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Finding Balance - **Part 2**

Considerations in the Treatment of
Post-Deployment **Stress Effects**

CEU By Net Course 5L



Guide for Clinicians

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Finding Balance

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Chapter 5. Preparing to Work With Service Members and Veterans

First, **civilians need to come closer to our world.** They need to read stories written by veterans who have been there and watch documentaries about the war. Civilians need to learn more about the heart and soul of a warrior. They need to stop asking, “What was the hardest part about being over there?” and start asking, “What’s the hardest part about being home?”

—Alison Lighthall (“U.S. Must Unite to Aid Vets,” *Army Times*)

Given the number of Service Members still deployed and the projected high levels of post-deployment stress effects, it makes sense for civilian providers of substance use disorder and mental health treatment services to become prepared to work effectively with this population.

Some non-military service providers have begun treating veterans for their post-deployment effects through subcontracting arrangements with the VA. However, some veterans also seek help directly from SUD treatment facilities, community-based mental health centers, and other providers. Their reasons are many and varied: Some are referred by family members or friends, some may not have access to the services they need through the military or VA, and some simply prefer to receive services in their communities. Others choose community-based services to avoid the real or perceived possibility of stigma and reprisals.

So the overwhelming question becomes, what will it take for civilian clinicians to become ready to treat veterans in safe, effective ways? This chapter focuses on steps that the civilian clinician can take to work with veterans in ways that respect the

individual, the military culture, and the veteran's experience in the theater of war. It includes four sections and one pull-out page:

- Inside The Effective Clinician
- The Individual and the Military Culture
- Avoiding Assumptions
 - Ten Things You Should Know to Help Bring the OIF/OEF Veteran All the Way Home
 - Army Values, Creed, and Code
- Earning Trust

Some of the considerations in this chapter are taken from written works, but more are based on conversations with or presentations by veterans or therapists who work with trauma survivors. The reader is encouraged, not to take these ideas as absolute or as the only important considerations, but to respond to them with curiosity and a desire to listen, read, and learn much more.

Inside the Effective Clinician

The Clinician's Self-Knowledge: According to Dan Taslitz, OIF veteran and trainer for a Colorado-based organization called ONE Freedom, three of the most important personal qualities that a civilian clinician working with veterans might have are:

- An openness and curiosity about the individual veteran and his or her experiences and realities
- An understanding of the clinician's own experience of trauma, and progress and stability in the conscious process of addressing and resolving any issues attached to that realm of experience
- The ability to keep any agendas the clinician might have about the war or the veteran's participation in it (e.g., political issues, feelings or opinions about war in general or the war in which the veteran was engaged) completely separate from the therapeutic process

Only someone who has lived in the presence of war can truly understand the experience of war. But each of us has had difficult and intense life experiences that can inform and deepen our understanding of trauma and healing and our ability to respond effectively. So although there will be many times when only someone who has "been there" can fill the need, there is still a significant role for civilian clinicians in this effort. As any skilled helper knows, it is possible to find elements of one's own experience that allow for greater identification with the experience of another, without comparing the two

or giving them equal weight. This both normalizes the veteran's experience and respects the ways in which it is different from the civilian's.

In the words of Steve Robinson, another veteran and consultant to ONE Freedom, "Simply be in touch with your own life trauma. Don't share it with them; you're supposed to keep it businesslike. But for clinicians it's very important to connect with your own life experience on a human level while you're connecting on a professional level. They need to know that you know what they've been through."

And the last of the qualities mentioned above—the ability to separate agendas from the therapeutic process—requires a thorough knowledge of one's feelings, opinions, and possible agendas concerning any of the issues connected with the veteran or his or her service. One of the most serious mistakes a clinician can make might be to (consciously or unconsciously) use the veteran to confirm an opinion about the war, its viability, or whether or not it should ever have taken place. If you are not certain that you are ready, willing, and able to keep your own feelings and opinions far away from the therapeutic process and relationship, then you have the right and the duty to decide you are not ready to treat veterans.

Take Care of Yourself: Most trauma specialists emphasize the importance of self-care in working with survivors of any kind of trauma. For example, psychotherapist Lia Gaty (2008) spoke of several self-care practices:

- Keep your self-inventory current, so you know how you are reacting and know your needs.
- Recognize your own limitations, and make sure you have the resources you need to stay healthy.
- Keep the "therapist's ego" out of the way ("I am THE one who can help!"), and remember that you may be only one step in a long process that leads to, and through, recovery.
- It is important to have good supervision and support from others who are doing similar work. If your agency has an atmosphere in which it is not safe to talk about the issues that might arise in your emotional responses to your work, find a group or a set of mentors who can help you gain the perspective and support you need.
- Seek consultation when you feel as if you are out of your depth or sphere of expertise.
- Remain vigilant for the countertransference issues (the clinician's feelings and issues projected into the therapeutic relationship) that are easily triggered in work with trauma survivors, and seek help in resolving those issues.
- If you find that you do not like a client, chances are that his or her "radar" will perceive the dislike, and you are likely to be less effective and possibly harmful in

the therapeutic relationship. In these cases, it is better that the client be assigned to another therapist.

Self-care can be particularly important in working with combat veterans, because of the extreme nature of the experiences they may describe. Even if you are strong and committed, you will want to remain vigilant for:

- Vicarious traumatization or “secondary trauma,” the process by which the listener can develop trauma symptoms from exposure to the traumatic experiences of another
- Compassion fatigue, a state of emotional exhaustion or a loss of interest or empathy following overexposure to traumatic material (Boscarino, Figley, and Adams, 2004).

People who have been through the experience of war—or of any traumatic circumstance—will tell you things that are completely overwhelming, very difficult for your own emotions to bear. But perhaps great difficulty is the only appropriate reaction to deeply traumatic material. As Lia Gaty said, “If it’s not difficult, you’re not listening” (Gaty, 2008b). Here are two things to consider:

- In absorbing the veteran’s narrative, you are bearing a small part of an enormous burden that the veteran has carried and few others have even considered carrying. Even if on a particular day you are shut down and wondering why you feel nothing, you are still helping to carry the load.
- You owe it as much to your client as to yourself and your family to get all the rest, self-care, and support you need to keep your own balance while you do this work.

The Individual and the Military Culture

For the civilian clinician preparing to work with veterans challenged by post-deployment stress effects, the central thing to remember is that you are preparing to work with a very different and clearly defined culture, one of which many civilians have little or no knowledge or experience. This preparation process must be characterized by:

- Cultural humility, the ability to appreciate the limits of one’s own knowledge
- Cultural openness, the willingness to suspend one’s usual assumptions and ways of doing things and learn about the other culture
- Cultural competence, words and actions based on knowledge and understanding of the other culture

One of the clinician's most important tasks is always to find out who the individual client is, regardless of diagnoses and assessment forms. Never is this more important than with a client who has lived through experiences so complex and foreign to civilian experience, and possibly undergone high levels of stress and trauma. As always, the most important tools in this task are the willingness and ability to listen, and the openness that lets it all in without judging or substituting preconceived assumptions.

As van der Kolk and colleagues (1995) noted, no matter how extreme the veteran's experiences at war might have been, it is also important to see those experiences in the larger and longer context of his or her life. This applies both to the many positive and negative experiences that might lie outside the war experience, and to the many strengths and resources the veteran possesses.

Statements from some Service Members and veterans reveal a tendency to feel largely forgotten by the civilian population, and to believe that civilians in general do not really understand their circumstances or appreciate their service. Given the incredible hardships many have experienced, a lack of appreciation by the public they serve may feel like a bitter disappointment, even a betrayal. By offering to help, you will go a long way toward helping to heal some of these wounds, but the second component—understanding—is also of vital importance.

Future drafts of this Guide will provide more information to start the learning process. Meanwhile, a few guidelines for the civilian clinician follow, based on interviews with veterans.

What to Call Service Members and Veterans: Whenever we communicate with someone of another culture, we naturally have questions about language. Learning about military terminology and values is an important step in preparing to serve this population, and one area of language—learning how to refer to service members and veterans—is an important sign of respect to the veteran.

The terms "Service Member" and "Military Member" are used in this Guide because they are the most inclusive, referring to people in all branches of the U.S. Armed Services (Army, Navy, Air Force, Marines) and to both Active and Reserve (e.g., National Guard, Army Reserve) Components. "Soldier" refers to someone in the Army (Active or Reserve), "Sailor" to someone in the Navy, and "Airman" to someone in the Air Force. Using these terms correctly is a sign that you know a bit about the culture, and a sign of respect.

With many cultures, there is a difference between the way we refer to ourselves and the way we are comfortable having others refer to us. The word "warrior" is a good example of a term that is used quite a bit within the military culture, and in a number of materials written about the military experience, but that term would be likely to fall flat if a civilian clinician introduced it in conversation. If the veteran introduced it and you

were responding, that would be a different matter. But according to one veteran interviewee, using “warrior” as a way to show your knowledge of the terminology would not be a good idea.

And a word that is used quite a bit in the media is “hero.” In many venues it is used almost as a synonym for “Service Member.” Its uses may range from an expression of admiration and respect to an attempt to flatter and manipulate. Veterans interviewed have expressed discomfort with the idea of having civilian therapists use it gratuitously, though it would make sense to use it in response if the Service Member has brought up the concept of heroism or told the story of a heroic act.

In “Ten Things You Should Know to Help Bring the OIF/OEF Veteran All the Way Home (Page 61),” former Army Nurse Alison Lighthall provides a number of insightful suggestions for anyone who seeks to help rather than make things worse. Among them is the following suggestion about this word: “Returning Service Members do not think of themselves as heroes, no matter how extraordinary their skills, courage, or actions may be. Their heroes are the ones still over there or coming home in a flag-draped boxes.”

“Thank You For Your Service”: This phrase, stated simply and clearly, is an important message for the Service Member or returning veteran. It has no politics, and it does not probe into the details of the Service Member’s experience. It is something the military culture recognizes as a sign of respect and gratitude for the sacrifices people are making.

Avoiding Assumptions

Steer Clear of Stereotypes: Regardless of how common the stereotypes of Service Members and veterans may or may not be among civilians, veterans themselves are strongly aware of the stereotypes, and this can widen the chasm between the military and civilian cultures. According to veterans interviewed, the stereotypes would say that Service Members are uneducated, less intelligent than civilians (as evidenced by the charge that they “had to” enlist in military service because they could find no other good career options), politically conservative “warmongers,” automatons who simply follow orders without question, and violent individuals who have no moral compass. The strongest expression of these stereotypes is a real or perceived attitude of condescension, and many Service Members and veterans are hyper-aware of that attitude.

Unless you have established a comfortable, trusting relationship, if you say or do anything that is interpreted as reflecting these stereotypes, it is likely to provoke what seems like “resistance” and shut down communication. Just as the amygdala is able to

bring up the whole traumatic experience at a single sound that reminds it of that experience, so is the human being able to bring up the whole tangle of stereotypes at a single condescending or judgmental word, gesture, or expression. Given the difficulty of repairing these misunderstandings, it is far easier to listen and “seek first to understand.”

In reality, many Service Members and veterans are highly educated, intelligent people, with interests, talents, attitudes, and opinions as varied as those in the civilian population. This is a group as diverse as any other—many ages, many races, many reasons for volunteering for military service. Their hopes, dreams, and life plans run the gamut, and so do their politics and their feelings about the wars they have fought (Lighthall, 2008).

They are also very much steeped in the military culture, which is a culture of courage, respect, discipline, loyalty, honor, obedience to authority, and patriotism. And each man and woman among them was willing to travel halfway around the world to live in unbelievably harsh conditions and face the possibility of permanent injury or death. Civilian clinicians owe it to themselves and to their clients to learn as much as possible about this culture and the individuals who have chosen to join it.

Understand The Positive Aspects: For the empathic soul who has not been to war but has heard enough to guess at the depth of its tragedies, it may be difficult to think of the Service Member as having had positive experiences in the war zone. But there are many aspects of the military culture and experience that are positive, reassuring, satisfying, and marked by deep bonds of friendship and mutual protection. It is frustrating to many Service Members and veterans that many civilians think of the experience in Iraq and Afghanistan purely in terms of violence and destruction. Here are just a few of the experiences some veterans have cited as positive:

- The deep friendships they formed within their Unit
- The knowledge that their buddies would be willing to die to protect them, and that they would be willing to die to protect their buddies
- A powerful sense of mission and purpose in their work
- The rush of sympathetic chemicals (e.g., adrenaline, norepinephrine, dopamine) that comes with battle
- A wonderful sort of “gallows humor” that helps them gain perspective and cope with life
- Interactions with children and other friendly civilians within the war zone
- The opportunities to help civilians within the community build a new society and recover from the effects of war

To assume that any particular veteran had experienced any or all of these benefits would be just as inadvisable as it would be to assume the worst about his or her experience. The key is to:

- Listen

- Follow where he or she leads
- Look for strengths, resources, and resilience
- Respect the complexity of his or her experience.

Earning Trust

For many who have lived with the effects of intense stress or trauma, trust does not come easily, and in some cases it may not come at all. Clinicians in the SUD, trauma, and mental health fields are well used to the challenges involved in the process of building trust. For veterans with post-deployment stress effects, with the amygdala always ready to pull up savage bursts of memory and ignite surges of stress chemicals, mistrust may be one of the healthiest and most reasonable self-protective impulses.

High Alert: Many veterans who have served in Iraq and Afghanistan have spent months or years hyper-aware and on high alert. Those who also grew up in homes where substance use disorders or other challenges created “sub-currents” in the family system may have been on alert long before their military service began. Many veterans’ radar is acutely sensitive, so they will miss nothing. And you might not be trusted until you earn their trust.

When some veterans walk into your office, you might perceive an attitude of polite, emotionally controlled wariness. This is not just a reflection of the disciplined military culture and the aftermath of war. It is also a very rational attitude in the midst of a civilian culture that often has little understanding of the Service Member’s experience and sometimes says things that are well meant but insensitive (e.g., “Too bad the war was all for nothing,” or “Did you kill anyone?”).

According to more than one veteran interviewed for this Guide, if you are going to be working with returning veterans who have post-deployment stress effects, you may well be tested. According to one veteran interviewed, clients may begin by saying a few things designed to evoke extreme responses, so they can test your personality, approach, and types of responses. They might tell you stories—accurate or inaccurate—about episodes of extreme violence or “abnormal” reactions in the war zone, and then watch your reactions.

In a sense, this testing process may be an important way for veterans to establish safety: Alison Lighthall (2008) spoke of a Service Member who had poured out his litany of traumatic war experiences to a civilian counselor for a full session. At the end, the counselor had told him, “I still can’t get my head around the fact that you kill people for a living.” The young man experienced considerable trauma and betrayal from this exchange, and a significant setback in his recovery followed that incident.

Ten Things You Should Know to Help Bring the OIF/OEF Veteran All the Way Home By Alison Lighthall, RN, MS

(Former Captain in the US Army Nurse Corps), Founder, HAND2HAND CONTACT

10. OIF stands for Operation Iraqi Freedom, also known as the Iraq War, and it began on March 20th, 2003. OEF stands for Operation Enduring Freedom and is a multinational military operation aimed at dismantling terrorist groups, mostly in Afghanistan. It officially commenced on Oct. 7, 2001 in response to the September 11th terrorist attacks;
9. Returning Service Members do not think of themselves as heroes, no matter how extraordinary their skills, courage, or actions may be. Their heroes are the ones still over there or coming home in a flag-draped boxes;
8. Service Members are as varied in their political beliefs as everyone else in America. Some are adamantly against the war, others staunchly support it, and everyone else falls somewhere in between. Assuming that everyone who joins the military is a card-carrying right-winger will only make you look stupid;
7. No matter what his or her opinions about the war are, every Service Member of every branch of the military takes a solemn oath to support and follow our Commander In Chief, the President of the United States, and therefore *cannot* say anything derogatory about him;
6. No one can describe how hot it was while deployed in a war zone, so don't ask a returning Vet about the heat. Instead, imagine yourself putting on every piece of winter gear you own, in multiple layers, putting a metal bowl over your head, turning your oven on to 120 degrees, climbing inside, and living there for 6 months;
5. Worse still is asking any Veteran, "Did you kill anyone?" It is an unanswerable question. Perhaps she did and wished she hadn't. Perhaps he didn't and wished he had. Perhaps she did, but it wasn't fast enough to prevent a comrade's death. Perhaps it was accidental or perhaps it was so many instances of killing, he lost count. War requires things of us and taps into parts of us that are never otherwise touched—things most people need to work through or want to forget. US military personnel do not take killing lightly, and anyone who has not been there simply cannot discuss it with those who have, much less pass judgment. Listen quietly if they choose to talk about it, but otherwise, leave it alone;
4. OIF/OEF Veterans often want to go back to the war zone. Sometimes it's because they feel called to go in to finish the mission or support their buddies, sometimes it's because they feel they can no longer fit into American society and its frivolous interests and fads. But regardless of reason, it is fairly common, so if they tell you they're planning on redeploying, please don't look at them as if they are insane;
3. They are exhausted when they get home—physically, psychologically, emotionally, and spiritually exhausted. They often do not have the energy or focus to talk for long periods of time. It will take some time for them to adjust, so follow their lead;
2. There is nothing black-and-white about what has happened to them. Almost always, there are good things that come from a deployment experience. Likewise, there are some pretty difficult things that they face once they are back home. Do not make any assumptions about their experiences;

And the # 1 thing you should know about OIF/OEF Veterans is ...

1. They are not the same people they were before they deployed. But do not assume that is a bad thing. The Service Member may come home more confident, with better problem-solving skills. He may return with a deeper sense of gratitude for the comforts that he used to take for granted or she may have found a greater sense of purpose and direction than she ever had before. Yes, there may be many unseen wounds of the soul and spirit. But there are tremendous resources to help heal those wounds, both for the Service Member and the Service Member's family, and an ever growing number of people who truly care and want to help.

If every American understood these 10 important facts about our returning Veterans, life would be a lot easier for them. So pass it on. www.hand2handcontact.org

This material is reprinted (with permission) from Alison Lighthall's web site, www.hand2handcontact.org. That web site provides a wealth of insight, information, and resources.

What is most disturbing is that, if a veteran's first fledgling attempt to reach out for help does not result in a positive, empowering, respectful interaction, he or she may never reach out for help again (Lighthall, 2008).

Clinicians' Own Emotions: Traumatic material can raise strong feelings in those who hear it, particularly in the empathic people who tend to gravitate to the helping professions. According to veterans and clinicians interviewed, a number of forces join to make clinicians' management of their own emotions particularly important—and particularly challenging. For example:

- It makes sense for a military culture to see strong shows of emotion as undisciplined and therefore threatening to the well being of the Unit. Depending on how thoroughly steeped the individual veteran has been in the military culture, a strong show of emotion on the part of the clinician might invoke some feelings of wariness.
- Some people with post-trauma effects are fighting off a number of triggers for their own powerful emotions, emotions they would rather not feel. Strong feelings on the clinician's part might seem like a threat to their own fragile sense of control.
- As mentioned earlier under "Avoiding Assumptions," Service Members and veterans are very much aware of the stereotypes and stigma that color some civilians' attitudes toward them. Veterans interviewed said that a clinician's expressions of shock or horror will often seem like a judgment of the veteran, and levels of sympathy that seem exaggerated will often seem like condescension.
- Veterans' experiences will raise strong emotions in the clinician. It will not be possible—and would not be healthy, authentic, or appropriate—to absorb the pain without showing emotions.
- Even veterans who fear or mistrust emotions will need to know that clinicians connect with their experiences on a human level. Without that connection, veterans are locked in with the trauma—and the stigma—and deprived of the empathic face-to-face communication that draws both the prefrontal cortex and the human spirit into the healing process.

So what does the clinician do? A cool, clinical "detachment" is nearly impossible, and in *War and the Soul* Edward Tick confirms that detachment would not be the answer. "In traditional therapy, the prevalent view is that healing can best occur if the therapist remains emotionally detached from the client's life and material. In working with vets, though, the opposite is true: If the therapist maintains detachment, the story remains solely the burden of the patient. Therapy becomes effective only when the therapist can affirm that he is personally engaged with the veteran's story and accepts the need to help carry the collective responsibility" (Tick, 2005, p. 238).

According to Lia Gaty, it is essential to tailor responses to the individual veteran. The key may also be to remember that it is the veteran's emotions that are the centerpiece of the relationship. The clinician's reactions cannot be allowed to distract from the central context that is the client's experiences. The clinician can and must have and show emotions, because these emotions reflect common human response to human experiences. These feelings should be genuine, ordinary, matter-of-fact responses to the veteran's experience (Gaty, 2008b).

Two words that come to mind are **dignity** and **openness**. Dignity carries both discipline and balance, and openness challenges the isolation and the stigma. If you can find that balance between empathy and unconditional acceptance of the person and the experience, you will not only fit in better with the military culture, but also help the amygdala loosen its grip.

Talking to the Amygdala: Some experts in the field speak of “talking to the amygdala,” saying things that are likely to calm that frightened, defensive structure deep in the brain and persuade it to refrain from triggering strong stress reactions. But when we are talking to someone affected by trauma, we are *always* talking to the amygdala. It is merely a question of whether or not we are saying what we would like to say.

The amygdala is always scanning our words, gestures, faces, and tones of voice for signs of threat—and using a fairly inclusive definition of threat. Even an expression of anxiety on the face or in the voice of another can trigger the amygdala's alarm system. The clinician's job is to:

- Learn the language of the amygdala
- Use that language to communicate safety and empowerment
- Teach the veteran to do the same

Army Values, Creed, and Code

U.S. Army Values:

Loyalty—Bear true faith and allegiance to the U.S. Constitution, the Army, your unit and other soldiers.

Duty—Fulfill your obligations.

Respect—Treat people as they should be treated.

Selfless Services—Put the welfare of the nation, the Army, and your subordinates before your own.

Honor—Live up to all the Army values.

Integrity—Do what's right, legally and morally.

Personal Courage—Face fear, danger, and adversity (physical or moral).

The Soldier's Creed:

I am an American Soldier.

I am a Warrior and a member of a team. I serve the people of the United States and live the Army Values.

I will always place the mission first.

I will never accept defeat.

I will never quit.

I will never leave a fallen comrade.

I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. I always maintain my arms, my equipment and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American Soldier.

The Soldier's Code:

- I. I am an American Soldier—a protector of the greatest nation on earth—sworn to uphold the Constitution of the United States.
- II. I will treat others with dignity and respect and expect others to do the same.
- III. I will honor my country, the Army, my unit, and my fellow soldiers living by the Army values.
- IV. No matter what the situation I am in, I will never do anything for pleasure, or profit, or personal safety which will disgrace my uniform, my unit, or my Country.
- V. Lastly, I am proud of my Country and its flag. I want to look back and say that I am proud to serve my Country as a soldier.

(From Chapter 4 of the *Operation: Military Kids Ready, Set Go! Training Manual*, posted at http://www.k12.wa.us/OperationMilitaryKids/TrainingManual/Chapter_4_Final.pdf)



Finding Balance

Chapter 6. Important Considerations in Treatment Delivery

“Combat veterans often hold such an apocalyptic-cathartic idea of healing, but before safety, self-care, and sobriety have been firmly established, active uncovering of trauma history only retraumatizes the survivor. Recovery from severe combat more nearly resembles training to run a marathon than cathartic redemption in faith healing” (p. 187).

—Jonathan Shay (*Achilles in Vietnam*, p. 187)

In the healing of trauma, all the forces that once taught the child to handle stress and threat rise up again. The safe human relationship, the body’s balancing act, the realization of one’s own power as a human being, the search for connection and meaning, these and other strengths are enlisted in service of recovery and well being. The clinician can play a vital role in helping veterans find and believe in these vital resources.

This chapter focuses on considerations for treatment and recovery, providing a very brief, very general overview of some things that civilian clinicians might want to consider in planning or refining their approach toward working with veterans. It includes five sections and one pull-out page:

- Building Safety by Building on Resilience
- Avoiding Iatrogenic Effects
- Empowerment and Destigmatization
 - Framing Services For Empowerment and Destigmatization

- Rituals and Reintegration
- Meaning, Purpose, and Posttraumatic Growth

Some of the considerations in this chapter are taken from written works, but more are based on conversations with or presentations by veterans or therapists who work with trauma survivors. The reader is once again encouraged, not to take these ideas as absolute or as the only important considerations, but to respond to them with curiosity and a desire to listen, read, and learn much more.

Building Safety by Building on Resilience

Like others who have experienced intense and threatening experiences, veterans with post-deployment stress effects are always at risk of having even harmless words and events retrieve vivid, painful experiences and trigger powerful chemical reactions. Many can also dissociate or “shut down” when their bodies sense that these powerful chemical reactions are on the way. And for those with co-occurring substance use disorders, their post-trauma effects may constitute ready triggers for binges or return to use of addictive substances.

Herman (1992) identified the development of safety as the first stage of recovery from trauma. Even if your time with the veteran is limited, and safety is the only element you have time to address, helping veterans build safety into their lives can be a huge contribution to their well being.

One way to approach issues of safety is to remember some of the elements that are critical in developing and maintaining human resilience in the face of stress (see Resilience and Vulnerability to Traumatic Stress, Pages 12-24). Here are some examples:

- **Balance** is the essence of the human stress and survival system’s work, and an important element of safety in recovery from trauma. Though that balance has been disrupted by the experience of war, you can help veterans learn conscious techniques for putting their stress systems back in balance.
 - They can learn to notice when their sympathetic fight-or-flight chemicals are rising and “put on the brake” by pulling back, invoking soothing images or affirmations, or temporarily leaving the situation.
 - They can learn to notice when they are shutting down and their parasympathetic systems are taking over, determine if this is happening because they feel unsafe, and take stock of other resources and safety measures that can help them.

- **The ability to separate past from present** is an important function that helps the hippocampus inform the amygdala and keep it under control. Even if that ability has been severely compromised by trauma, you can help veterans learn to:
 - Become observers of their own situations and reactions
 - Ask themselves questions that will help them distinguish past from present experiences
 - Practice techniques that will help ground them in the “here and now”
- **A sense of control over one’s destiny** is one of the qualities associated with stronger resilience to war-zone stress (Herman, 1992). Although people with strong post-deployment stress effects may feel a decided lack of control over even their basic moods and reactions, you can find many large and small ways of helping them regain a sense of control. A few examples are:
 - Establishing non-verbal “stop” signals they can use when the conversation becomes too intense
 - Letting them make informed choices about therapeutic techniques and the focus of therapy
 - Teaching them about the nature of stress reactions, so these reactions become more predictable
 - Providing and directing them to community-based and web-based resources
 - Teaching them techniques for controlling their stress reactions, and giving them chances to practice these skills
 - Providing information about self-care options they can use, like the ones listed in Chapter Eight, “Ideas for Recovery, Re-Balancing, and Self-Care”)
- **Attuned, responsive face-to-face communication** is essential to the development of resilience in the human brain (Schoore, 2001) and equally important in the development of safety in and through the therapeutic relationship. Simply listening and making genuine and responsive eye contact can help build safety and promote recovery (Scaer et al., 2008; Gaty, 2008a).
- **Collaboration** is an important element of resilience to trauma (Herman, 1992) and an important skill in maintaining emotional safety in the therapeutic relationship, and in the world. By being thoroughly collaborative, you can model and teach collaboration and provide a laboratory for its practice.
- **Strong bonds with fellow Service Members** are important protective factors overseas and equally important in building safety in recovery. If veterans are not in touch with other Iraq/Afghanistan veterans in their community, anything you can do to help them find these connections will be important to their emotional safety and well being.

- **A sense of meaning and purpose** is an important element of resilience and an equally important element of recovery. Although you cannot force or create this meaning for the veteran, you can be a witness to and appreciator of his or her own sense of meaning and purpose as they emerge in the therapeutic process. This focus activates the prefrontal cortex and allows it to exert its calming influence on the amygdala.
- **Hope:** A sense of hope and optimism can be a powerful component of resilience and treatment effectiveness (Hubble, Duncan, and Miller, 1999) and an equally powerful element in creating a sense of basic safety. You can foster hope in many ways, including:
 - Taking care not to judge, stigmatize, or “pathologize” their war-zone experiences or post-deployment stress reactions, either through your reactions or the words you use to describe conditions and options
 - Providing information about the success of the approaches you use and encouraging contact with other veterans who have overcome similar post-deployment stress effects
 - Letting the individual veteran choose treatment practices that he or she believes in, something that automatically raises the level of hope and trust in the success of the therapeutic process
 - While not diminishing their challenges in any way, encouraging veterans to make and continue to add to an “appreciation list” or a “gratitude list,” in which they can note anything and everything that inspires even trace amounts of appreciation or gratitude in them; In many ways, gratitude is to the past what hope is to the future, and it can serve as a sort of “pump primer” for hope

Avoiding Iatrogenic Effects

Iatrogenic effects are problems caused by the treatment itself, or by the words or actions of the person delivering it. Trauma of any sort is fertile soil for these effects, given the great vulnerability and reactivity of people’s stress systems and the fragile state of their self-concept. The following are nowhere near the only important considerations, but they may be a good place to start.

Pacing the Processes of Storytelling and Exposure: The amygdala’s unconscious memories are not accessible to conscious processes. “Severe trauma explodes the cohesion of consciousness,” wrote Jonathan Shay in *Achilles in Vietnam*. “When a survivor creates fully realized narrative that brings together the shattered knowledge of what happened, the emotions that were aroused by the meanings of the events, and the

bodily sensations that the physical events created, the survivor pieces back together the fragmentation of consciousness that trauma has caused” (Shay, 1994, p. 188).

Many therapeutic techniques for working with trauma (e.g., exposure therapy, systematic desensitization) involve repeatedly activating traumatic memories and the associated feelings, and teaching clients to monitor and control their stress reactions. However, if this process is allowed to begin before there is a solid grounding in safety, to accelerate too rapidly, or to accelerate beyond the client’s skills in self-management, it is likely to increase traumatic symptoms and/or drive people toward substance abuse or other self-destructive defenses (Courtois, 2006).

Many experts advocate letting veterans choose when and how to tell the stories of their war-zone experiences. In the words of the Iraq War Clinician Guide, “... the best rule of thumb is to follow the patient’s lead in approaching a discussion of trauma exposure. Clinicians should verbally and non-verbally convey to their patients a sense of safety, security and openness to hearing about painful experiences. However, it is also equally important that clinicians do not urge their patients to talk about traumatic experiences before they are ready to do so” (VA, 2004, p. 27).

van der Kolk (1989) also recommends pacing the storytelling process once it has begun. Progressing too quickly can lead to escalation of traumatic symptoms and increased likelihood that he or she will find some way to reenact the trauma in present life. The point of telling the story is to gain conscious control over it, so it is important first to gain control over the secondary defenses that the veteran has used to defend against trauma (e.g., alcohol and drug use, violence against self or others) and to establish a secure bond within the therapeutic relationship (van der Kolk, 1989).

Courtois (2006) warned against the use of methods that provide prolonged and escalating exposure to traumatic cues (e.g., Implosion Therapy, Flooding), as a way of inducing strong sympathetic or parasympathetic stress reactions and then using therapeutic techniques to bring down these responses. Unless the clinician has great expertise in these methods and the client has a strong grounding in safety and management of stress responses, these practices can harm the client and derail the therapeutic process. These methods can be particularly dangerous with people who have complex trauma or DESNOS (Courtois, 2006).

Avoiding Mixed Groups With General Populations: Several safety issues might arise in treatment systems in which group therapy is the norm. Veterans interviewed unanimously warned against placing veterans in groups with civilian clients, consumers, or patients. A therapist may have good control over what he or she says, but generally has no control over what group members might say. Mixed groups have too strong a potential for damaging questions (e.g., “Did you kill anyone?” “Do you think the war was worth it?”).

Even within all-veterans' groups, Lighthall (2008) also recommends not mixing veterans of different wars, different ages, or different phases of the wars in which they served (e.g., not mixing people who served in the early phases of Operation Iraqi Freedom with those whose service began after the onset of the Surge), if this can be avoided.

Monitoring the Need for, and Use of, Medications: When veterans' post-trauma symptoms are not yet stabilized, appropriate medications may be important safety measures. "A number of medications safely ameliorate one or another symptom of PTSD and assist in the achievement of safety and sobriety by reducing the pressure toward self-medication with alcohol or street drugs and, even more valuably, by reducing explosive rage" (Shay, 1994, p. 187).

For example, medicines such as fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) are considered first-line treatment for trauma (Courtois, 2006; Lineberry et al., 2006). Benzodiazepines are used widely to stabilize early hyperarousal symptoms, though they should be avoided with people who have co-occurring substance use disorders or risk of developing these disorders (Courtois, 2006; Lineberry et al., 2006), and they may in some cases make the trauma symptoms grow worse (Scaer et al., 2008; Lineberry et al., 2006).

At this writing, a number of innovative medical remedies for trauma symptoms are also being proposed and tested. For example, a physician in the Chicago area begun to use an injection of the local anesthetic bupivacaine into the sympathetic nerve tissue in the neck (called a **stellate ganglion block**) to treat people with PTSD. This injection, he says, temporarily calms anxiety symptoms by "rebooting" the insular cortex (Hageman, 2008), the structure that assigns emotional meaning to sensory experience.

As the SUD treatment field knows, medication can be both a life-saving tool and—in some cases—a double-edged sword. You can help ensure the safety of your clients' and patients' medical interventions by:

- Keeping up with the growing body of research on psychotropic medicines used in trauma treatment and their use with people who have substance use disorders
- Monitoring reactions to medications and combinations of medications
- Monitoring the potential for dependency on medications (e.g., benzodiazepines given for hyperarousal, pain medications given for injuries)
- Collaborating with the prescribing physicians
- Working with a psychopharmacologist who is well versed in trauma medicine

Friedman (2006) cautioned that, in the clinical trials in which many trauma medications are tested, patients are given a single medication only, while in real life most receive multiple medications.

As important as medication may be to stabilization in some cases, medications can also raise safety issues, especially if:

- The patient becomes dependent on the medication
- The patient is over-medicated
- The wrong medication is used
- Too many medications are used
- The patient is given “competing” medications (e.g., sedatives and stimulants) that trigger different arms of the autonomic nervous system
- The patient is given combinations of medications that cause dangerous interactions in the liver enzyme system (e.g., the cytochrome P450 system)
- The patient is left on medications after they are no longer needed (Scaer et al., 2008)

Former Army Psychiatric Nurse Alison Lighthall reported hearing quite a bit of anecdotal evidence from veterans that some of the medications commonly prescribed have side effects that they cannot or choose not to tolerate. For many of these veterans, marijuana is the medication of choice (Lighthall, 2008).

Empowerment and Destigmatization

Helplessness and powerlessness are vicious components of the traumatic experience, so it is important to look at ways of making your services as empowering as possible and using them to reduce the stigma associated with post-deployment stress effects.

Much of the information in this chapter comes from interviews with individual veterans who not only have served in the wars in Iraq and Afghanistan, but also have worked professionally and/or on a volunteer basis with veterans suffering from combat stress injuries.

Healing the Effects of Stigma in the Military Culture: The military culture has a long history of stigmatizing post-deployment stress effects, in both overt and subtle ways. Many veterans with post-deployment stress effects have deep levels of shame about these effects and fear of having others judge them for their reactions—or for the events that led to those reactions. And the civilian society that now surrounds them holds a strong stigma toward substance use disorders. So the language you use to frame their experiences, their effects, and the work of therapy may have powerful effects on their engagement, participation, and retention in treatment.

Younger Service Members, who often have less experience and grounding in adult civilian life, are in general more likely to be thoroughly steeped in the military culture and the tough, “macho” mind-frame. They are also more likely to:

- Have internalized the stigma toward combat stress injuries
- Resist any knowledge of their own stress reactions
- Have powerful self-stigma and shame about those reactions and their symptoms

Younger veterans will often require the strongest efforts to normalize and destigmatize their experiences, reactions, and symptoms.

A diagnostic label such as “PTSD,” “substance abuse,” “addiction,” or “depression” may or may not be helpful in working a particular veteran. For some, particularly older veterans, the label might be a useful educational tool, putting a name and a knowledge base to an experience that would otherwise have seemed chaotic and menacing. For others, it might be a label of shame that carries with it images of weakness, cowardice, and a life sentence of inferiority.

Words tend to gain toxicity from the negative ways and situations in which they are used (Woll, 2005). Explaining that your words really do not mean all those negative things will not be enough, just as explaining that fireworks are only fireworks does not keep the amygdala from telling the rest of the brain and body to “hit the dirt!”

If you need to use diagnostic labels for reimbursement purposes, you might want to explain them in that context. Then the most empowering approach might be to negotiate with the veteran the words you will both use to describe what is happening.

Empowerment: An important part of empowerment is the right and ability to choose. In the therapeutic process, this includes the ability to make informed choices about treatment approaches and techniques. According to Lighthall (2008), most veterans seeking help for their post-deployment stress effects will be looking for something that is:

- Quick and time limited
- Capable of answering in an empowering way the question that most troubles them: “Am I going crazy?”
- Focused on training and skill building, rather than exploring their traumatic experience
- Likely to provide resources they can seek out and continue to use
- Likely to bring immediate relief to their most troubling challenges
- Capable of giving them the thing they need most—hope

Veterans with these priorities are more likely to seek and accept services that provide education, training, and resources that can give them power over their symptoms. And given the short amount of time many clinicians are able to spend with clients, this may be a safe and rational way to approach treatment. “Framing Services for Empowerment

and Destigmatization (Page 73) offers some ideas for civilian clinicians who want to focus and frame their services in terms of education and training that will help veterans:

- Understand and destigmatize of their post-deployment stress effects
- Learn to prevent, eliminate, and manage symptoms of these effects
- Find internal and external resources for continued empowerment

The military culture is one in which power is of great importance. All forms of helplessness—including all the forms of helplessness that contribute to and spring from the trauma of war—are unwelcome. In general, the more empowering the process is from the start, the sooner veterans will engage and the more likely they are to stay with the process (Lighthall, 2008).

The therapeutic use of images or feelings of helplessness or powerlessness (e.g., metaphors of powerlessness in 12-Step recovery programs) may not be a strong selling point for your approach, at least not at the beginning of treatment. If veterans have co-occurring substance dependence disorders and choose to seek recovery through 12-Step groups, you might want to help them:

- Reframe the concept of powerlessness as something that applies to the ability to drink or use drugs without consequences, rather than the feelings of life-threatening powerlessness associated with trauma
- Focus on the empowerment that comes through reliance on a Higher Power, however they choose to define that Power

No matter how much confidence or pride veterans might bring into your office, they have faced experiences strong enough to jar their stress and survival systems. These experiences—and the violent reactions that arise in their bodies and emotions later—can leave veterans with significant questions and challenges to their sense of:

- Who they are
- What they are worth
- Where they fit in
- Whether or not there is any safety in the world (Herman, 1992).

The better you are at teaching empowerment and removing stigma, the more your efforts will help, no matter what treatment practices you might choose.

Avoiding Confrontive Traditions in SUD Treatment: Although in the past several years most experts have been spreading the message of respectful and empowering treatment, the SUD treatment field had a long early history of harsh, confrontive approaches toward client care. These approaches began in the 1970s, when the early therapeutic communities sought to tear down the addictive ego, believing they could rebuild the human being in more perfect form. This often led to disastrous results (White, 1998).

Framing Services for Empowerment and Destigmatization

A Colorado-based organization called ONE Freedom has been offering some innovative services to returning veterans and service members preparing for deployment, all designed to empower and reduce stigmatization. ONE Freedom offers returning veterans and their families “meaningful education and training on prolonged stress, trauma and personal, self-managed skill-sets for maintaining **strength after service.**” Their education and training programs “re-frame the way warriors and family members experience stress, and provide a normalizing look at why and how we are changed by our experiences and what we can do to positively move forward” (www.onefreedom.org).

In an interview, ONE Freedom Consultant (and Desert Storm veteran) Steve Robinson offered a number of the organization’s ideas and options for framing and shaping the therapeutic process:

- Frame and speak of ideas and practices in terms of training rather than therapy. Service Members “train up” before deployment, so now it is time to “train down” to function effectively in civilian life. This immediately normalizes and destigmatizes both their presenting conditions and the therapeutic process.
- Use a performance optimization model, like the model used in the military. The veteran seeking therapy may be admitting what the military culture defines as a weakness. But the veteran seeking training is becoming a better representative of the Armed Forces by optimizing performance in the home environment, and the peace environment.
- Frame the skills and insights gained as “resources,” a term compatible with the military culture. Help the veteran identify and gain access to resources, within him/herself, within the family, within the community, within the military and veterans’ community, and within the nation.
- ONE Freedom uses the terms “combat brain” or “survival brain” to identify the amygdala’s action in triggering the sympathetic and parasympathetic stress chemicals. The task of “training down,” then, is to down-regulate the combat brain. You are also providing post-combat stress-management training.
- Speak in terms of understanding the brain and the body. Speak of regulating the autonomic nervous system, helping restore it to balance, homeostasis, resiliency, and normal functioning.
- Rather than speaking of the trauma that veterans have experienced, frame these as “intense life experiences.” You are helping them learn better ways of negotiating their present and past experiences—and better ways of identifying and maintaining the boundary between the two.
- The word “balance” is a non-stigmatizing one that has many uses, including a balanced stress system, balanced energy levels, balanced emotional energy, balance in terms of habits (e.g., drugs, alcohol), and balance in sleep cycles.
- You may already use the metaphor of becoming an observer of one’s own thoughts and emotions. This is particularly crucial with veterans who have post-deployment stress effects, because of the suddenness and savagery with which the amygdala’s unconscious feelings and memories will intrude on the present and distort people’s thoughts, words, and actions.
- Avoiding all judgmental words is a good idea. If, for example, a veteran describes an outburst with a family member, it is better to avoid the question of whether his or her words or actions were “good” or “bad.” Instead, the question might be, “Was this choice helpful or not helpful?”
- When a client becomes more comfortable with trauma terminology, it can be gradually introduced. But you will still want to take care to help reframe it from the “defective soldier” model to something that reflects both the realities of the human stress system and the honor of the individual veteran.
- In this collaborative educational process, it is important to remember that the clinician does not “hand the solution to the veteran.” Instead, you negotiate together to work toward a solution, once you both understand the options.

ONE Freedom has developed these approaches based on work with large numbers of returning veterans and pre-deployment Service Members. According to Robinson, they have found that these approaches fit in well with the military culture and promote greater engagement, even among people who would be inclined to avoid anything that looks or sounds like “therapy.”

For SUD treatment practitioners serving veterans with post-deployment stress effects, the warnings against these confrontive approaches are even stronger. Given the easily kindled stress systems and badly shaken self-concept that many veterans bring home with them, it is essential to leave all traces of harsh confrontation behind, replaced with respect and empowerment.

Rituals and Reintegration

For many reasons, and on many levels of human experience, ritual is an important tool in recovery from substance use disorders, post-deployment stress effects, and other conditions related to challenges to the human stress and survival system. Ritual is certainly a strong element in the cultures of addiction and recovery (White, 1996), with a variety of rituals prominent in the many mutual-help recovery options. Clinicians can choose clinical practices that include elements of ritual (e.g., Mindfulness training, visualization, somatosensory practices) and recommend positive rituals (e.g., faith traditions, Mindfulness, yoga) in recovery and self-care. They can also work with veterans, empowering them to establish healing rituals within their lives, families, support networks, and communities.

Ritual and the Brain: Elsewhere in this Guide (see “Resilience and Vulnerability to Traumatic Stress”), several brain structures have revealed themselves as particularly important to the balance of our stress and survival systems. Positive ritual can have strong positive effects on the functioning of many of these structures, particularly the amygdala, the prefrontal cortex, and the anterior cingulate gyrus (Siegal, 2007).

The amygdala is an essentially concrete structure, storing and retrieving bites of sound, scent, images, and raw emotions. It does not understand concepts, but badly needs evidence of basic safety before it will stop throwing out frightening fragments of memory and triggering powerful surges of stress chemicals. Ritual is made up of concrete, symbolic words, silences, sounds, scents, stories, gestures, movement, artifacts, etc. Ritual talks to the amygdala in a language it can understand. And positive rituals speak of safety and comfort (Scaer et al., 2008).

Ritual also reaches the all-important prefrontal cortex (PFC), whose GABA fibers can descend to the amygdala and provide comfort and soothing. Some rituals (e.g., Mindfulness) have been shown both to focus the prefrontal cortex and to promote cell growth in both the PFC and the anterior cingulate gyrus (Siegal, 2007).

Finding Rituals: For the individual veteran, therapist Eduardo Duran recommends a simple approach: “Find a place in your home or yard, and designate it as a sacred space. Give your offerings to the earth or whatever you believe in, trying to correct what

has been done.” According to Duran, rituals and ceremonies are everywhere, but the challenge is to replace the “dysfunctional” ceremonies—like those used in addiction—with healthy ones.

Storytelling can be an important ritual, particularly among people with shared experiences, like groups of veterans.

In *War and the Soul*, Edward Tick wrote that “When we tell our own stories and listen to those of others, we come in touch with all three: life, divinity, and soul. Telling our story is a way of preserving our individual history and at the same time defining our place in the larger flow of events. It reveals patterns and meaning that we might otherwise miss as we go about the mundane activities of living; it invites us to see the universe working through us. Storytelling also knits the community together. It records or re-creates the collective history and transforms actor and listeners alike into communal witnesses” (Tick, 2005, p. 217).

Rituals in Community: Bonding and affiliation are important components of:

- Resilience to stress and trauma
- Recovery from post-deployment effects, substance use disorders, and other common aftereffects of war.

As strong as the bonding within the Unit might have been, the sense of alienation and isolation back home can be equally strong (Armstrong, Best, and Domenici, 2006).

One of the civilian clinician’s challenges is to find ways to encourage veterans to find positive rituals in the family and the community—and to encourage families, communities, and communities of faith to form positive rituals for welcoming veterans home. “We must witness for and initiate each other,” wrote Edward Tick. “Our transformations are not completed in solitude; they are honored in public and integrated into the culture as its shared history” (Tick, 2005, p. 217).

According to veteran and trainer-of-veterans Steve Robinson, the importance of ritual in trauma recovery is something ancient cultures understood, but contemporary American society has largely missed. “We have no traditions in 21st-century culture to deal with traumatic experiences, so we all end up having to deal with them on our own, because we have no cultural ritual. There needs to be a call to action. We as a society need to develop a ritual for negotiating life’s intense experiences that is understood by all. Each culture may do it differently, but it provides a place to go when these things happen.”

Native American Reintegration Rituals: Many who work with traumatized veterans have studied and admired traditional Native American rituals for welcoming and reintegrating warriors back into the tribe. These healing ceremonies generally addressed both body and mind, reflecting a tendency not to make any sharp distinctions between the two (Silver and Wilson, 1996). Although these rituals would not be

accessible to veterans of non-Native cultures, they illustrate some ways in which ritual can be used to address the effects of war.

“The wisdom of such rituals lies in their ability to decondition the intense emotions produced and learned in combat. Ritual purification, embedded in cultural meaning, begins the process of transformation in identity and role expectation. Moreover, ceremonies and rituals for both preparing warriors for battle and reintegrating them into the tribe not only acknowledge combat reactions but also rely heavily on the participation of the family, clan, and tribe” (Silver and Wilson, 1996, p. 303).

Reintegration within the tribe does not mean returning to one's previous state as if nothing had happened, but rather the taking on of a new role that often includes self-discipline, leadership, and generativity (passing knowledge and wisdom on to the next generation). This improvement in the warrior's status reflects this new wisdom, reframes what would otherwise be seen as a negative experience, and addresses survivor's guilt by providing opportunities to make atonement through service and contribution to the tribe (Silver and Wilson, 1996).

Meaning, Purpose, and Posttraumatic Growth

Traumatic Growth: “Traumatic growth” is one term that has been applied to the positive life change that sometimes comes out of trauma or life crisis. While the term “resilience” implies a return to earlier levels of functioning, the terms “thriving” and “post-traumatic growth” both suggest the development of something higher and more desirable (Chesler, 2003). According to Chesler, the development of a coherent narrative is an essential element of post-traumatic growth, allowing people to make sense of their experiences and integrate them into conscious memory (Chesler, 2003).

In his interview, psychologist Eduardo Duran spoke at length about the effects of the experience of killing on the post-deployment lives of veterans. He also spoke of the healing that many veterans in his care—including himself—had experienced. A Vietnam veteran, Duran told the story of a suicide conference a few years ago, in which participants were discussing the act of asking forgiveness from people they had harmed. In a group setting, Duran found himself facing one of the other participants, a Vietnamese man. “I basically looked at him and asked forgiveness for my role in hurting his people. It was really a profound shift, both for me and for him. It was a spiritual moment.”

In one review of 39 empirical studies that reported positive change after trauma and adversity—something that the Linley and Joseph called “adversarial growth”—they found adversarial growth to be associated with:

- Cognitive appraisal variables (the way people's interpretations of events affect their feelings about those events)
- Coping through problem-focused acceptance and reinterpretation
- Optimism
- Religion
- Cognitive processing
- Positive affect (Linley and Joseph, 2004)

Shaw, Joseph, and Linley (2005) found 11 empirical studies that identified connections between religion, spirituality, and post-traumatic growth. Their review showed them that:

- Religion and spirituality can help people address the aftermath of trauma
- Traumatic experiences can affect people's religious or spiritual lives
- Post-traumatic growth is often associated with positive religious coping, religious openness, willingness to face existential questions, religious participation, and intrinsic “religiousness”

Meaning and Purpose: As safety is the foundation of effective treatment of trauma, SUDs, and other challenges, the finding of new meaning and purpose is often its crowning achievement. Although clinicians will have many more concrete tasks to attend to in serving returning veterans, it is also essential to be on the lookout for these moments of grace and transcendence that sometimes arise at unlikely times.

The generation of meaning from adversity has long been a cherished concept in the field of recovery from substance use disorders (Kurtz, 1979; Kurtz and Ketcham, 1992; White, 1998). The history of this field is rooted in partnership with mutual-help recovery groups that:

- Named addiction as a disease long before science was able to provide the evidence that it now possesses
- Have successfully harnessed psychological and spiritual growth as effective tools for recovery from what is essentially a neurological challenge
- Have now become partners with the treatment field in grassroots and nationwide efforts to transform systems of care for people who need recovery (White, Kurtz, and Sanders, 2006; White, 2007)

Ernest Kurtz and Katherine Ketcham characterized a central force in recovery as the “spirituality of imperfection.” In their words, “The spirituality of imperfection speaks to those who seek meaning in the absurd, peace within the chaos, light within darkness, joy within the suffering—without denying the reality and even the necessity of absurdity, chaos, darkness, and suffering. This is not a spirituality for the saints or the gods, but for people who suffer from what the philosopher-psychologist William James called ‘*torn-to-pieces-hood*’” (Kurtz and Ketcham, 1992, p. 2).

Many people in the field of trauma recovery have also recognized the importance of meaning and purpose in the healing of post-trauma effects. Not the first to articulate this concept, but certainly one of the most eloquent, was Viktor Frankl in *Man's Search for Meaning*, the story of his imprisonment in Auschwitz during World War II. For example, Frankl wrote of a breakthrough that a fellow prisoner had experienced in the process of grieving for his wife: He found peace when he realized that by surviving he had protected her from the experience of his death (Frankl, 1984).

According to Frankl, even trauma itself can provide a foundation for meaning and purpose. "The way in which a man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity—even under the most difficult circumstances—to add a deeper meaning to his life. It may remain brave, dignified and unselfish" (Frankl, 1984, p. 76).

Silver and Wilson (1996) wrote that "For some veterans, their old view of reality is forever shattered by war trauma, inevitably creating the need to reformulate the existential meaning of life itself as well as their role in it. Thus, war can alter individuals in many ways, depending on events in the postwar recovery environment. Some men never come home from war. Others become more fully human and wiser" (Silver and Wilson, 1996, p. 299).

But to think of new meaning as simply an element in the resolution of the traumatic experience would be to oversimplify the healing from trauma, just as so many tend to oversimplify the experience of trauma. Sometimes the traumatic experience itself "clears the way" for meaning and purpose that we would not have found otherwise.

Trauma has a way of shattering those three fundamental assumptions that Janoff-Bulman identified, "The world is benevolent; The world is meaningful; The self is worthy" (Janoff-Bulman, 1992, p. 6). The healing process forges new meaning, and it is the shattering and reshaping of meaning that can make way for more authentic and sometimes transcendent growth.

According to Janoff-Bulman and Berg (1998), "Survivors commonly experience the terror of a shattered, malevolent world, as well as the gratification of a deeper, more meaningful existence. They move from perceiving a meaningless universe to creating a meaningful life, and this journey involves a potent and disturbing process of disillusionment. It is not simply that some trauma survivors cope well and perceive benefits *in spite of* their losses, but rather that the creation of value and meaning occurs *because of* their losses, particularly the loss of deeply held illusions. In the end, survivors often feel both more vulnerable and more appreciative, two states that are fundamentally linked" (Janoff-Bulman and Berg, 1998, p. 35).

This is the end of Study Guide 1 for Course 5L. You may take the quiz for Study Guide 1 now, by going back to the Study Guides and Quizzes page for this course, and clicking on TAKE QUIZ, for Study Guide 1.

OR, you can move ahead to Study Guide 2 in this course, and return to take the quiz for Study Guide 1 later.

You must pass both quizzes [one each, for Study Guides 1 and 2] AND complete and submit the Feedback Form, before you can download your certificate.