, taste, touch and, think about that will make me feel more peace at this moment?)

Sleeping better:

1. Maintaining a regular sleep schedule

2. Having a comfortable sleep environment
3. Using the bed only for sleep or sex
4. Having a wind-down routine before you go to bed
5. Not having food or drinks with caffeine (e.g., coffee, sodas, chocolate) within six hours of bedtime
6. Not using alcohol or drugs to help you fall asleep
7. Not having regular or extended use of over-the-counter or prescribed sleep aids
8. Regular exercise
9. Staying active
10. Avoiding heavy food before bed
11. Quitting smoking or chewing tobacco
12. Avoiding or limiting naps during the day
13. Not watching the clock as you try to fall asleep
14. Getting up if you can't sleep
15. Trying not to worry at bedtime (make a worry list for tomorrow)
16. Making sleep a top priority
17. Including your partner in this process
18. Talking to a doctor
19. Talking to a therapist

Coping with redeployment anxiety:

- Understanding that anxiety is reasonable and normal
- Talking to families and other servicemen and women
- Talking to a therapist or counselor
- Being prepared for redeployment
- Considering all options regarding contract with the military
- Getting help from military and civilian doctors and the VA

From "Post-Deployment Stress": In a booklet (based on extensive PTSD studies) called "Post-Deployment Stress: What You Should Know, What You Can Do," the Rand Corporation offered a comprehensive list of suggestions, including:

- Keep in contact with other veterans
- Be patient with yourself: increase activity slowly, and don't expect improvement overnight; you're more likely to feel a little better every day
- Exercise and eat well (stay away from junk food)
- Get enough sleep and by keeping a regular sleep schedule and avoiding vigorous exercise before bed
- Stay away from alcohol, tobacco, and caffeine
- Think about the things you like to do, and do them
- Set realistic goals, and don't take on more than you can handle
- Break large problems into smaller ones
- Start with the tasks that are most important
- If you're having trouble remembering things, carry a notebook or set a regular routine for what you do

- If you have a flashback, remind yourself where you are and that you're safe; get up, move around, and talk to someone; tell your doctor or someone close to you
- Manage your anger by walking away from situations that make you angry or by talking things over with people who have made you angry
- Use the military resources available to you
- If you feel depressed and you're thinking of hurting about yourself, ask a family member or health care provider for help, or call the National Suicide Prevention Lifeline (1-800-273-8255 or 1-800-273-TALK); if you need immediate help, call 911

If you have a brain injury:

- Avoid physical activities that would lead to further injury
- Avoid alcohol, caffeine, pesudophedrine (Sudafed), and heavy use of sleep aids that can put more stress on your brain

Some signs that alcohol or drug use is becoming a problem:

- You feel guilty about your alcohol or drug use
- Your family or friends comment on how much you are drinking
- Your drinking or drug use makes it hard to live up to your responsibilities at home or at work
- You need more alcohol or drugs to get the same effect
- You've tried to cut down on your use but you can't

With your family:

- Sometimes the best thing you can do for your family is to talk openly about your thoughts, feelings, and actions
- Talk to them about your concerns related to post-deployment stress; you might want to set a time every day to check in with the people you care about
- Understand that it's normal for children to feel uncomfortable at first if things are different when you come home
- If they ask you about your symptoms, you can explain some of how you're feeling in a way that they will understand

From *Conflict Unraveled: Fixing Problems at Work and in Families*: Although *Conflict Unraveled* is not specific to veterans or people with post-trauma effects, author Andra Medea provides an extensive list of tips for controlling "flooding," that surge of adrenaline and other chemicals you get when your stress system is triggered. Those chemicals cut off communication with the higher portions of your brain, making it hard to:

- Think of the words you want to say
- Think of options you have, and weigh their risks and benefits
- Anticipate the consequences of your actions

Instead, they leave you alone with the amygdala or "survival brain," whose main instructions are usually, "fight, flight, or freeze." Flooding is contagious, with each person's amygdala "picking up on" the other's anger or panic. If two people are flooding, each one's symptoms are likely to escalate the other's symptoms.

Suggestions for Getting Back in Balance: The final "pull out" page is a table from *Finding Balance After the War* Zone, developed by Pamela Woll for the Great Lakes Addiction Technology Transfer Center and Human Priorities. This table looks at:

- Common automatic responses to combat stress
- Power of these responses
- Possible impact afterwards
- Suggestions for getting back in balance

Each of these elements is considered on each of seven levels:

- The body
- The brain
- Thoughts
- Feelings
- The Spirit
- The Unit
- Home

Medea's Tips for Controlling Flooding

From *Conflict Unraveled: Fixing Problems at Work and in Families*, by Andra Medea

Flooding is that "Fight or flight" adrenaline overload that everyone gets now and then, but it may happen more often if you have post-deployment stress effects. In *Conflict Unraveled*, Andra Medea describes flooding and gives a number of concrete, practical strategies for dealing with it.

What to Remember

Flooding happens to everyone. It happens in different ways, with different styles, but no one is immune to it. We're hard wired for this. When it hits—when, not if—you have got to be prepared to bring yourself out. Only then do you have any chance of getting back to problem-solving and a sane, functioning life.

To Control Flooding in Yourself

- **Watch for physical symptoms first:** Pounding head, racing heart, short breath, sweaty palms, dry mouth. Make a list of your personal signs. Check the list when you're under stress. Checking the list is more important than yelling at someone.
- **Watch for mental symptoms:** Jumbled thoughts; rotary thinking; or an inability to see options, to sequence, or handle math. Also watch for sudden inarticulation, disjointed speech, or suggestibility.
- **Use large muscles:** Go for a walk. Close the door and do jumping-jacks or swing your arms in windmills. Use isometrics if you're stuck in a meeting.
- **Reverse symptoms:** If your breathing goes short, breathe deep and slow. If your fists are clenched, open your hands and stretch your fingers.
- **Focus on specifics:** List facts and read them back to keep your mind focused. Slow the pace.
- **If you can't break free of flooding at the time:** Recognize that you can't think and stop arguing. State clearly that you'd like to talk later, then leave and re-group. Try again after you have repeated the earlier steps.
- **Prepare in advance:** If a tough situation is approaching, practice taking yourself out of flooding. Your mind learned flooding; it can unlearn it. You can develop a resistance to flooding or train yourself to snap out of it.
- **Get it out of your system:** Go smash something, just not people or living things.

To Handle Flooding in Others

- **Watch for symptoms,** such as flushed face, pulsing veins, or disjointed sentences.
- **Don't talk at them since they can't hear you.** Instead, let them talk; give them time to vent. Ask sequence questions: What happened first? What happened next? Use a low, calm tone of voice.
- **Don't crowd them, don't touch them, and don't make fast movements.** If they want to leave, let them.
- **Be prepared for thinking problems.** Don't demand math from someone who is flooding, and don't give complicated directions. Keep it simple, or wait until they calm down.
- **Avoid jargon.** Use short, clear sentences.
- **With chronic cases talk pain control, not anger control.** High levels of adrenaline are toxic; this isn't a comfortable feeling. But the process will take time. They didn't learn flooding in a day, and they won't unlearn in a day.
- **Work on yourself first.** Flooding is contagious, but so is calm. You can't hope to stop someone else's flooding unless you can stop your own.

From Medea, A. (2004). *Conflict Unraveled: Fixing Problems at Work and in Families.* Chicago: Pivot Point Press. Reprinted with permission.

The Power of Common Responses to Combat Stress—and Suggestions for Getting Back in Balance

	1. Common Automatic Responses	2. Power of These Responses	3. Possible Impact Afterwards	4. Suggestions for Restoring Balance
The Body	Powerful chemicals go into "overdrive"—heart racing, "super-human" strength, "freeze" responses, tensing protective front core muscles.	In combat, speed and strength help you feel confident, react quickly and decisively, fight, save lives, escape harm. "Freezing" can save lives.	After these chemicals go into overdrive, the body has some unfinished business. It may be shaky, "jumpy," or very tired or weak (feeling "paralyzed") for a while.	Patience with the time it takes to "normalize." Exercises to relax front core muscles. Good diet, rest, exercise, vitamins/minerals/herbs. Medical care so the body can learn to handle stress and make stress chemicals again. Counseling to help you learn to regulate your stress systems.
	In constant threat, these systems can stay on overdrive for a long time.	You can stay ready for battle at all times, for long periods of time.	Constant stress makes the body jumpy, weak, vulnerable to chronic illness.	
The Brain	Some chemicals speed up thoughts, raise feelings of alarm and fear.	Speedy thoughts help you take action. Alarm and fear help you judge threat.	"Speedy" chemicals cause jittery nerves, anger, feeling threatened, sleep trouble.	Understand that these are normal chemical reactions to sometimes unimaginable events. Become an observer of your own reactions. Watch your reactions to things that seem like threats or insults, and question whether they really are, or if it's just your brain chemicals talking. Avoid alcohol, drugs, and caffeine, and get medical advice if you think you might need help. Get help for depression and any other reactions that last more than a month.
	Some chemicals calm you down, help you control your actions/reactions, and keep your moods stable, even in unstable situations like combat.	These calming chemicals help you think more clearly, make better decisions, react in more effective ways, cooperate better, be a better leader.	Calming chemicals can "wear out" after they've been needed too much, causing anxiety, depression, urges to drink or use drugs, higher risk of getting addicted.	
	Some chemicals relieve pain and sometimes help you forget what you experienced under intense stress.	Pain relief during the crisis—and forgetting the pain afterwards—helps you keep going in spite of the pain.	You might lose important memories later, or memories might "come at you out of nowhere," even long after combat is over.	
Thoughts	"This isn't happening. It isn't so bad."	Makes it easier to cope and function.	You might neglect signs you need help.	Talk about what happened, how it really was. Balance helping others with getting the support or professional help you need. Let trust grow back slowly. Question blame, and put it in context. Talk about responsibility.
	"I'm strong; other people need me."	Brings more hope, courage, action.	You might see needs as weaknesses.	
	"I can't trust anyone outside the Unit."	Helps you spot danger and react to it.	You might not trust anyone outside Unit.	
	"This is all happening for a reason."	Helps you accept pain and move on.	You might blame yourself or others.	
Feelings	Not feeling emotions (numbing them).	Less pain/fear, more decisive action.	You might not grieve important losses.	Let the grieving happen in whatever form or timetable it seems to want to take. Practice feeling whatever you feel. Remember: It takes great courage to feel. Learn and practice skills in managing your feelings.
	Feeling only "safe" emotions (anger).	Helps you focus on fighting and winning.	You might take feelings for weakness.	
	"Projecting" your feelings onto others.	Helps you not notice/feel your feelings.	You might resent, damage relationships.	
	Giving in to just feeling overwhelmed.	Lets people know you need help.	You might ignore real strength/courage.	
The Spirit	Connecting with your spiritual beliefs.	Strength in safety, connection, meaning.	You might reject others' help or beliefs.	Know that there's plenty of room for your beliefs, others' beliefs, and human help. Use questioning to strengthen your beliefs and get closer to what you really believe. Balance acceptance with need for action.
	Questioning or rejecting your beliefs.	Helps explain painful and unfair things.	You might lose connection, meaning.	
	Finding new spiritual feelings/beliefs.	Brings in new spiritual strength/hope.	You might lose beliefs when crisis is over.	
	Accepting and transcending events.	More clarity, calm, sense of purpose.	You might accept things you should change.	
The Unit	Military discipline, high expectations.	Standards promote strength, discipline	You might be ashamed of reactions to stress.	Know that it's **not** weak or disloyal to get help for the body's and brain's reactions to war-zone stress. Make and keep deep friendships with others who have served.
	Staying alert for danger at all times.	You're ready to react to any emergency.	Toll on body and brain (see above).	
	Sense of unity within the Unit.	Cooperation saves lives, wins battles.	You might feel lost/alone after deployment.	
Home	Keeping in contact (emails, phone).	Sense of connection brings strength.	Stronger feelings of loss, homesickness.	Accept that you've changed, and those at home have changed, too. Learn who you all are now. Use resources for re-learning trust, communication, and relationships.
	Not talking about bad experiences.	Protects loved ones from pain and fear.	You might feel disconnected from home.	
	Remembering your home as ideal.	Reminds you what you're fighting for.	Nobody can live up to an ideal in real life.	

From *Finding Balance After the War Zone*, developed by Pamela Woll, MA, CADP for the Great Lakes Addiction Technology Transfer Center and Human Priorities.

This is the end of Study Guide 2, and the end of Course 5L. You must pass both quizzes for this course, and also complete and submit the Feedback Form, before you can download your certificate.

If you wish to know more on this subject, you may wish to enroll in Course 5K, which is Part 1 of 'Finding Balance After the War Zone - Considerations in the Treatment of Post-Deployment Stress Effects'. Course 5K focuses upon:

1. Clinical Considerations - The Role of Substance Abuse in the Treatment Process

2. Resilience and Vulnerability to Traumatic Stress - How the Body Responds - Sustaining Stress and Trauma in the Body

3. Service Members' Experiences at War from the Perspective of Iraq and Afghanistan

4. Post-Deployment Stress Effects - The Biology, Onset, and Complexity of War Zone Stress Injuries (PTSD, TBI, Depression, Physical Damage, etc.)

There are references which you may wish to consult beginning on the next page, and also some active internet links to good resource materials on the last page.

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Finding Balance

References and Other Resources

The following pages contain:

- A list of References
- A beginning list of books beyond these references that might be useful to people who want more information on veterans, post-deployment stress effects, the neuroscience of stress and trauma, or the treatment of trauma
- A few web-based resources that offer more information on these subjects

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A Few Resource Web Sites

For information and free HTML texts of scholarly articles on trauma and post-trauma effects, David Baldwin's Trauma Pages is a valuable resource.

The VA's National Center for Posttraumatic Stress Disorder has a wide range of materials for clinicians, veterans, and families on its web site, http://www.ncptsd.va.gov/ncmain/index.jsp. (This site also has materials relevant to disasters and other sources of extreme stress.)

You can download a PDF file of the Second Edition of the VA's *Iraq War Clinician Guide* (VA, 2004) at http://www.psychceu.com/war/iraq_clinician_guide_v2.pdf

You can download the Rand Corporation report, *Invisible Wounds of War* (Tanielian and Jaycox, 2008) and accompanying materials for veterans and families at http://www.rand.org/multi/military/veterans/

You can download the Expert Consensus Guidelines on the Treatment of PTSD from the *Journal of Clinical Psychiatry* (Foa, Davidson, and Frances, 1999) from http://www.psychguides.com/ptsdgl.pdf

You can get ongoing information and news updates by subscribing to *PTSD Combat: Winning the War Within*, the free e-journal at http://www.ptsdcombat.blogspot.com/.

Alison Lighthall's "Hand 2 Hand Contact" web site has a number of valuable resources and links, at http://www.hand2handcontact.org/