

**PTSD 101**

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**COURSE TRANSCRIPT FOR:**

**PTSD & the “Difficult Client”: Using a Developmental Model to Inform Treatment**

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**Slide 1: PTSD and the “Difficult Client”: Using a Developmental Model to Inform Treatment**

Hello. My name is Fred Gusman and I am the Director of the National Center for PTSD at the VA Palo Alto Healthcare System at Menlo Park, California. Today I want to discuss with you something that we all seem to struggle with from time to time, and particularly with Vietnam veterans... and that is, how do we deal with the veteran who comes to us or the Active Duty, Reserve, Guard person who is experiencing combat related stress or PTSD.... but at the same time is presenting clinical obstacles in terms of engaging them in treatment? Today, we're going to take a look at a model that actually can be sort of a foundation or staging area that allows for other types of evidence based treatment models or best practice models to be implemented.

**Slide 2: Overview**

So here are the things that we're going to take a look at over the next hour. One, we're going to get a handle on who is the new warrior. What is the difference between these Iraq, Afghanistan returnees and the Vietnam veterans who the VA is so much more familiar with dealing with? And, what are some of the “lessons learned”? What are the red flags from the other eras in terms of treatment? We'll look at general treatment principles. Clearly, we're going to focus on difficult patients. But also keeping in mind that the developmental model can be utilized for any veteran regardless of gender, culture, and so on as, as a sort of foundation if you will, to help us understand how trauma can impact across one's lifespan. And then, we'll look at application of the developmental model.

**Slide 3: Perspectives: New Warriors**

Here you're seeing a photo that sort of illustrates what the new warrior looks like-- at least this is a Marine group. They're all having a break and they have nice smiles on their faces and it's a quiet time in Iraq at that particular moment. But, let's take a look at what are some of the issues and how do these new warriors present themselves to us today.

**Slide 4: “New Warriors” – OIF/OEF Personnel**

So the new warrior can be generally as Active Duty, Reserve, or Guard and in some cases we'll be seeing those who have been recently discharged. They've likely joined for a variety of reasons, likely didn't expect to be deployed, particularly when we talk about the National Guard,

because most folks that joined the National Guard see themselves as sort of citizen soldiers that will be utilized for local disasters, if any.

Most of the folks that were deployed and as we know almost half of those deployed to Iraq, are actually Guard folks. They have jobs, careers, families, and their age range varies from eighteen to sixty. So many of them already have established jobs and careers and financial responsibilities. And of course, there are the young ones too, who have just joined in the last year or couple of years. And what we see now, is that many of these younger soldiers, Marines, airmen, sailors, are married, and we didn't see that with Vietnam veterans. As we all know, in Vietnam the average age was between nineteen and twenty-two serving in Vietnam. Most folks served one tour which was either twelve months or thirteen. So there are quite a few differences.

One of the major differences that we're going to talk about a little later, in terms of how can we utilize this one particular difference, to benefit the clinical interventions and that is the "comfort zone" that these new warriors feel with technology. They're very technologically savvy. They're very comfortable with accessing the Internet and using MP3 and iPods and so on. So they're more likely to want to be somewhat independent when it comes to searching for answers in terms of whether it has to do with medications or the treatment we might be trying to provide for them or so on. But at the same time, like I said, later we'll talk about how that can be a positive tool. We also find that in this particular period of time with this war, we have more women in a wider range of roles and responsibilities-- everything from the enlisted person to the officer in charge. And of course, sad to say but very true, most of our warriors have had multiple deployments. And for some right now, particularly the Marine Corps, we are seeing anywhere from three to four deployments.

#### **Slide 5: Current-OIF/OEF Personnel Mental Health Needs**

So what are some of the current OEF, OIF personnel mental health needs? Some of you are familiar with Colonel Hoge, United States Army, who has done some research looking at deployments and pre and post deployment. And in his data, he indicated that prior to deploying, approximately five percent of those that they were looking at, a few thousand, already had predisposed, met predisposed, criteria for PTSD. Upon post deployment approximately 12 percent who were exposed to combat sort of predicted the risk of some sort of mental disorder, everything from depression to combat related stress, some with PTSD, some with other comorbid issues such as depression and substance abuse.

We should note that in the general population, the general civilian population we only find 3-4 percent rate of PTSD. As you can see, in 2006, Colonel Hoge was able to replicate this study with an even higher number of personnel. And you can see that there isn't much change--19.1 percent of those returnees from Iraq and 11.3 from Afghanistan and 8.5 from other locations such as Bosnia and Kosovo were all experiencing some kind of mental health issue. And 35 percent of those folks that he identified, that I just mentioned, accessed mental health services within a year after return home.

One of the concerns that I have is that other 70 percent that did not access. So it's, it's great to see that at least some are accessing mental health but I think one of the things that's important

here that might get lost in Colonel Hoge's data is because some people might say wow that's 35 percent are going, that's great, please keep in mind that we're talking about a major portion of people that are not getting services now for whatever reason.

### **Slide 6: The VN Cohort-Common Chronic Problems**

The Vietnam [veteran group] has experienced chronic problems that the VA has dealt with for years, for example on the psychiatric side is PTSD, depression, and substance abuse. On the medical side, it's been hepatitis, HIV, diabetes, obesity, chronic pain, high blood pressure. And of course, this is not a comprehensive or all inclusive list. But our goal should be to aim to reduce or prevent in the OIF, OEF cohort some of these comorbidities. Although we already started to see, and DOD is already reporting at some military installations, a [great deal of] comorbid combat related stress, depression, and substance abuse. So we're well on our way to almost seeing some similarities between two populations that are almost thirty years apart. But we have an opportunity to take some preventive measures here.

### **Slide 7: Lessons Learned**

So what are some of the current OEF, OIF personnel mental health needs? There are many and one of the things we want to do is first pay attention to lessons learned. These lessons come from our extensive experience throughout the VA nationwide and working with veterans from World War II, Vietnam, and other cohort warriors. Each warrior's combat stress experience and their perception of it is unique. So one of the things that we want to do is honor that—respect it. We also want to minimize the dependency on the system. As we all know, if we are to go to a number of clinics throughout the VA system, we can find Vietnam veterans who have been in support groups or so called “PTSD groups” in some instances for five to ten years. We have to question, what we are doing in that regard. For sure there's a dependency that's created, not to say that these veterans don't need some kind of support, but we really have to start to take a look at what role we're playing in maybe supporting dependency on our system-- as opposed to assisting them in becoming more independent of traditional mental health support systems.

The other thing is that we should expect, support, and develop resiliency. This new population of warriors clearly understands the concept of resiliency and we'll talk about that a little later. And then keep it in mind, another lesson learned regardless of best practice or evidence based treatment, we know that “one size does not fit all”.

### **Slide 8: Combat Stress/Trauma-General Treatment Principles**

So what are some of the general treatment principles for combat stress or trauma? Well first, we can say that there's a universalized common combat stress reaction and we want to make sure that we normalize those responses as we engage these new warriors. Those would include the physiological, psychological, and behavioral. We also want to de-stigmatize post-combat trauma reactions and aim for more of a proactive preventive intervention process. We want to focus on adaptive strengths and avoid pathologies and the diagnostic labeling.

An example, with Adjustment Disorder versus PTSD we want to take advantage of something that there has been much talk about more recently in the field of PTSD. And that is resiliency. Some of you might know, particularly those of you who have served in the military probably know better than most, that the military tends to focus and develop a sort of combat resiliency. And what we've learned over a number of years is that can be translated into very positive everyday coping.

### **Slide 9: Possible Challenges for Mental Health Providers**

So what are some of the challenges for us as mental health providers and, and healthcare providers in general? Well these new warriors-- they're more likely to question intervention and authority, not like the Vietnam veterans that came back challenging and being very angry and, if you will, with some distortion that the VA was an extension of the military and part of the military combine and so on. So those of us who were trying to provide some sort of services were sometimes labeled as the group that did it to them or abandoned them. I don't believe that is true with the new warriors.

With the new warriors though they are likely to question the types of interventions and question our authority, but we should understand that that's coming from a different perspective. It's not like the Vietnam veterans point of view. Also it's a very diverse group demographically. We have actually folks from all over the country and not only that, they're diverse in terms of racial and cultural backgrounds. For me, it's sort of interesting... in my work with the Marine Corps the first time I'm working with the unit there and seeing Vietnamese Americans who are part of our military, and here, many of us who have worked in the VA, it's something that you know you never thought would occur, that you would see it. So we have a fairly diverse racial, cultural backgrounds in the military and we need to be prepared for that and, and incorporate some knowledge about and sensitivity about cross-cultural issues.

So how do we assist the combatants? What do we have to assist them? Well one is to transcend their combat-related stress into everyday living, coping. To help make meaning of those experiences. To help them to grow from their experiences. And as well, last but not least, and very important-- to move on, in preparation for possible redeployment because many of these folks that we are now seeing actually are not being discharged from the military. Of course our hopes are that in the immediate and near future they will all be discharged and they will all be veterans and, that all of these courses that you're having access to on PTSD 101 will still be of great value.

### **Slide 10: Trauma is experienced by and affects each individual differently**

(no audio)

### **Slide 11: PTSD Can Manifest in Numerous Ways**

PTSD, or combat-related stress, is what we're seeing more of right now. It can manifest in numerous ways, anger, rage, agitation, physical aggression, verbal aggression, and indirect self-harm.

## **Slide 12: Common “Difficult” Patient Presentations - 1**

So the difficult patient presentation looks like this. They generally have a lack of compliance. They're very challenging. They're more likely not to want to follow up with appointments. Seem to disagree with the treatment plans. They have an inability to make a treatment decision. Of course, we want to have the warriors that we're working with participate and be part of the treatment planning, and of course they have to help carry those treatment plans out. They tend to project intense anger over routine issues. Everything from just having to wait in the waiting room, to being frustrated with being in line at a checkout stand in a grocery store, or being stuck on the freeway. They're easily startled, resulting in irritability and anger. And I'm sure some of you who are seeing these new warriors already experienced that as you heard them talk about how they become irritable and then feel like there's just no way to control their anger. Their concern is that they start to become or have thoughts of being aggressive, and making threats or just thinking about making those threats either verbally or just or some gesture form. And of course, as we get to know them better we see that for some, for the difficult patient, we see some manipulative behaviors already beginning to take hold.

## **Slide 13: Common “Difficult” Patient Presentations – 2**

There's another interesting phenomena related to this new warrior group and we can draw a similarity between the “Vietnam veteran”. As we know, Vietnam veterans-- not all but many of them, had some real issues and concerns and felt betrayal about the Vietnamese being here in our country. And, at the same time thirty years, later we're hearing some of the same feelings from the Iraq, and Afghani returnees. As we know, our country is made up of many nationalities, cultures, and so on and it's impossible not to run into somebody that you would see in some other part of the world. And of course, this presents a dilemma for some of these warriors who have not worked through their issues and are suffering from some sort of combat related stress or PTSD. That they can tend to project their anger or their fear on these people that look similar to the people that they felt were a threat to them in the war zone. There can be some extreme behaviors, everything from being depressed and manic and demanding to passive aggressive behavior. Clearly, we've seen some entitlement issues already and inappropriate comments whether it be sexual or threatening and so on.

## **Slide 14: “Difficult” Patient: Contributing Factors**

Some of the comorbid problems with the difficult client -- because this is not Vietnam and they're coming fresh from the war zone-- we can see Acute Stress Disorder, or a sub-clinical PTSD, use of substances or abuse to self-medicate, and family discord. And we're hearing a lot about that within the military. As you might have heard there is a high divorce rate right now within the military. You see a lot of depression, panic, chronic pain. Part of this has to do with the fact that we are saving a lot of lives and there is better protective equipment, but of course that could be debatable. But for the most part, we're seeing less deaths, but we are seeing more injuries that people are surviving from. This presents the opportunity for pain and pain always becomes the management issue for people who are also suffering from PTSD or combat related stress. And of course, there are the personality disorders. That we can basically chalk up to the fact that there are people who have been predisposed, as Colonel Hoge's data indicates, of

having some kind of problem prior to even joining the military. And then, we have the more extreme schizophrenia and other psychosis. One of the things that saddens me is that we're already starting to see that some of these Iraq and Afghani returnees are becoming homeless.

### **Slide 15: "Difficult" Patient: Impact on Care Providers**

So how does dealing with the difficult clients, this difficult warrior, how can that impact on those of us who are providing care? Well, there are many ways and let's talk about two particular processes. One is the negative and the other is positive. On the negative side they can be very threatening and for some of us who might have been exposed to, or heard of, some major disasters that have occurred when somebody gets really angry and blows up-- there can be an element of fear and that's sort of normal and natural. Another is frustration and the frustration comes from just running it, feeling like you're running into a wall with this client that you seem to be going nowhere, and there's sort of this "blame us" sort of projected attitude that gets old after awhile. And then of course, we're human. As providers we can get angry and we can even have resentments and apathy can build.

On the positive side, we can have a better perspective, empathy, patience, understanding, caring, professionalism, implement limit setting, and always put up a united front. That united front, what we're really talking about there is working with your colleagues and not being caught in a split between the client and the rest of your clinic or a setting that you're providing services in. But all in all, there is no question that working with a difficult returnee is a major challenge for us and we have to pay attention to what we bring to the setting. In other words you know, we have a life too. We have things that are going on in our lives, some positive, some negative. Anything from being happy about just buying a new home and then on the other hand maybe somewhat distressed because in our family there are changes that we don't have total control of. And yet at the same time, we're supposed to be providing a service for those folks who've been exposed to trauma and are suffering. We all want to be sort of acknowledged and respected and sometimes that is not as accessible when you're dealing with a difficult returnee.

### **Slide 16: What might be underlying the client's presentation?**

So what might be some of the underlying issues be? We need to talk about that a little bit so that we don't get stuck reacting to their behaviors. So for example-- extreme difficulty controlling or managing emotions. I'm reminded of the young warrior who came in to the office setting and had been waiting for a long time and was upset about having to wait so long in the waiting room and being in a mixed population where there were also schizophrenics and he felt like, for the most part he felt that he had been disrespected. And so, when he came into the office, the garbage can was close to the door and when he was asked how was he today, how was he doing-- he kicked the garbage can. And that garbage can made a very loud sound and actually startled the therapist. Actually, I was across the room and you could hear that sound vibrate down the corridor. So they can have some clearly difficulty in controlling their emotions and tend to do a lot of projection. It's a struggle for them to express their anger and range in an appropriate way. So there's a lot of distortions of issues and situations. And many of these things are triggered by authority issues, physical illness, chronic illness, pain, exposure to person's of Middle Eastern ethnicity (not true for everybody but for some), exposure to death and associated settings.

Medical and dental procedures [can uncover psychological difficulties]. This is interesting because when we looked at data in the VA nationwide we tried to see where are many of these Iraq and Afghani returnees are going in some of our clinics. We're finding a lot of them are obviously in primary care but a lot of them are going to dental procedures and more recently in our VA Integrated Service Network, in VISN 21, we've had the opportunity to work with Dental Services and help them come up with strategies on how they can deal with some of the concerns that these warriors present to the dentist. They fear giving up control and having to lay back on that chair, and to let somebody work on you is not an easy thing for somebody who feels that they have to be on alert at all times. Some of the other fears are that its like being controlled or trapped. And, and then there's government red tape and trust issues. I think that particular issue, the trust issues related to the government, we haven't seen as much but it's starting to raise itself- I think particularly with men and women who are discharged and have been out for about a year. We see, as they talk about their experiences and they relate that to authority figures and so on, that their general attitude about their service time is starting to shift from somewhat of a positive experience, to maybe possibly negative, at least in their minds.

### **Slide 17: Action Steps to Avoid or Minimize Problems**

So what steps can we take to avoid or minimize these problems? Well, we could take a stance of prevention rather than repair. What that means is that rather than trying to rationalize with them and end up in-- and I know we don't try to do this but sometimes it comes off this way-- but we end up sort of being defensive, defending the organization, defending the VA, defending the military or whatever. We really need to try to form an alliance early on by listening to their story, by not being judgmental, by trying to hear about what their concerns are and asking what their concerns are in regards to how they feel the war has affected them and what are some of their fears. I think when we take that sort of stance, rather than getting caught up in trying to rationalize and defend and so on, we do much better because remember, the part of the therapeutic intervention and forward movement relies tremendously on the relationship between the client--that returnee, and the therapist.

The other [idea] is that as we listen to them talk about some of their exposures in the combat zone we'll be able to work with them to identify triggers. We want to help them to begin to minimize those triggers, and we can talk about how we do that a little bit later.

We want to make sure that we don't personalize their inappropriateness in behaviors and verbalization. I've seen that happen at times where the returnee, the client or veteran sometimes can be so frustrated from whatever has been going on in their life that week, that they come into the session and they just sort of, if you will, "throw up" in the session and end up venting on the therapist. Sometimes they can feel like it's a personal attack. We need to make sure that we understand that it isn't.

Now there are the exceptions. And I'm not saying that sometimes there isn't somebody actually doing a personal attack but for the most part it's really their inappropriate, rather their inability, to express themselves in a way that feels safe to them. So anger is very much a survival tool. In many instances something they learned in the combat zone. So we need to be mindful of that

and make every effort to communicate with them and find opportunities and keep it in mind that as I said earlier, one size doesn't fit all. That's also true in terms of how we communicate with these returnees, both the men and the women. We need to consider where they're coming from you know how they engage people. You know there are some people that don't want to be asked when you first come, they first come into the office "how are you today?". They prefer maybe to say "how's your family?" or something different. And I think we have to use our clinical judgment and learn [about] the client and, and that way we begin to build sort of a mutual alliance if you will.

### **Slide 18: Disarm and Empathize**

Many of you are familiar with the concept of disarm and empathize. It's actually a very good tool to use in working with the difficult patient or any patient, clients, veteran or whatever we're going to call them. I know we all use different terms when we're interfacing with the folks that we're providing a service to. But the disarm and empathize as a "tool" can really help deal with a number of things. For example, it helps us pay attention to therapeutic boundaries. It sort of aims for advocacy versus adversarial. It acknowledges the client's feelings. There is sort of an active listening that gets employed and remains respectful of the client, but in turn gets the clients to also respect us. It helps establish clarification in terms of what seems to be the problem and is a good way to sort of approach that. We all might have different styles but the idea is getting clarification. That's what we really want to do. We don't want to assume anything.

It's really important that we understand that with Vietnam veterans we have a history. We have a lot of literature. We have a tremendous amount of research. We have a lexicon, if you will, that we can apply to Vietnam veterans. So we know the different parts of Vietnam, the different units, the equipment, different points, time of the war. But with Iraq and Afghanistan we don't have all of that. We have CNN. We have newspaper articles. We have some research, some information, like from Colonel Hoge and a few others. But we really don't know a lot about this war. So it's really important that we, as we did with Vietnam veterans in the early days, we learned them. We have to learn about that. We have to learn about their exposures. That does not mean that we take everything they say as truth, but rather that we try to hear it and then feed it back to them to get a better understanding of what their exposure was, and what the issues really are, and how those issues are translating into some sort of maladaptive coping today.

So in essence, we're focusing on the veteran's feelings and being real[ly] good listeners. We want to try to lose neutral descriptions of emotions. So for example, "I can see this is bothering you". That's a question and it gives them the opportunity say, "No it's not". But we need to find ways-- and I just gave a few bullets there that you're looking at--on this particular Power Point just to sort of stimulate you in thinking about maybe different ways to ask the same question. And keeping in mind, as I said, it's almost like a broken record but I've got to say it again, that they're all different.

And then always ask. You know it's something we don't always do as therapists, we don't always ask them, "Well what do you want of me?" I guess it's something that maybe we're not told, that this is the thing we should do in our training-- regardless of whether we're a

psychiatrist, psychologist, or social worker. But I think it's a good question because it begins to pin down if you will, and helps the client to pinpoint what their expectations are. We need to really lay those out as to what we're going to do, what we're going to provide, what we expect them to do and provide as well.

### **Slide 19: Trauma is a Violation of the "Self"**

Here's another photo from the Marine Corps and as you can see, it says, "trauma is a violation of self." We have four Marines, one on the ground and the other three are tending to him in some fashion. And again, although they're all in the same room seeing their wounded comrade, this event and other events that they're being exposed to are going to impact them independent of each other.

### **Slide 20: The Developmental Model**

So let's move to the developmental model and take a look at how the developmental model can be a staging area, if you will, or a foundation that really supports other types of intervention, other best-practice. Even some of the models that have been researched, evidence-based models employ some of the same concepts that the developmental model holds in place. This model actually comes historically from a number of different schools of thought and was developed at Menlo Park back in the early eighties and was published in the nineties or so. We found it to be very useful, particularly in helping those who are suffering from extreme anxiety and anger, frustration, and having great difficulty in trying to make sense out of treatment. But it can be used for anybody who's struggling with combat-related stress or PTSD. And, as we get into it you'll see why I'm saying that.

So the developmental model provides an understanding of the treatment of the client, particularly the difficult patient. It provides an integration of trauma into the client's post-trauma self-functioning. And, it assists the client in the understanding of self. What we're talking about there or implying is that when people are exposed to traumatic events (and this is no news to all of you I'm sure) there is a sense of loss. And the world is not the same as one has known it. And so that can be very discombobulating and difficult to sort of "put a handle on" when we're trying to help our clients move forward. And so, one of the things that we've learned is that it's important to understand that this individual who's been exposed to a traumatic event or events, was somebody before that event. That they actually had a life history. That they might have even had some predisposed factors that contributed and complicated maybe their PTSD today. So helping the client to understand who he is and, and how he's transcended over time is crucial, and this model provides that opportunity. It's also great for treatment planning and process and identifying progress.

### **Slide 21: Representations of the "Self"**

So there are basically three components-- that we're really going to focus on here, and that are the representation of self. There is the "experiential self" which we're all very familiar with, that's the subjectively viewing and effectively processing person, you know, like when it happens to you--you're there feeling it at the moment. You're not able to step back and try to

understand nor do you want to at the moment. Sometimes it's about survival, particularly if this is in a war zone situation or if it's in any kind of traumatic situation. You're definitely subjectively viewing it and effectively processing it.

You're not at that place where we would like somebody to go to eventually-- which is the "observing self" where you can be more objective, where you can have a better perspective, where you can see and get some emotional distance from the trauma and see how it's sort of effecting you. The overarching goal that we want to achieve, and what the developmental model supports, is the new integrated self.

This occurs when the warrior can move flexibly between the experiential and observing modes of processing. So the bottom line here is that this is when one can step back and see really what's taken place, and understand how it's affected him over time, and then be able to make choices. Then to understand the choices that they make today and how those choices will connect with the past, with the present, and the future.

### **Slide 22: New Integrated Self**

In the new "integrated self" what we're doing is, we're working through and incorporating the combat stress trauma experiences within a unified and continuous trauma narrative. With the warrior trauma survivor experiences, we're looking for self-cohesion and some degree of meaningfulness and an integration across the life experiences. So the bottom line is making meaning of this traumatic event and changing the meaning from the horrific, sad, frustrating experience to something that can be viewed as a lesson learned for growth. And move it, as hard as it might seem, but move it from a very negative experience to something that's a little more positive. Very much a challenge for the survivor of the trauma-- but also for us as clinicians.

### **Slide 23: The Challenge for Providers**

So again let's, let's repeat some of the challenges for providers. One is, remember we're trying to assist the survivor, the combatant to understand and transcend stress and trauma, make meaning, and grow from those experiences and then move on.

### **Slide 24: Developmental Model (DM)-1**

So the developmental model aids in the integration of combat stress and trauma. It facilitates a construction and reconstruction of self. The self-organization and integration. It's based on past experiences. It clarifies self in relationship to combat stress and prior to the military, during the military, and after the military. What we're saying is that when you think about it and you take any issue, for example let's say that the client that you're seeing, the veteran, the active duty person that you're seeing seems to always communicate in a very angry fashion. For some clinicians, they might run with that and believe, "Well this is probably related to their PTSD and whatever happened to them and now they're just really angry and they can't get past it". Well there might be some truth to that, but on the other hand, by taking a look historically at how one expresses themselves and whether or not anger has been a "tool" prior to the traumatic event, we might realize that well, yes, anger is something that was natural and it helped him to get by in

that particular firefight or whatever the situation is. But it won't be just about extinguishing anger in regards to that event.

We're going to use the developmental model-- we can see that the inability to express one's self in a variety of ways is something that this person struggles with. So we're going to have to add to-- beyond just dealing trauma focus group. We're going to have to help them learn how to express themselves in a variety of ways because there's a learned response here that goes beyond just a traumatic event. So in essence, that's what we're saying when we're talking about the clarification of self in relationship to combat stress. We want to look at, across time, what things are connected to what parts of their lifecycle and how do they interact?

### **Slide 25: Developmental Model – 2**

The other thing that the developmental model would do, it helps to identify the origin of symptoms-- such as I just gave an example of. Meanings can be made accessible after careful questioning. By asking them, and taking the time, and of course employing the model-- which you'll see it, it has a nice diagram that's easy for the clients to use and it helps them to be able to attach meanings and see how they move across periods of their lifecycle. Also, using the developmental model helps them to sort of become a "detective"-- something that that will stay with them once they learn how to use this model. It's sort of like a way like some of us can do off the top of our head; "Oh I know why I'm doing that!"

Well, for people that have been exposed to trauma, sometimes just talking about things doesn't always hold for them because you know they're struggling with intrusive thoughts. They're struggling with a lot of different images at different times. So they really need, I believe anyway, something that's helpful to them is a visual tool. And the developmental model, which you'll see soon, has a set of panels. You think of it as mirrors. And as they begin to place different points and issues of their life in these different panels that represent their life across time, including the military, from the very beginning, the time that they enlisted through the time they get discharged-- it starts to make more sense to them. They can see cause and effect and it helps them to feel a little more empowered. It clearly identifies the warrior's coping mechanisms-- both the ones that are adaptive and maladaptive as I just pointed out.

### **Slide 26: Developmental Identity Factors**

Identifying factors. Well, first there are the issues. Those are the beliefs, values, expectations, fears, behaviors, and patterns. And we want to take all of those issues and take one element or one of these themes-- depending upon what we're finding when we're dealing with this client. We have two cases that we're going to utilize to illustrate this in a moment. We need to look at cultural practices or the issue of control and power or vulnerability or relationships or intimacy. Let me give you an example so this becomes clearer. Many of us have had a moment with our clients, or many moments, when they come in and they say:

"You know, I can't get close to anybody. I love my wife. I, I love my parents. I love my kids. But I just can't close to them. And the other day I was in the market and my wife tried to hold my hand and I pulled away from her

because I felt uncomfortable with it. She got upset with me. I tried to explain to her that I didn't feel safe with her holding my hand in there, but that I do love her. And of course she was upset. She doesn't understand it. And I don't understand it. I kind of feel like, you know, what I'm thinking is that I just don't feel safe, and I know from being in Iraq and Afghanistan, things happen and there is no such thing as a safe zone. But my wife thinks that I'm rejecting her, and I just don't know what to do with it. And I'm sort of wondering whether or not she's right because I'm feeling like I'm withdrawing from people, that I'm struggling, and I wasn't like that before. I don't think I was like that before."

Well, for most of us, we might run with that right away and say, oh yeah this is clearly combat related stress or PTSD. It's probably related to a traumatic event. And as we do research with our client, when we hear their stories and we hear about these horrific events we can see, you know it's not rocket science, that possibly there are some fears about being close because it's the fear of loss. They don't want to experience that overpowering feeling of lack of control and that bad things happen.

But then you know guess what? We do great work and we think we're done with this client and six months later, nine months later we hear back from them. They come back to our office and they're telling us that even though they feel better and they've talked about it everything that happens to them in Iraq and Afghanistan they're still have the same problem. They say, "You know, I'm not having a problem in the market anymore. I feel a little safer. Partly maybe because I'm shopping at midnight now but, but I do feel safer. And my, you know but, but my wife, I think my wife still feels that that I don't love her and I'm, I'm not sure what's going on."

Well, had we been utilizing the developmental model, we would have looked at intimacy, for example, historically. We would have looked at what has been the history of this person in terms of developing that knowledge and understanding of intimacy? What was it like growing up in his family? Let's look at the male role models in his family. Were the men demonstrative? Did they hold hands with their wife and their children? Were they the kind of people that hugged and really showed their emotions? Or was dad the kind of guy, a nice guy, a good provider and everything, not an abusive parent, but just the kind of guy that wasn't a touchy feely person? And that really instilled in his son that one of the most important things that you can do is to provide for your family and protect your family, and that in turn translates into loving your family.

Well, this guy married a woman who comes from a different family background where in her family they're very demonstrative and part of the signs of love is showing affection. So we wouldn't know that had we not gone back in time to try to get a handle beyond just the traumatic events where this person shut down and said, "Okay I'm not getting close to anybody." We would have not known had we not gone back in time. That's why we want to employ this sort of historical perspective to a certain degree when utilizing the developmental model. It's to sort of get the origin of intimacy with this individual. What do they know about it? How is it played out over time? So that's one example. And we can come up with a number of them. We could use spirituality or religion and try to understand about beliefs and values and expectations, behaviors, patterns, and expectations that one might hold in terms of spirituality.

Now I'm going to give you another example real quick. Many times we are confronted with somebody who comes into our office who feels that they can't participate in their religion any longer. In part because they feel that either God betrayed them or they betrayed God by getting angry at God or whoever, whatever their spiritual beliefs are. And so you know, we as good clinicians do our best to work with them and focus again on the traumatic exposure, try to get an understanding, and we try to rationalize with them. But you know, it doesn't always go too far. Why is that?

Well, had we not really delved further back to understand: what are the ties here? How much of this person's identity is linked to spirituality? Had we gone back and looked historically, we might have found that their whole life, their whole identity-- based on how they grew up and their family and the social network in their family, in their community-- all is connected to the church. Well it's understandable that this person is going to struggle. And, had we known this, we might have then employed another person into the treatment and that might have been the spiritual leader of their choice-- to help clarify for this particular individual what might be misinterpreted as anger or guilt when, in fact, it might be sadness and a major feeling of loss, or of loss of identity.

Okay let's move forward.

### **Slide 27: 3 (+)-Way Mirror**

So the three-way mirror, as I said earlier, is a visual tool. It helps; it can be an investigative process. It allows us for the warrior, the client, veteran, to be an active participant. This, we take a life narrative approach so it's, it's, you know they're engaged in this. They're telling their story but we're, we have a system, a process for them to do it that's easy for them to follow. I mean ask yourself how many of us take the time to reflect you know where we come from and how we got where we are and, and why we feel the way we feel. I think you know some people might say, "well gee are we talking about analysis here?" No we're not talking about analysis here. We're talking about acknowledging that people have had a life before and they're going to continue on and that that life is, has been influenced. And sometimes because we're too busy we don't recognize where these influences come from and that maybe some of these things we could disengage from or we can modify. And that might be able to free us up. So that's why it's so important that, that we utilize and incorporate as part of the model a narrative approach. And of course in terms of context we're looking at pre-military so we're looking at early development, adolescence. We're looking at early military training and then eventually deployment, post deployment, and for some redeployment and for others discharge.

### **Slide 28: 3(+)-Way Mirror (cont.)**

Some of the other things that the developmental model does is it engages and empowers the warrior. Because when they can see visually as they're talking about this and make the connections it, it, it starts to take away that sense of loss of control if you will. It starts to force them to acknowledge that, "I have to take some responsibility for my behavior. I can't chalk this all up to being impulsive or to, it went boom for me in Iraq and Afghanistan and that's the way I

am". So that's what's one of the beauties of using a visual tool. And the developmental model, given that it uses a historical frame of reference moving forward, provides that. So it reveals like I said and fosters choices. It reduces shame and blame and it promotes resiliency and relief. And how it promotes resiliency is that when we're doing this we look for you know positive coping skills. Even some of those that might have been maladaptive from the civilian point of view but not in a war zone. Sometimes anger in a firefight is the right, right tool. Unfortunately for many folks they don't turn it off. It becomes too easy for them to utilize and more difficult for them to deal with the fear of loss and control. But by having them look at this visually they get a clear sense of how it's affecting them and others. And so at the same time we can take that, what might have been a negative coping mechanism and turn it around into more of a positive one.

### **Slide 29: Three-Way Mirror**

So everybody now is saying finally we get to see what he's talking about. Here's what we used to call the three way mirror and actually it has many panels. But as you look at it right now you see that there is a, for better or for worse we call that first panel pre-trauma. And that might be a misnomer because we know that, that people sometimes during their childhood are exposed to a traumatic event or events. But what we were trying to say here early on when we first started working on this model is that we're trying to look at pre-trauma if you will to a war zone traumatic experience. But this doesn't mean that we're not acknowledging in that first panel that this person has had a life and they might have experienced some terrible things. Also they might experience some very positive things.

In the larger center panel you see it says traumatic context. And what we're saying there is that panel will probably be divided up into or will be divided up into early military, war zone, post and deployment. You'll see that later on. That what we're doing is in that center one is looking at over time in respect to military experiences how things have transpired.

Then in the last panel there we're looking at post-trauma. Down below you see those elements that I was talking about early on, the experiential self, you know the self that is just in the midst of it and having those raw feelings and not able to, not able to really look and see and step back. That's all understandable. That's, that's one of the things by looking and utilizing this tool and visually the client, returning veteran, warrior can see that you know what I don't have to be upset with myself because I was in the midst of experiencing this. And it wasn't, it wasn't like I could declare a timeout and step back and figure out okay I shouldn't be doing this or I should be doing this or whatever. You know that what if, should of, could of thing you've heard some people sometimes talk about.

The other circle you see is the observing self and that's, that happens obviously in treatment. That's what we're doing in treatment. When they're talking about their experiences we want to allow them and that sort of takes that sense of not necessarily a [flooding] but it, it allows them to sort of, we want to allow them to have those feelings as they talk about what happened as, as close to the experience as possible feeling wise. But then again we want to bring them back after to that observing self so they can see you know what transpired and not be as judgmental on themselves. This helps tremendously in regards to guilt issues and second guessing one's self.

Then finally moving to the new integrated self and that's where we can see across one's life course and understand how all of these things fit. It's a very empowering process for the individual who engages in this. And it's really helpful to the therapist because it's sort of easier to connect the dots if you will and, and figure out you know okay what do we have to do because if we find that for example pre-military or pre-trauma there's some pre-disposed factors maybe this person was raped prior to the military or was otherwise severely abused or so on then we know that this person already has layers of issues that are going to have to be dealt with. We then can understand and not set unrealistic expectations for the client or ourselves that just talking about the war zone experience is going to relieve them. That, that actually in fact those early childhood experiences might be exacerbating if you will or in the other, might be the other way those traumatic war zone experiences might be exacerbating early on childhood issues.

### **Slide 30: 3 Way Mirror**

So now you're going "oh my God look at all of these words in these panels and there are more panels". What we're doing here is just trying to illustrate how you can take any one of these things and move it across time. So for example let's just take one and keep it simple for right now. Let's take a male, and we look at the male role. What we're saying here in that first panel, let's find out from the time he was growing up what were the values, beliefs, expectations, behaviors and fears and fantasies about being a male and where did that come from? How much, you know did it come from role models at home or did it come from school or church? How did it transcend over time? You know you take for example as a male maybe one of the things that the individual clearly and probably wasn't aware of this because most children are not in subtle ways are being influenced that, that he realizes that being a male in his family meant that you were sort of a tough person. You were the kind of person that didn't cry. The kind of person that got tasks done and always volunteered to do more, always volunteered to carry the heaviest thing because you know girls don't do that.

Then while going to school and, grammar school that gets reinforced. You know sometimes in certain schools in certain parts of the country this whole thing about you know if you want to call it, I don't like using the term [module] but I will to illustrate this at the moment, sort of being that, that male, male, that little boy that's more like a little man. And then over time going to junior high school and, and maybe noticing in this instance let's say for this individual noticing the opposite sex. And, and, and sort of like being attracted to the opposite sex but not really knowing what the differences are other than what the individual has been exposed to. That boys are supposed to be stronger. That boys are supposed to be in charge. That boys sort of give the command. And maybe part of that might be coming from you know a reference point of his own family where dad you know did certain things. Dad provided certain things. And mom asked dad for dad's opinion and dad sometimes had the final say. Even though dad was a great guy and I'm not saying this person came from an abusive family or anything like that.

It's just that the influences of how his male identity and intimacy are being shaped. He goes into the military, those of us who have been in the military learn right away that there is no room for intimacy. That what we have to do is we have to be resilient. We have to learn how to be interdependent. We're part of a team. We learn we have to carry our part, you know carry our

load. And so it's, it does not necessarily the early stages of the military during training, during boot camp does not necessarily lend itself to hugging and you know sort of like let's, let's sing Kumbaya and have a group. So it's sort of moving [this first] in a sense to, and the military is doing what they need to do, which you want to do. You want to train this person to be a warrior. They're not there to learn to be a diplomat. They're there to learn to how to be a warrior and be a survivor. Then they go into the war zone and in the war zone they're as equipped as possible, as psychologically as much as possible.

We might not totally agree in this but I'm just saying in terms of from the military's perspective they're as equipped as much as they are going to be psychologically. And that is the sense of resiliency and being a team member, being able to be interdependent and being a warrior. But then you know things happen and things do go wrong and there are traumatic exposures and that happens in a war zone. And then the raw emotions come forward and whatever coping mechanisms are in place or ingrained move forward and come to the top.

One of those might be for this particular individual, this particular male that what he understands based on let's see only his military training because they're not, he's not thinking about well how his dad was or whatever. He's just thinking about being this Marine now, this, this soldier. I'm not going to cry. Things just happen. I feel bad. I'm angry. I'm frustrated. And, and I might even want revenge even though I might not want to say that. And that is the raw feelings at the moment, shock and, and fear and anxiety but then it changes and shifts quickly in a heartbeat to anger, you know because we have to get in that mode. It's a survival mode.

Okay so post-war zone this person eventually gets out of the military, you know, and is, is now sort of moving into another part of the, his lifespan and finds some discomfort and troubling effects from being in the military. He comes to us for treatment and he ends up talking about his war experiences. And we end up putting him in a trauma focus group or something like that in dealing with that. Then we're hearing this story as I told you earlier about the fellow that was struggling with intimacy.

Well here we go. Here's a good illustration of the same thing. That basically we put him in a trauma group and we do get good histories and we try to understand their backgrounds and all of that. But it's really hard for them to conceptualize this because they're struggling with all of this influence of intrusiveness and trying to recall all of these experiences. And so when we can slow them down and they can visualize and understand okay you employed numbing and anger to survive that combat situation and now you understand that but yet you're still struggling with being close to your wife and family. So now we're putting sort of the, the light on if you will. Shedding light on the fact that this particular person now has to sort of own this and take a look and say okay I can't be projecting my war experiences onto my family. I need to take a look. Is there something going on with me unrelated to the war that maybe has prevented me? Or maybe let's look at it another way.

Remember what I said earlier about coming from a positive perspective. Let's talk more about what can we do, what new tools can we learn to help us with intimacy? So we have to explore that and of course we know the origin now where what he learned and didn't learn as he was growing up. But now we're moving forward to giving him some tools of how to sort of embrace

the concept and better understand intimacy and be able to differentiate it from his combat experiences.

So that, in essence, is how you would work this model through. And you could take any element if you will on, because remember what I said trauma is a violation of self. It's not a group experience. We might be in the same room. We might be in the same firefight. But how we incorporate that, how we respond to that is that as an individual. And in order to understand the overall impact one needs to know who it is they're seeing in front of them today in their office or in their residential program. To not do that, to not know who that individual is really in some ways doing more harm to the person in trying to work through their experiences without really getting a handle on who they are and how they were affected. So if we're going to respect them as we do and as I know you all do this is one of the major ways of doing that. It doesn't sort of put any blame like one, sometimes people say well gee you know are you going to sort of tell them that the reason why they are the way they are today is because of the way they were as a kid and blame it on that? No. What we're trying to do here is help them understand how life transcends itself over time and that we're a living thing. We're not sort of a standstill item if you will. And we're affected and in many different ways.

### **Slide 31: 3 Way Mirror - Combat Stress**

Okay now I've confused you even more. You're now looking at another Power Point with some new headings. Basically everything is the same here except that in our working with the Marine Corps and the Army over the last three years, both with family services, as they're trying to understand how to deal with the spouses trying to understand and deal with combat related stress and then with the healthcare, uniform healthcare providers and the Navy and the Marine Corps trying to find a way to deal with combat related stress. And moving it forward so people can be re-deployed. We took the developmental model and added a component to it, which is the resiliency building. I've already addressed that a little bit and I'm going to give you an example right now as to how resiliency can be used as a, as a tool if you will to move somebody forward in a clinical situation.

### **Slide 32: Case #1: Agitation and Destructiveness: Masking Fear of the Loss of Control**

So here's the case. We have a Marine who is thirty-eight years old and has had over a decade of service in the Marine Corps. He's a gunny sergeant. And those of you who know those titles he is held in high regard. He's one of the key folks in a unit. Think of him as sort of like the father if you will of the unit but a tough one. One who everybody sort of looks to for leadership and so on. This particular gunny is African American. Prior to, he's had multiple deployments in other peacekeeping missions and so on but also to Iraq and Afghanistan. And prior to that he was considered to be a very stoic person but friendly, a person who had an excellent disposition who would also eventually crack a smile and that everybody felt that he was tough but they could go to him. Okay when I met this individual he was perceived to have a quick trigger. He was, as he told me, he was starting to isolate himself from others. Now this, this is an active duty person, okay. This is a person on a military installation.

He was experiencing being hypervigilant. He was having a sense of loss of track of time. He felt that maybe he wasn't getting along with his colleagues but as we talked about that it was more that he was afraid that if he spent too much time with his peers, which were the other gunnies that they would pick up that there was something wrong with him. He was very concerned about his sleep problems. That it was affecting his wife. And he was becoming distrustful. He was a little paranoid about the clinicians, the psychiatrists and so on. And he was evening questioning whether not he should continue his career in the Marine Corps.

So this first case is that of somebody who is in an agitated and, and destructive scenario which really was masking the fear of loss of control. So what happened was as I ended up talking to this individual and getting a history, which you have in front of you, part of the history. What I found was that that he needed to allow the providers that were there more then willing to help him but he was struggling with a number of issues, one with stigma. The fear of looking like he couldn't cope, not only with his peers but also with the people he was responsible for. And so the other part of this was that he was also afraid that he wasn't going to be allowed to deploy with his unit. So I was asked if I could help him get past that hump if you will and, and make better utilization of, of the mental health services that were there for him. And what we did was I asked him a couple of questions and this is where this whole issue comes into about remember I said that we don't have a Lexicon for Iraq and Afghani returnees yet as we do for Vietnam veterans. Remember I said something about using resiliency. Well what I did was I, I kind of paradoxed them. You're all familiar with that. I said to him you know I said gunny if right now an alarm went off, if a horn blew here at Camp Pendleton you would probably know exactly what that meant. He said yes. And I said you know if, if you were in a situation where your troops needed to be able to clean their weapons in the blind they could do that. He said yes. And he said, I asked him, I said well how do they, how do they know how to do that? And he said well practice, practice, practice.

And I said well when you were in therapy you told me that the therapist was, had given you a rubber band and put it around your wrist and you had told me how upset that made you because she was trying to tell you that if you snapped that rubber band on your wrist that somehow that was going to help you stop having an intrusive thought. Help you get grounded. He said: "yeah I said how is a rubber band going to help me in a war zone?". And so we both kind of smiled and I said let me ask you the question again. If your devil dogs, that's what they call Marines [more] enlisted below the rank of gunny, right now if we, they were in the sand, if they were in Iraq and it was in the dark and they needed to clean their weapons and you gave that command would they be able to do it? He said you're darn right they'd be able to do it. And I said again, gunny why can they do it? He said because I have them practice, practice, practice. Well I reached over to his wrist where he had that rubber band still and I pulled on it three times and I said practice, practice, practice. Okay he kind of smiled and he said I can't believe it. He said is that what she was trying to tell me was, he was talking about the therapist, and I said yes but you weren't able to hear it.

And I said but so it's not, this is something you know, gunny. You have this ability already. You know that if you're going to help yourself and support yourself you're going to have to work with people, just like you have your men working with you. You're going to have to work with that psychiatrist. You're going to have to work with that therapist. And you're going to

have to communicate with them. You know it's a joint venture, a learning process. And I'm happy to say that we did that and that was actually, even though I didn't use sort of the developmental grid, I didn't pull it out or anything because I only had about a half hour to deal with this situation I was coming from that frame of reference. I looked for historical strength. I looked for meanings. And to move this person forward and I can tell you now that that individual eventually did get deployed, is already on his way back, did quite well, and worked well with the psychiatrist and his therapist prior to deployment. It wasn't magic that I did. It was just taking the time and, and trying not to let's say go for some core traumatic event but rather looking across and trying to find some key turning points and apply them.

### **Slide 33: Case #2: Anger and Isolation: Masking "Spiritual Loss/Betrayal"**

Okay I'm going to give you one more take. Bear with me. We're almost done. So here we have a case of anger and isolation masking spiritual loss and betrayal. We have another Marine, active duty, he's twenty years old. He's had about two years in the Corps. He's Hispanic. He's never been lethargic but now he's being perceived as being lethargic. He's always been sort of a smiley friendly kind of guy, can do kind of guy and now being perceived as irritable, surly, argumentative. He's isolating himself from others. He's increasing his smoking, starting to drink heavily and he's very suspicious of controlled substances. What we mean by that is that they, they were trying to in psychiatry and this is an active duty guy trying to you know help him with some medication but he was very suspect of that.

And remember what I said earlier about that these warriors being a little different? That it's not about them being so much like Vietnam veterans in that Vietnam veterans didn't trust anybody for a number of reasons, some very good reasons as it relates to the country and the social politics of the time thirty years ago. This has more to do with the fact that these people, these younger folks are, it's so easy for them to access information. They're not dependent nor do they choose to be dependent on others. So they're a little reluctant to just go with the flow so to speak.

So anyway to move quicker on this particular case, this individual was exposed to some major traumatic events. And initially the therapist was working around those events and again trying to utilize pharmacotherapy therapy and so on to move them forward. And part of the, part of what this Hispanic Marine talked about was his feeling of betrayal, both that God had betrayed him and, and that he had also in his own mind betrayed his belief system. And so originally the therapist tried to take this on as to what happened in the war, in that trauma, in the combat scenario. And there was some immediate relief that this young Marine experience through that dialogue but then it really didn't change his overall mood over time. And so we went back and took a look historically to try to understand more about you know the spiritual issue and the betrayal that he kept talking about. Because you know most of us as therapists were not a priest or rabbi's whatever, although there are some and there are some very good chaplains who have a good handle on doing with traumatic exposure. But for the most part most clinicians in the VA are not.

And here is an instance where by using the developmental model we were able to go back historically and see and understand that this particular young man his whole family, his whole

life system has been built around a church. Church was an event three times a week for them. All of the social activity had to do with the church. Growing up in his community, everything was related to Catholicism. He was a Catholic. So he played in the little boy's Catholic basketball league. He was a, an altar boy. He went to a parochial grammar school. Although he did go to a public high school he still maintained because of the tight knitted extended family a very close belief system and practice from a Catholicism perspective.

So while he was going to boot camp he, when we asked about, which these are the things we probably never would have asked in a hundred years but using the developmental model we did. We asked well you know when you went into the Marine Corps what did that, what did you expect and how did that fit with your belief system and the church, you know about not killing people and things like that?

So that led us into moving forward and then looking at how he, and he was able to see how he was transcending from this "Catholic boy" from this very tight knit Catholic family into this Marine, this very good Marine and actually a very happy Marine initially. But there was some choices he made and one of those was that the first time they had some free time after boot, boot camp, he was, they had choices they could have free time, go to, go for a swim or go make phone calls or go write letters or go to chapel. He chose to be with his buddies who were more sort of like hard corps guys. You know they were the, you know the real kind of go for it type Marines. And he didn't go to chapel. And he said that he felt a little guilty about that but he also felt he was moving in a different direction.

Well in the combat zone he prayed every morning and every night. And he prayed that nothing would happen to his fellow Marines and that they would all come home okay. But then you know war is war and bad things happen. And at first you know he handled it fairly well. He went through the same that most people go through when they're exposed to that kind of war zone exposure. But then it happened a few more times and people died. And during, and he had been asking God in his way to bring everybody home. Obviously now they weren't coming home. He was very angry and in, in one of those moments of rage he cursed God out as we, as he tells us that story. And it was after that that when he came home ironically the family and the priest and everybody was there to greet him. They were going to have this big activity at the church hall and all of this because you know he was a well liked kid and, and a very staunch member of the church and so on. He couldn't go. He refused to go. The family didn't understand where he was going. He took off. And he proceeded to self-medicate. And of course he was still active duty so he had, you know he had a few weeks leave.

He went back to the base and continued the same behavior. So in working him through we were able to see that what we really needed to do now was to engage him with somebody that comes from the spiritual perspective. So that meant in this particular instance since he was active duty was to get the chaplain priest. And again I'm glad to say that the chaplain was able to help him come to terms with his experience and his, and from his Catholic posture, this young Marine. So that's, I gave you an example now how you can employ this model. It, it allows us to do a lot of work and what it, what I really like about it doesn't interfere with employing other models, evidence based models or best practice models because all of the developmental model does, I

shouldn't say all that it does. But, but it lays the foundation. It, it's, it's a visual tool if you will that allows the traumatic victim to participate.

### **Slide 34: Treatment of Combat Stress/Trauma: An Integrated Approach**

So there are a few other ingredients that I want to share with you in, in my final two Power Points. One is that, that we need to utilize other types of groups. The developmental model can be a stand-alone but I don't think it should be used as a stand-alone. I think employing some type of trauma focus group, in some cases dealing clearly with relapse prevention. And we're not talking about relapse prevention with substance abuse although that is important but relapse prevention regards to PTSD or combat stress. Parenting skills, a lot of these people are young, as I mentioned earlier, are even the ones that are not so young. You know we don't go to school to learn how to be parents. So for people who get exposed there's a lot of issues about safety and concern for family and parenting can be a really good group process. Anger management, for a lot of folks that's crucial. Again substance abuse, conflict resolution, and so on. For many we're seeing that coping with anxiety and panic is very important. To assess to see if we have somebody with a panic disorder and give them that opportunity to gain from the knowledge that now the [field] has moved forward in terms of arresting panic and anxiety.

The other thing is that one needs to be able to self-actualize treatment. Treatment doesn't begin and end in the office or in a ward. We need to look at complementary sort of process such as using recreational therapy, job skills training, particularly these young folks. They're more likely to want to learn job skills as opposed to being in treatment but there's a way to combine that. So I list a few things there.

Then finally but not last is the networking and resource out in the community. This is crucial. You know in order for them to really understand whether or not treatment is working they have to be able to be out there and put it into practice and then come back and tell us what's working and not working so that we can help them and re-tool whatever it is we need to do. Or if we're fortunate we can be very happy and applaud them, as they are successful.

### **Slide 35: Summation Points: Developmental Model**

Okay in summation, the developmental model provides a safe arena, of support and reinforcement. It can be used in individual or group application. It allows for individuality in a group process. As you saw, we've done this a number of times in groups, small groups to groups as large as fifty actually in helping them, using that as a psychoeducation component actually. So you could use this developmental model in many different venues. It builds structure and assists in group dynamics. It sets goals and expectations. It provides for education and universalization of combat stress and response. It provides for solidarity and being heard. It decreases shame and blame, which is really important. And it promotes a greater understanding and acceptance of self and others and facilitates understanding of the difficult client.

### **Slide 36: (no title)**

So in closing you see a last photo of two Marines in Iraq moving through a sand storm. We can see one of them, the outline of them, the one that you're looking at on your left side but we can't see it very clear. We could see the outline. And yet on the other one on the right hand side we can see from the shoulders up fairly clear. We can't distinguish the face but we can see that that's an individual there, moving forward. The reason I like this photo it's because it illustrates what we're challenged with and what they're challenged with, and that is to be able to understand and come to some agreement with themselves as to how their combat exposure has effected them. I strongly suggest that you consider utilizing the developmental model as an additional tool to the other things that I'm sure you're using well.

As well I'd like to suggest to you that you look at the number of different courses that we have listed on PTSD 101 because I think they can all be helpful at different points in time.

Thank you again for bearing with this presentation and we look forward to you utilizing the developmental model approach.