It Takes a Community

by
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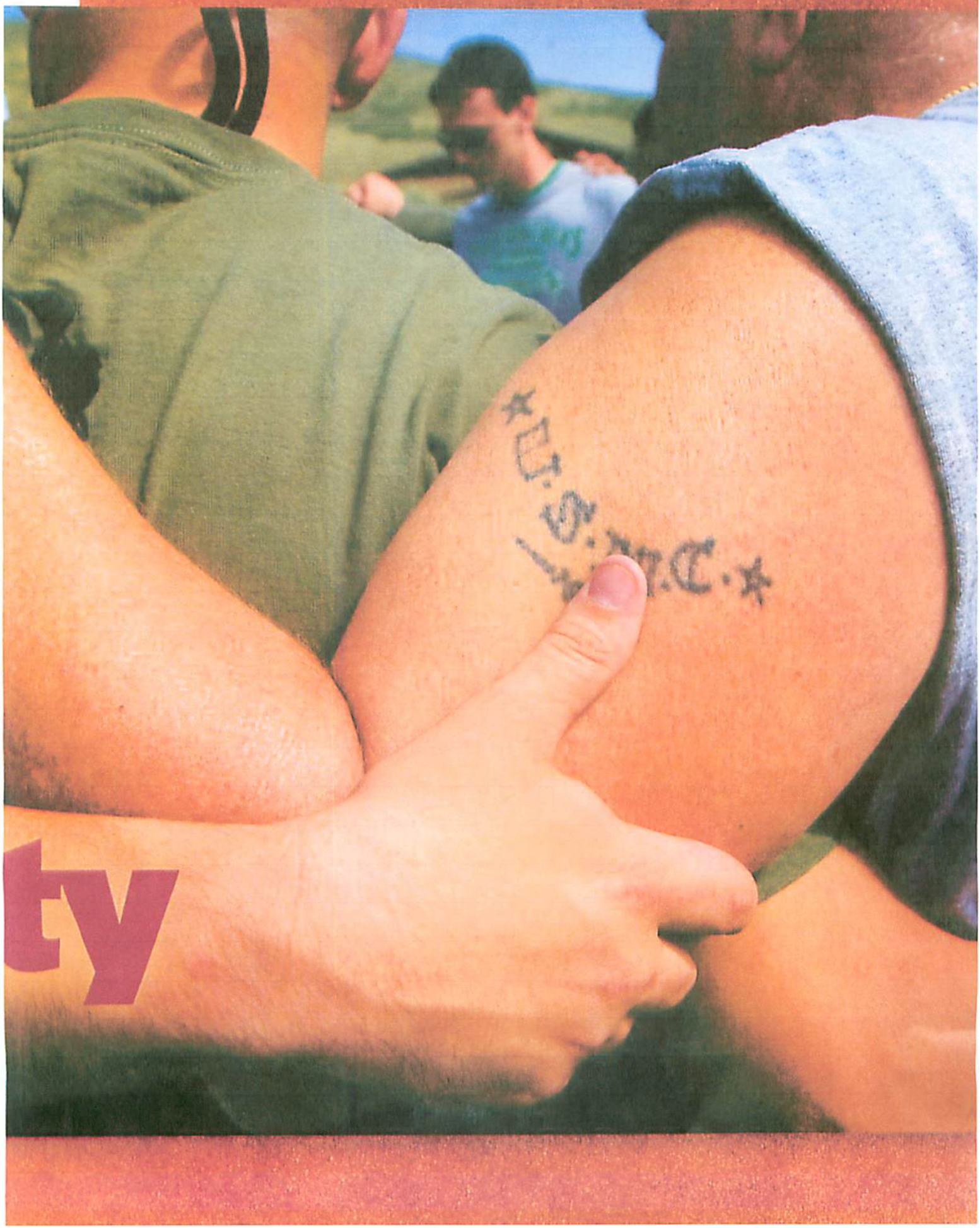
THERAPY-AS-USUAL CAN'T SERVE THE NEEDS OF OUR RETURNING TROOPS

The debate about our involvement in Iraq and Afghanistan has raged for a decade, but no one disputes one fact: as a result of those conflicts, thousands and thousands of young men and women have been profoundly wounded—physically, emotionally, and spiritually. The statistics measuring the effects of wartime service on our troops reveal high rates of drug and alcohol abuse, homelessness, homicide, suicide, divorce, depression, traumatic brain injury, and post-traumatic stress disorder. Yet, unless we're closely related to someone in the military, many of us still feel insulated from the impact of these wars, detached from the sacrifices of those fighting them, and removed from the problems they experience once they return to civilian life. ■ Our detachment and



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complacency about the consequences of these wars are profoundly miscalculated. Although combat missions have ended in Iraq and the countdown to the withdrawal of troops from Afghanistan has begun, the long-term impact of these engagements will be far more pervasive and widespread than many of us realize. In addition, it's becoming increasingly clear that our mental healthcare establishment, both civilian and military, isn't capable of handling this public healthcare crisis. Those in the trenches of service delivery already know that our standard psychotherapeutic paradigm—one mental health professional with one client, applying one or several standard interventions—fails to meet the needs of this population, both because of the number of potential clients and the complexities of war trauma. As professional psychotherapists, we need to rethink our ideas about how to reach out to the troops and their families struggling to return to ordinary life. It's time to move outside the limited conceptual box that now defines how we provide care to our homeward-bound warriors.

The Scale of the Problem

About 2.1 million troops have served in Operation Enduring Freedom in Afghanistan or Operation Iraqi Freedom. Assuming that each returning veteran has five or more close family members (spouse or significant other, mother, father, two siblings), these wars directly affect at least 10 million people. If we include children, other relatives, coworkers, and friends, the number of Americans affected could be 40 million or more.

Beyond the growing numbers of people whose lives have been touched by the war, our troops disproportionately experience a range of mental health problems, some related to traumatic brain injury—which, along with PTSD and depression, is one of the signature injuries of these wars. A report developed by the RAND Corporation in 2008 estimated that 300,000 veterans suffer from significant PTSD, anxiety, or major depressive symptoms; an additional 320,000 may have experienced a traumatic brain injury. The number of soldiers forced to leave the Army solely because of a mental disorder increased by 64 percent between 2005 and 2009. The actual numbers of veterans suffering from these problems is probably much higher than these figures indicate, because of the latent onset of PSTD in some individuals and the widespread misdiagnosis, or lack of diagnosis, of traumatic brain injury.

Meanwhile, divorce rates among returning troops are at record levels, particularly for women. According to the Army's Mental Health Advisory Team's 2007 survey, as many as 30 percent of soldiers and marines consider divorce by the midpoint of their deployment. Given the stressors that deployment imposes on entire family systems, it isn't surprising that cases of intimate partner violence and child maltreatment are up 30 percent in military couples and families. In one study of 250,626 wives of active-duty U.S. Army soldiers receiving medical care between 2003 and 2006, those whose husbands were deployed for up to 11 months exhibited more than a six-percent increase in diagnoses of depression, anxiety, sleep disorders, acute stress reaction, and other problems over those whose husbands stayed home.

Unfortunately, the mental health system responsible for serving these men and women is already stretched to the breaking point, even as many thousands are returning to civilian life or are between multiple deployments. In a survey of its members by the National Council for Community Behavioral Healthcare, a nonprofit association of 1,600 behavioral healthcare organizations, nearly two-thirds of the respondents said that veterans and their families, even when in crisis, report long delays and excessive wait times before they get to see a mental health provider. In addition, it often takes veterans living in rural America as long as five hours to travel to a Veterans Affairs (VA) office or a military base for an appointment. Some don't have access to a vehicle or public transportation, or may be unable to drive or take public transportation because of combat-related physical and mental limitations. Civilian agencies already take up some of the slack: about 22 percent of veter-

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ans seek mental healthcare outside the VA system.

Most clinical interventions, including cognitive-behavioral therapy, exposure therapy, EMDR, and exposure therapy using virtual reality, are delivered in standard clinical formats: one-on-one or group therapy sessions provided by professional psychotherapists. These interventions are expensive, time-consuming, and often unavailable outside urban areas, and there aren't enough trained therapists to deliver them to the many thousands of troops and veterans suffering from PTSD and the array of other war-related symptoms.

In addition, there's a growing chasm between the number of military personnel who need mental health services and who actually try to get them. Many of those who are experiencing the unseen wounds of war frequently avoid seeking help, fearing that they'll be stigmatized as "weak" or "crazy" by their peers and superiors—that they'll be, in effect, abandoning the fight and "letting down" their battle buddies because they can't take the pressures of war. One sergeant (who did finally get help for his PTSD from a private nonprofit counseling agency), interviewed anonymously in a recent issue of *Stars and Stripes*, said, "People are going to call you psycho. Even if people just see you going into the mental health offices, they're going to think you're crazy." Many active-duty troops fear that if they admit they've got "problems," they'll lose the chance at promotion—or may even be discharged and separated from their combat-experienced peers.

Added to that, many will shun help because they don't want to stir up intense and, at times, overwhelming memories of their war experiences. Many bolt from intake interviews because standard clinical procedures raise too many emotions. Even if they do muster the courage, dogged persistence, and time it takes to get the help they need from overloaded facilities, the usual therapy models may not be appropriate for the complex physical, spiritual, and emotional wounds resulting from the unique circumstances of these seemingly interminable wars. The way our therapy establishment—military and civilian—is organized isn't necessarily effective with the kinds of chronic trauma resulting from protracted and repeated deployments to war zones. Nor do therapeutic models—with their focus on treating the individual—mesh well with the realities of military culture and its communal values.

An Alternate Approach

During the past several years, we've traveled throughout the world to help populations experiencing mass traumatization following natural disasters and violent social unrest. We've provided disaster relief in China following the Sichuan Earthquake of May 2008, worked in Rwanda with genocide survivors, and in Kenya with displaced persons after the postelection violence of 2007. Currently, we're working in Haiti with survivors of the January 2010 earthquake.

Our goal the first time we responded to a disaster—after the tsunami in Thailand—was to offer support and assistance to individual trauma sufferers, but we've seen repeatedly that teaching simple, self-regulating, stabilization skills can help people learn to rebalance their own nervous systems and create communities whose members learn to help each other. As individual self-stabilization skills become community-wellness practices—often delivered by peers, chaplains, community activists, and teachers, rather than by mental health professionals—this process of community healing can create a social ecosystem that fosters wellness and repairs shattered lives.

Our method, the Trauma Resiliency Model for Communities (TRM-C), is a biologically based approach, which primarily focuses on expanding sensory self-awareness, although emotion and meaning are incorporated as they emerge naturally from the sensory-oriented work. The focus is to help traumatized people reset the natural balance of their nervous system. Unlike talk therapy, which requires the trauma story to be told in *words*, TRM pays more attention to the story told by the *body*. It focuses on the client's posture and gestures, facial coloration, muscle-tension patterns, breathing, and heart rate—indicators of how the traumatic event is stored in the nervous system. TRM emphasizes educating clients about their nervous system, and then teaching them alternately to track sensations connected to the traumatic event and sensations connected to calmness or, at least, less distress.

When attention is turned inward in this way, awareness is expanded beyond that which is painful and frightening, often resulting in a renewed inner sense of balance, well-being, and self-management, even when one has faced unimaginable losses. Naturally, expressions of grief, sadness, or terror emerge as a traumatic event is remembered; however, shifting a person's attention to sense-resource states within the body can have the dramatic effect of making the body an ally in healing, rather than an enemy.

TRM begins by front-loading the nervous system with memories of survival and resilience. When our trainees begin their work with peers, whether in an internally displaced persons camp or a peer-to-peer program, they start by asking questions like, "What or who helped you get through this?" or "Do you remember the moment you knew you were going to survive, or that it was over?" or "Who else lived?" This method doesn't require repeated exposure to traumatic details or bad memories, nor does the client even have to tell the "trauma story," if he or she would rather not—though we always take into account the meaning, emotion, and importance of bearing witness to their suffering.

As the TRM practitioner helps the client understand his or her nervous system and learn to track sensations connected to the traumatic event and sensations connected to resiliency, the nervous system begins to return to its normal balance or rhythm. Humans are neurologically programmed for this balance. Cognitions, emotions, behaviors, and physical symptoms often begin to change and even remit as the individual's natural resiliency is restored.

TRM draws from several sources, including Jane Ayres's Sensory Integration Theory (SIT), Eugene Gendlin's concept of the "felt sense," and Peter Levine's Somatic Experiencing model. Sensory integration is our unconscious ability to take in and organize the deluge of sensory experience to which we're continually exposed (taste, sight, hearing, touch, smell, movement, gravity, and position), without being overwhelmed and paralyzed. A traumatic experience can profoundly affect our

ability to absorb, modulate, and use sensory information, resulting in overload, which prevents us from responding to the world in a coherent, purposeful way. Although SIT has been widely used by occupational therapists to treat children with autism spectrum disorders, it isn't commonly used in psychotherapy.

Gendlin's concept of the "felt sense" refers to a mode of engaged, accepting attention, a way of getting in touch with an inner-body sense or preverbal "knowing" of something important. By focusing on this sense, individuals can feel important physical and emotional shifts in how they experience their lives, leading to fresh insights, new attitudes, and a different "take." Because our ancestors lived as both hunters and prey, our nervous systems are highly attuned to danger. In essence, we're wired for survival-oriented vigilance—a tendency that traumatic events exacerbate.

Peter Levine's Somatic Experiencing is a body-awareness approach based on the idea that traumatic symptoms result when the survival responses of the autonomic nervous system (fight, flight, or freeze) are aroused during a trauma, but never fully discharged after the traumatic situation has ended. The model helps people become aware of, and gradually release, the traumatic energy "locked" in their bodies.

Our model trains people to attend to body sensations that are less distressing, neutral, or even positive, which allows us to work with traumatic activation in a gentle, graduated way. This process of shifting between organization and disorganization in the nervous system expands awareness, decreases anxiety and depression, and helps individuals achieve a degree of calm and inner stability.

A Public Health Focus

Our international work in impoverished areas that have suffered catastrophic trauma has shaped our shift from a clinical to a public health perspective. In these areas, there generally is a communal orientation, rather than an emphasis on the individual. People often reject clinical services because their culture doesn't focus on emotional expression or insight. They may even have negative perceptions about what it means to seek mental health treatment—an attitude that also characterizes many of our troops.

We consider the military to be its own kind of communal culture, which, like others we've encountered, distrusts outsiders and prefers being served by people like themselves. Those in the military don't want to feel like patients receiving standard *clinical* interventions. They're drawn to *skills-based* programs that teach them how to self-regulate and build strength, preferring to see themselves as simply learning techniques that enhance their own ability to rebalance and carry on their daily roles in the most "normal" way they can, without being marked as somehow different from others.

Our biologically based TRM skills are compatible with communal populations because they can be taught to large numbers of people at one time by nonclinicians who are just like them. This enables many people to receive stabilization skills that they can practice independently and teach to others in the family, platoon, school, or village.

As an alternative to reliance on a small contingent of professionals, peer-to-peer interventions offer the possibility of reaching far larger populations and fostering resilience throughout a community. We've seen proof of it in Haiti, where the nearly 100 community "animators" we've trained in TRM-C have now taught hundreds of others. If individuals need clinical or medical care, they can be referred to a mental health professional or physician, in areas where one is available. We're learning, however, that sometimes TRM-C's biologically based stabilization skills can be enough to set someone on a path of hope and resiliency. While there haven't yet been any formal studies that have measured the effectiveness of the TRM-C approach, no other trauma treatment—CBT, EMDR, or any other—has demonstrated its effectiveness with the cohort of troops who've gone through the intense stresses and repeated deployments experienced by our military in Iraq and Afghanistan.

We currently have two research studies under way (one in the U.S., the other in Haiti) that systematically assess TRM-C's impact at the individual and community levels. Preliminary evidence suggests that TRM skills can be taught to large groups, learned by people with low literacy levels, and used in ways that reduce symptoms, even after only one or two sessions.

Military Culture and War Trauma

All work with our troops needs to be "culturally appropriate," taking into account the special context of the military culture and combat setting. Not only does the military have its own language, filled with formal and informal acronyms, but its own organizational structure, values, and expectations, along with rigorous training designed to override our natural biological programming to avoid danger and seek safety at all costs. The life-saving skills warriors learn impart focus, competence, self-confidence, and inner strength that can keep them and their comrades alive in a combat zone.

What makes it even harder for those with war-related trauma and other emotional disorders to get the help they need is that therapists often don't understand the unique, confounding, and anomalous situation of the war zone. As in no other potentially traumatizing situation, troops are predator and prey and witness, sometimes all three at once. We call this role complex the Predator-Prey-Witness triangle (PPW). For example, Joan, who was sent into Afghan villages to ferret out the Taliban, had the job of searching Muslim women suspected of carrying explosives. Armed and ready to engage with the Taliban, she was in the *predator* role, but she was simultaneously frightened *prey*, because if one of the explosives she was looking for actually detonated, she'd die instantly or be horribly wounded. She might also be shot from behind by a sniper. While she herself never discovered explosives, she did, tragically, become a direct *witness* to a traumatizing event—seeing one of her closest buddies blown up.

Under other trauma circumstances, no matter how stressful, the roles and troubling emotional responses called forth by each segment of the PPW triangle are far more distinguishable, because different people are involved or the same person at different life stages. A woman is "prey" when raped, while her rapist is the "predator," though someone abused as a child ("prey") may grow up and perpetuate abuse ("predator"). A witness to such

abuse—for instance, a spouse—may or may not intervene, or may also be prey. In combat zones, however, these three roles often are experienced simultaneously, with the corresponding physiological arousal: as prey, the biological impulse may be to flee; as predator, to fight—often with great ferocity and rage (if a buddy has been killed, for example)—and as witness, to freeze while terrible events unfold before one's eyes. Since the battlefields in Iraq and Afghanistan have neither boundaries nor any predictable let-up to the violence, a soldier can be experiencing these states serially or simultaneously much of the time. Add multiple deployments with little chance to decompress in between them, and we can begin to appreciate the difficulties so many of our troops experience when they attempt to reintegrate back home.

The intense and inherent ambiguities of war are complicated further by the current demands of counterinsurgency tactics, which require warriors to be somehow both friend *and* foe—at one moment, they're conducting full-combat operations, and in the next, handing out candy and soccer balls. They may be engaged in a variety of noncombat missions with the local people, all the while not knowing who the enemy is. The warrior thus becomes the reluctant diplomat to people, including women and children, who, if she lets her guard down, may try to kill her.

Today's wars are increasingly fought and supported by women warriors, even though there's a lag between current legislation prohibiting women from being in combat roles and the actual roles women are playing. Although women may perform the same duties as men, including fighting, their unrecognized status may detrimentally impact credit for the risks they take and disqualify them from receiving awards and services as veterans.

The incidence of gender-based violence, commonly referred to as Military Sexual Trauma (MST), is another disturbing factor in today's wars. According to our interviews with female veterans, there's secrecy and shame about being a victim of MST, along with fear that reporting it will damage opportunities

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Speaking the Language of the Nervous *System*

THE 5 TRM SELF-STABILIZATION SKILLS

The Trauma Resiliency Model (TRM) is based on teaching people a basic set of self-stabilization skills that help reregulate the nervous system in the wake of upsetting and traumatic experiences. Below are the five biologically based TRM skills that we teach within this model.

Skill 1: *Tracking* is achieved through observation, self-report by the client, and attunement between the practitioner and client. As the nervous system is tracked, the client learns to discriminate between dysregulated states within the body (constricted muscles, rapid breathing, heart rate), and sensations of comfort (expanded breathing, slower heart rate, muscle relaxation). Tracking is used with all skills.

Skill 2: *Grounding* refers to our sense of the present time and space, and is the secure foundation upon which we build our interpersonal relationships. It's introduced by inviting the client to bring awareness to how the body is physically supported at the moment. The sensory attention to the present stimulates in the nervous system a parasympathetic response that the practitioner can observe and the client can sense.

Skill 3: *Resourcing* is a technique for focusing awareness on positive experiences—highly valued relationships, fond memories, imagined events—that trigger a sense of well-being. For example, a person might be asked to think about a beloved family member, and then be instructed to attach the somatic sensations that arise to the inner image. Those positive sensations can then become resources for counterbalancing negative sensations and reregulating the nervous system.

Skill 4: *Resource Intensification* refers to the process of helping people enhance the multisensory sensations that arise from paying attention to personal resources. This helps override the stress and anxiety—tied to the amygdala's strong survival focus—that are typically present in traumatized people.

Skill 5: *Shift and Stay* is a self-help skill. The client learns to shift attention from distressing sensations that may arise or be triggered during the day to more comforting sensations associated with Grounding and Resourcing, and then stay attuned to the comforting sensations until regulation occurs. ■

—Laurie Leitch and Elaine Miller-Karas

for advancement or add to the risk of combat. Because of warriors' dependency on others in their units, especially those superior in rank, MST can be experienced similarly to childhood sexual abuse by a trusted family member, engendering commensurate feelings of shame and distrust of others.

A New Vision

So a kind of "perfect storm" is brewing: we have a large and growing population of war-weary troops and veterans; a mental healthcare system lacking the person-power to treat them; and conventional professional therapeutic approaches that fail to recognize the uniqueness of military culture and trauma. Current clinical interventions like CBT, EMDR, and Exposure Therapy may be helpful to many of those who seek assistance, but even if enough therapists and mental health facilities were providing these treatments, many individuals would miss out on help because of stigma, cost, fear, distance, or the unpleasantness and intensity of the therapy. Understandably, many active military and veterans resent being labeled with a psychiatric diagnosis, regardless of how their symptoms are categorized in the DSM. They don't want to be, nor should they be, pathologized for having done what they deeply believed was their duty and later suffered disproportionately for it.

A critical shift is needed in how we think about the challenge of helping so many struggling young men and women. Traditional methods that rely primarily on professional practitioners operating within the mental health establishment can't respond to a problem of this scale. We need to provide healing alternatives that build on the resiliency of the human mind-body system, rather than assumed pathology. We need to do this—at least as a first line of approach—within a nonclinical community setting that won't alienate these clients or make them feel worse, while taking advantage of local organizations, peer-group support, and family participation. But how do you create this public health-oriented treatment mode, which includes trained nonclinicians?

We like to think of the answer to these questions in terms of what's called "appropriate technology" (AT), referring to inventions and methods that use the simplest levels of technology that can effectively achieve an intended purpose in a particular location. Supposedly originating with Mahatma Gandhi, who advocated for small, local technologies (the sewing machine, the bicycle, the spinning wheel), AT models are affordable, practical, culturally and socially appropriate, and based on local skills and materials: they're inventive grassroots solutions to grassroots problems. As author John F. C. Turner puts it, "Truly appropriate technology is technology that ordinary people can use for their own benefit and the benefit of their community, that doesn't make them dependent on systems over which they have no control."

TRM-C falls into the category of AT. We've developed a comprehensive approach to war trauma from a public health perspective. If we apply simple, skills-based treatments that foster independence and self-reliance and that can be implemented by peer counselors and paraprofessionals as well as psychotherapists, we're creating new models of healing, which could have a wider impact than our traditional, Western approaches to treatment, and could be taught within communities and to larger groups, thereby expanding the potential for treating the reactions to traumatic stress.

We're advocating a form of AT as an approach to war trauma from a public health perspective: teaching, for example, peer counselors, mentors, and paraprofessionals—even in large groups—a method of treatment that fosters resiliency skills, independence, and self-reliance in war-traumatized veterans, active military, and their families. The Trauma Resiliency Model-Community (TRM-C) provides a perspective that depathologizes symptoms and creates a new paradigm of service delivery by training nonclinicians to work with their own community members.

Providing educational materials to support a community-oriented approach is another way we promote independence and educate others about the biology of threat and fear. Supporting tools are ever popular, including silicon bracelets featuring the "resiliency equation" and ballpoint pens with a pull-out scroll listing the skills. By the end of 2010, the iPhone app iChill will be available to guide people through the biologically-based skills whenever they need help. We currently have two research studies funded and about to begin: one is in the PTSD and Chronic Pain unit of the VA office in Los Angeles, and, in addition to standardized self-reporting measures, it will use three physiological measures to assess the stabilization of participants' nervous

systems. The other study will test the feasibility of using our iChill app with Army chaplains before and during deployment to Iraq and Afghanistan.

We've walked into the worst disasters and have witnessed firsthand the power of community resiliency models to change the nervous system in ways that allow rural villagers in China, farmers in Haiti, veterans from California, and community workers in Africa to begin to attend to the healing potential of their bodies and their minds, and then pass the skills along to others. It's remarkable that, regardless of the culture, the human nervous system is neurologically programmed with the same inherent capacity to respond to threat and fear, or to seek balance.

When gently guided through the basic and simple skills of TRM, people often come back to themselves. This has a ripple effect, because as one person heals and teaches the skills to another, the next person heals, and the next. Soon you have a community that's tapped into the deep reservoir of resilience that—just as much as our capacity to experience vulnerability, pain, loss, and trauma—is a defining characteristic of being human.

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