Understanding PTSD with the Veteran Population

Camellia A. Westwell, Psy.D.
Staff Psychologist
Veteran’s Health Administration
Viera VA Clinic
(321) 637-3788
Thank you Dr Mary Beth Shea – Orlando VA for assistance with data and slides!

*Disturbing information alert*
Our Environment

- The VA
- Addressing the retired, disabled, reservists, National Guard, and active duty military.
- Fast paced, stressful, demanding, satisfying.
- Focused on supporting the “mission” or “cleaning up the aftermath” after the mission.
- Injury, “lay offs”, disability, discharge, completed terms, retirement
Our population

- World War II Veterans
- Korean War Veterans
- Vietnam Veterans
- Cold War Veterans
- Operation Just Cause Veterans (Panama)
- Operation Desert Shield and Desert Storm
- Operation Enduring Freedom / Operation Iraqi Freedom / Operation New Dawn
- Peacetime Veterans
World War II
Korean War

Photo # SC 357227  Troops watch bombardment of enemy-held area in Korea, Feb. 1951
Vietnam War
Gulf War: Desert Storm and Desert Shield
Enduring Freedom, Iraqi Freedom, New Dawn
Differences between our Veterans

- Age
- Gender
- Maturation effects
- Education
- Medical issues
- Lethality risk factors
- Military experience
- Occupational Stages
- Family Stages and Stressors
- Risk of Exploitation and Abuse
- Legal status
- Potential for substance abuse
Characteristics of Veterans

- Positive Characteristics
- Challenges

When a service member comes home, he/she may find it hard....
...to keep from ridiculing someone who complains about hot weather.
...to be understanding when someone complains about a bad night’s sleep.
...to control his/her emotions when they hear someone say that the war is about oil.
...to control his panic when his wife tells him he needs to drive slower.
...to sleep through the night.
...to forget the things they have seen and done.
...to feel comfortable with a stranger behind them.
...not to startle at loud noises.
..to make new friends.
...to remember what it was like to be carefree.
...to be civil to people who complain about their work.
...to be tolerant of people who complain about the hassle of getting ready in the morning.
Post Traumatic Stress Disorder

- “The complex somatic, cognitive, affective, and behavioral effects of psychological trauma”
- Pathophysiology unknown
- Consider genetic factors, environmental situation, pre-morbid functioning.
- Risk factors: age at trauma, gender, race, education, lower SES, prior trauma, childhood adversity, personal and family psychiatric history, childhood abuse, poor social support and initial severity of reaction to traumatic event.
PTSD Defined....

- Shellshock
- Battle Fatigue
- Nostalgia
- Stress Response Syndrome
- Combat fatigue
- Anxiety Neurosis
- Soldiers Heart
- Homesickness
- Hysteria
- Compensation Sickness
Course of the Condition

- WWII - cases being classified from 1933
- Belief the cases were acute and transitory
- Anyone would have these issues and they would eventually remit

- Vietnam War
- Stress Response Syndrome
- Existing more than 6 month suggested a pre-existing condition.
Course of the Condition

- 1980’s- chronicity idea.
- Anxiety disorder vs. short term adjustment
- 2015- Trauma related disorder

- Can be either acute or chronic
- Some remit, others maintain over time
Trauma

- Military combat
- Violent personal assault
- Natural and man made disasters
- Motor vehicle accidents
- Rape
- Incest
- Childhood sexual abuse
- Diagnosis of life threatening illness
- Severe physical injury
- ICU Hospitalization
- Vicarious trauma
Conceptualize PTSD as...

... a recovery failure ...
What makes PTSD so different?

1. A mental illness that is brought on by external factors.
2. It’s a true bio-psycho-social disorder.
3. It’s a shift from one way of “knowing” to another, considerably less pleasant one. “Just World Belief”
4. It affects how we experience ourselves, others, and the world at large.
PTSD Symptoms

- Trauma Exposure (A)
  - Direct
  - Witnessing
  - Indirectly
  - Repeated or extreme exposure on the job
PTSD Symptoms

- Intrusion (B) (1)
- Involuntary memory
- Traumatic nightmares
- Dissociation
- Distress at reminders
- Reactivity at reminders
1. Intrusive Images and Sensations

- Sensory memories
- Images
- Flashbacks
- Nightmares

Intrusions
PTSD Symptoms

- Avoidance (C) (1)

- Avoid thoughts or feelings

- Avoid external reminders
PTSD Symptoms

- Altered Cognition/Mood
- Inability to recall
- Persistent negative beliefs about self or the worlds
- Negative trauma emotion
- Diminished interest in activities
- Detachment
- Constricted affect/no emotional expression
PTSD Symptoms

- Arousal and Reactivity
  (E) (2)

- Irritable/aggressive
- Self destructive or reckless
- Hypervigilant
- Exaggerated Startle
- Sleep disturbance
3. Negative Affect and Hyperarousal

Intrusions

Cognitions

Hyperarousal

Emotions/Arousal

Fear

Sadness

disgust

Anger

Startle

EVENT
In normal recovery, intrusions and emotions decrease over time and no longer trigger each other.
However, in those who don’t recover, strong negative affect leads to escape & avoidance.

- **Intrusions**
- **Emotion/Arousal**
- **Cognitions**

Core Reactions: Aggression, Self-harm behaviors, Substance abuse, Binging, Cognitive avoidance, Behavioral avoidance, Dissociation, Emotional suppression, Social withdrawal, Behavioral inhibition, Somatic complaints.
Statistics

- 6.8-12.3% prevalence in adults in US
- Higher rates in subgroups: refugees and Native Americans
- Women x4 as likely to have PTSD

- PTSD higher in women for assault and molestation
- Increased risk for angina, heart failure, bronchitis, asthma
- With combat PTSD correlated with extent of injury and TBI occurrence
Statistics

- PTSD in soldiers hospitalized for war injury showed 4.2% at one month and 12.2% at four months.

- ICU hospitalization who survived showing prevalence rate of 20% for PTSD in a data analysis from 2008.
The Body and the Brain

- Fight or flight reaction is “damaged”. We perceive danger when there is no danger present.
Fight-Flight-Freeze Response

**FIGHT or FLIGHT**

**Noticeable Effects**
- Pupils dilate
- Mouth goes dry
- Neck and shoulder muscles tense
- Heart pumps faster
- Chest pains
- Palpitations
- Sweating
- Muscles tense for action
- Breathing fast
- Shallow - hyperventilation
- Oxygen needed for muscles

**Hidden Effects**
- Brain gets body ready for action
- Adrenaline released for fight/flight
- Blood pressure rises
- Liver releases glucose to provide energy for muscles
- Digestion slows - or ceases
- Sphincters close - then relax
- Cortisol released (depresses the immune system)
Chronic Stress / PTSD

Fight or Flight

Homeostasis

Perceived Threat

Exhaustion

Chronic Stress

Return to Homeostasis
Why?

- Event occurs
- Take it in
- Senses take pictures
- No trauma “files”
- “Float”

- No emotional processing
- Surviving is “key”
- “Frozen” emotionally
Genetics

- Researching a genetic vulnerability to depression, anxiety and PTSD
- Gastrin Releasing Peptide
- %-HTTLPR Gene
The Brain

- Amygdala - role in emotion, learning and memory.
- Size
- Active in fear acquisition and learning not to fear
- Chronic stress = Cortisol Elevation = Neurotoxic effects on the amygdala (our rapid response system)

- Prefrontal cortex - storing extinction memory and dampening the fear response
- If it deems a source of stress controllable, it suppresses the amygdala (the alarm center) and controls the stress response
So, now you understand PTSD, let's look at our military population...
Readjustment
Readjustment

- Tough to “turn it off”

- Combat is a severe trauma
  - 95% observed dead bodies or human remains
  - 93% were shot at, or received small arms fire
  - 89% were attacked or ambushed
  - 65% observed injured or dead Americans
  - 48% were responsible for the death of an enemy combatant

- Failure to recover from severe trauma can lead to PTSD
“Battlemind is the Soldier's inner strength to face fear and adversity with courage.

Key components include:

A. Self confidence: taking calculated risks and handling challenges.

B. Mental toughness: overcoming obstacles or setbacks and maintaining positive thoughts during times of adversity and challenge."

U.S. Army Medical Command
Coping with the “Battle-Mind”

“Battlemind” must be adjusted when you get home or it may cause the soldier problems.
Combat Skills

- Battlemind skills helped you survive in combat... but may cause problems when you get home... if you haven’t adapted them

  - **Buddies (cohesion)** vs. Withdrawal
  - **Accountability** vs. Controlling
  - **Targeted Aggression** vs. Inappropriate Aggression
  - **Tactical Awareness** vs. Hypervigilance
  - **Lethally Armed** vs. “Locked and Loaded” at Home
  - **Emotional Control** vs. Anger/Detachment
  - **Mission Operational Security (OPSEC)** vs. Secretiveness
  - **Individual Responsibility** vs. Guilt
  - **Non-Defensive (combat) Driving** vs. Aggressive Driving
  - **Discipline and Ordering** vs. Conflict

- **Battlemind Checks** allow Soldiers and their Buddies to identify when help is needed.
Lethally Armed vs. “Locked and Loaded” at Home

**BATTLEMIND Check**

- Threatened someone with a weapon?
- Carry a loaded weapon in your car?
- Keep an unsecured loaded weapon at home?

**Lethally Armed vs. “Locked and Loaded” at Home**

- **In Combat:** armed at all times
- **At Home:** urge to be armed continues

- **In combat, it’s dangerous to be unarmed**
- **At home, it’s dangerous to be armed**
Tactical Awareness vs. Hypervigilance

In Combat vs. at Home

- In Combat: alert & aware at all times; react immediately
  At Home: Hypervigilant. You may feel keyed up

- Combat requires constant alertness
  Back home it takes time to learn to relax

BATTLEMIND Check

- (self & buddy)
  Still jumping at loud noises...revved up?

  Still have trouble with sleep or nightmares?

  Drinking to calm down or to help you sleep?
Non-Defensive (combat) Driving vs. Aggressive Driving

In Combat vs. at Home

- In Combat: Unpredictable, fast driving to avoid IEDs

At Home: **Aggressive driving** leads to speeding tickets, accidents, fatalities.

- *In combat, driving fast avoids danger*

Back home, driving fast ‘feels right,’ but is dangerous

**BATTLEMIND Check**

- (self & buddy)
  - Chasing adrenaline highs by driving fast?
  - Involved in driving accidents?
  - Easily angered while driving?
## Consequences for Traffic Safety

<table>
<thead>
<tr>
<th>In Combat</th>
<th>At Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drives as far as possible from the road edge to avoid IEDs</td>
<td>Drives in the middle of the road, straddling lanes</td>
</tr>
<tr>
<td>Changes direction and lanes unexpectedly, especially at tunnels or underpasses where insurgents might be waiting.</td>
<td>Weaves through traffic. Does not signal turns, merges, or lane changes. Avoids or changes lanes at underpasses and tunnels</td>
</tr>
<tr>
<td>Always moving. Does not stop for traffic or people. Always has the right of way</td>
<td>Anxious when stopped. Rolls through traffic lights and stop signs. Does not yield right of way to other vehicles</td>
</tr>
<tr>
<td>Speeds as fast as the lead vehicle in a convoy</td>
<td>Drives over posted speed limit</td>
</tr>
<tr>
<td>Hyper-vigilant of road-side elements</td>
<td>Overly attentive to road</td>
</tr>
</tbody>
</table>
Accountability vs. Controlling

In Combat vs. at Home

- **In Combat:** Maintaining control of weapon and gear

- **At Home:** Too controlling. Become angry when someone messes with your stuff. Nobody cares about doing things right except for you.

- **Back home, the small details are no longer important**

  Family decisions are best shared.

BATTLEMIND Check

- **(self & buddy)**
  Overreacting to minor events?

  Trouble letting family/friends share in making decisions?

  Trying to control things that don’t really matter?
Discipline and Ordering vs. Conflict

In Combat vs. at Home

- In Combat: Survival depends on discipline and obeying orders
- At Home: Too rigid. Trying to order around family & friends causes conflict
- Giving and following orders involves a clear chain of command...
  - which does not exist within families.

BATTLEMIND Check

- (self & buddy)
  - Relationships aren’t going well?
  - Ongoing conflicts over decisions?
Targeted Aggression vs. Inappropriate Aggression

In Combat vs. at Home

- In Combat: Targeted aggression involves making split second decisions that are lethal.

- At Home: Inappropriate aggression e.g. snapping at the kids or buddies or your NCO; assault or spouse abuse.

- In combat, the enemy is the target; Back home, there are no enemies.

BATTLEMIND Check

- (self & buddy)
  - Still snapping at your spouse, kids or buddies?

- Getting into fights or heated arguments?

- Avoiding people?
Emotional Control vs. Anger/Detachment

In Combat vs. at Home

- **In Combat:** Controlling your emotions is critical for mission success.

  At Home: Failing to display emotions (detaching), or only showing anger, hurts relationships.

  - In combat, controlling emotions is necessary
  
  At home, limiting your emotions leads to relationship failures

**BATTLEMIND Check**

- (self & buddy)

  Can only show anger or detachment?

  Feeling numb?

  Having relationship problems?

  Friends & loved ones tell you that you have changed?
Individual Responsibility vs. Guilt

In Combat vs. at Home

- In Combat: Your responsibility in combat is to survive and do your best to keep your buddies alive.

At Home: Guilt. Feel you have failed your buddies if they were killed or seriously injured. Bothered by memories.

- In combat: life and death decisions...in the heat of battle

Back home: learn from what happened...without second guessing

BATTLEMIND Check

- Certain memories of the deployment keep bothering you?

Still feeling guilt about things that happened in combat?
Mission Operational Security (OPSEC) vs. Secretiveness

In Combat vs. at Home

- In Combat: Talk about mission only with those who need to know (OPSEC).
- At Home: Soldiers may avoid sharing their deployment experiences with loved ones.

OPSEC: The “need to know” now includes friends and family

It’s important to share your story with loved ones

BATTLEMIND Check

- (self & buddy)
  Haven’t shared your deployment experiences with those closest to you?
  Get angry when someone asks you about your deployment experiences?
Buddies (Cohesion) vs. Withdrawal

In Combat vs. at Home

- In Combat: No one understands your experience except your buddies who were there (cohesion).


- Combat: form bonds with fellow Soldiers that will last a lifetime;

  Home: friends and family changed while you were away; re-establishing these bonds takes time and work.

BATTLEMIND Check

- Felt close to buddies over there but now feel alone?

  Not connecting with loved ones?
Other considerations...
Challenges - Physical Symptoms

- Headaches
- Hyperventilation
- Tachycardia
- Muscle spasm
- Sweating
- Indigestion, nausea, vomiting, bowel changes
- Chest pain
- Hypertension
- LOC
Challenges

- Employment
- Housing
- Relationships
- Family
- Clearance
- Reservist Status
- Arrests
- Bankruptcy
- Foreclosures
- Child Support
- Disability Status

- Social Readjustment
- Violence
- Lethality
- Domestic Abuse
- Substance Use
- Hospitalizations
- Losses and Death
- Academic placement
- Physical Problems
Lets switch gears for a moment....PTSD but not from combat...
What is MST?

- Sexual harassment or
- Physical assault of a sexual nature
- While the victim was in the military

Dept. of Veterans Affairs, EES, *Military Sexual Trauma*, 2004
Why the big deal?

- 1991
- Tailhook scandal
Recruits Speak Out

- 1997, Aberdeen
  - Jesse Brown’s letter: “Dear Fellow Veteran”

- 2003, Air Force Academy

- 2004, Pentagon study of the military academies
The VA Responds

1992, Senate hearings,
- Public Law 102-585: Health care services for WVST.
Veteran’s Health Administration

- Monitor military sexual trauma (MST) screening and treatment
- Provide care for both physical and mental health conditions relating to MST
- Provide staff with training on MST-related issues
- Provide outreach to Veterans about available services
Veterans with MST in VA

- 21.9% females (53,295)
- 1.1% males (46,800)
What makes MST different?

- Compounding nature of Trauma
- Characteristics of their Trauma
- Others’ Reactions
- Scope of the Consequences
Prior Traumas

- 50% of female soldiers report childhood sexual assault
- 17% of male soldiers report childhood sexual assault
- 50% of all soldiers report childhood physical assault
  

- 55% of Navy recruits reported one or more forms of childhood family violence.
  
  Merrill, Standler, et al., *Military Medicine*, 2004

- 25% of females and 1% of male soldiers reported sexual assault during childhood.
  
Characteristics of the Trauma

- Perpetrator is frequently a person in authority position over the victim—turns their perceptions of the world on their side
  - Don’t trust self or others
  - No fairness or justice
  - Etc.
The Military Culture

• Can’t get away from the reminders or, often, the perpetrator
  • “If you ... try to get out, you can’t just quit and find another job. You end up working with these other soldiers, living with them, dining with them..., riding with them...your life is permeated with them virtually 24/7.”

S.Y. Army veteran, 2008
Others’ Reactions

- Inability / Unwillingness to report
  - Suck it up and drive on
  - No person is more important than the mission
  - Bad for the team
  - Self-blame, guilt, shame
    - Reinforces old negative thoughts about self
  - Blaming the victim
  - System backs up the perpetrator
    - Reinforces old negative thoughts about the world
So what do we do about all this?
Treatments for PTSD

- Biological Treatments (Bio)
- Cognitive Treatments (Psycho)
- Behavioral Treatments (Social)
Where is the easiest point of entry?

- Biological Intervention?
- Psychological Intervention?
- Behavioral Intervention?
1. Prevent Avoidance

Core Symptom Clusters

- Intrusions
- Emotions/Arousal
- Cognitions

- Aggression
- Self-harm behaviors
- Substance abuse
- Binging
- Cognitive avoidance
- Behavioral avoidance
- Dissociation
- Anhedonia/numbing
- Social withdrawal
- Behavioral inhibition
# Medical Treatments for PTSD

<table>
<thead>
<tr>
<th>R</th>
<th>Significant Benefit</th>
<th>Some Benefit</th>
<th>Unknown</th>
<th>No Benefit/Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>SSRIs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>TCAs, MAOIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Sympatholytics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Novel Antidepressants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>Anticonvulsants, Atypical Antipsychotics, Buspirone, Non-benzodiazepine hypnotics</td>
<td></td>
<td>Benzodiazepines, Typical Antipsychotics</td>
</tr>
<tr>
<td>Drug Class</td>
<td>Global Improvement</td>
<td>Re-experiencing (B)</td>
<td>Avoidance/ Numbing (C)</td>
<td>Hyper-arousal (D)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>SSRIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sertraline</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>TCAs</strong></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>MAOIs</strong></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sympathomlytics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prazosin</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Propranolol</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Novel Antidepressants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trazodone</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nefazodone</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Valproate</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Atypical antipsychotics</strong></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Other medications...

- Benzodiazepines (anxiety, sedation)
- Antipsychotics (psychosis, mood, agitation, sleep, )
- Other Antidepressants (sadness, anxiety, sleep, irritability)
# Cognitive Treatments for PTSD

<table>
<thead>
<tr>
<th>R</th>
<th>Significant Benefit</th>
<th>Some Benefit</th>
<th>Unknown</th>
<th>No Benefit/Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cognitive Therapy [CT]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exposure Therapy [ET]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stress Inoculation Training [SIT]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye Movement Desensitization and Reprocessing [EMDR]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Imagery Rehearsal Therapy [IRT]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychodynamic Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>PTSD - Patient Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence-Based Treatments

- **Prolonged Exposure Therapy**
  - 12-15 weeks
  - 90 minute sessions
  - Individual
  - Confront avoidance
  - Imaginal Exposure
  - In Vivo exposure
  - Cognitive processing

- **Cognitive Processing Therapy**
  - 12 weeks
  - 60 minutes sessions
  - Group or individual
  - Challenging thoughts/stuck points
  - As thoughts balance emotions reduce
CPT & PE on PTSD Diagnosis at Pre-treatment and Long Term

% Meeting PTSD Diagnostic Criteria (CAPS)

Pre  5+ Years

CPT (n=63)
PE (n=64)
# Social Interventions for PTSD

<table>
<thead>
<tr>
<th>If the client and clinician together conclude that the patient with PTSD:</th>
<th>Service/Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is not fully informed about aspects of health needs and does not avoid high-risk behaviors (e.g., PTSD, substance)</td>
<td>Provide patient education</td>
</tr>
<tr>
<td>2. Does not have sufficient self-care and independent living skills</td>
<td>Refer to self-care/independent living skills training services</td>
</tr>
<tr>
<td>3. Does not have safe, decent, affordable, stable housing that is consistent with treatment goals</td>
<td>Use and/or refer to supported housing services</td>
</tr>
<tr>
<td>4. Does not have a family that is actively supportive and/or knowledgeable about treatment for PTSD</td>
<td>Implement family skills training</td>
</tr>
<tr>
<td>5. Is not socially active</td>
<td>Implement social skills training</td>
</tr>
<tr>
<td>6. Does not have a job that provides adequate income and/or fully uses his or her training and skills</td>
<td>Implement vocational rehabilitation training</td>
</tr>
<tr>
<td>7. Is unable to locate and coordinate access to services such as those listed above</td>
<td>Use case management services</td>
</tr>
<tr>
<td>8. Does request spiritual support</td>
<td>Provide access to religious/spiritual advisors and/or other resources</td>
</tr>
<tr>
<td>OTHER CONDITIONS</td>
<td></td>
</tr>
<tr>
<td>9. Does have a borderline personality disorder typified by parasuicidal behaviors</td>
<td>Consider Dialectical Behavioral Therapy</td>
</tr>
<tr>
<td>10. Does have concurrent substance abuse problem</td>
<td>Integrated PTSD substance abuse treatment (e.g., Seeking Safety)</td>
</tr>
</tbody>
</table>
Treatment defined

**Therapy**
- Individual therapy
- Family therapy
- Conjoint therapy
- Child therapy
- Group therapy
- Support groups
- Substance Abuse
- Pharmacotherapy

**Other**
- Social Work
- Case Management
- Primary Care
- Specialty Care
- Legal Assistance
- Vocational Rehabilitation
How can YOU use BATTLEMIND to defuse a bad situation?

**Remember:** it’s about strength and courage in the face of adversity

**So:** Normalize
Are you a veteran?
Who did you serve with? When were you in?
Where is your weapon?
So, what do we say?
Using BATTLEMIND

- Life there vs. life here
  - At ease, soldier.
  - Give him/her space; Don’t fire too many questions at once.
  - Be aware that YOU may be a trigger. Use your authority gently.

- Readjust
  - Where’s your head at?
  - Were you aware that.....?
Grounding

- Look at me for a minute
- Listen to my voice
- Safety check – 2015, Orlando, my name, building, State, sunshine,
- Objects- keys, phone, wedding ring,
- Just focus on the room- “what do you see”
- Breathing- “just lets stop and breathe for a minute ok”
- Distract - Pictures, changing topics, children, hobbies
Listening Actively

- Support personal pacing - let them talk about their “trauma”
- Non-verbals - nods, eye contact, expressions
- Paraphrasing - “it sounds like you...” or “so you are saying that...”
- Reflect feeling - “you seem upset right now..”
- Allow for expression of emotion - tears, venting
I understand this is tough, you’ve been through so much... but understand for me to help you we need to address these questions....

I’m saddened by what I hear. Still, I can’t help you unless we deal with ....

I’m amazed at your strength right now...
Contact and Communication

- Orient the situation – Westwell, meet with you, last about 45 minutes, purpose is, may be difficult at times.....
- Do you have any questions of me?
- Are you comfortable? What can I get you?
- Ask questions, no assumptions.
- Here to help you vs. being in charge
- Controls; “I need to get some information from you today. Ok with you?”
- Tell me about you? What is it you would like me know about you?
Contact and Communication

- Voice tone and volume
- Sudden movements
- Standing over vs. sitting across from
- Door open vs. closed
- Seating and positioning – yours and theirs
- Look at “decoration” in office – offensive, provocative?
- Noise and interruption
- Safety - weapons, violent history, paranoid patients
- Note taking and recording
Addressing the issue...

- Problem solve- “how are we going to get from A to B”, options are,
- You have been an expert in... let me share with you what I know about something I have studied for a long time to see if it helps you...
- Effectiveness...what needs to happen to get you what you want
- Participate- I need your help..you are going to need to help make this happen...
The Dealbreakers.

- It could be worse...
- Well you made it home....
- Did you kill anyone...what was it like...
- You’ll be okay...
- Lots of people have been through this...
- Don’t worry about it...
- I know how you feel....
- I’ve not been to war but I can relate....
To conclude..

- Complex but treatable disorder
- Key is understanding the symptoms, the Veteran and their needs
- Accepting the condition affects many different spheres of life and could be chronic although manageable
- Allowing for the Veteran to collaborate and feel control
- Avoidance does not work long-term.
- Help is out there in different modalities
Thank you for your time today and for your help with our Veterans.
Questions?

- Dr. Camellia A. Westwell, Staff Psychologist
- Camellia.Westwell@va.gov
- (321)637-3788