PTSD 101
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COURSE TRANSCRIPT FOR:
Posttraumatic Stress Disorder for the Primary Care Clinician: Focusing on OIF/OEF Returnees

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Slide 1: Posttraumatic Stress Disorder for the Primary Care Clinician: Focusing on OIF/OEF Returnees

Welcome, everyone. The title of today's presentation is Posttraumatic Stress Disorder Techniques for the Primary Care Clinician. My name is Dr. Greg Leskin. I'm from the National Center for PTSD of VA Palo Alto Health Care System.

Slide 2: Introduction

Today you'll be hearing about some of our integrated primary care projects, and how we have here at Menlo Park built integrated models of care for posttraumatic stress disorder treatment within primary care and medical clinics. The focus today will be on coordination of mental health teams within primary care clinics. The integrated primary care projects create multi-disciplinary behavioral health teams that include the primary care provider, nursing, behavioral or mental health, and chaplains to actively screen and treat PTSD within the primary care setting. The emphasis on treatment within these settings is small steps, and I'll talk more about that in a minute.

Slide 3: What is PTSD?

PTSD is post-traumatic stress disorder. It's an anxiety disorder observed in people who have been exposed to extreme stressors such as combat, but not exclusively to combat. Other kinds of stressors can include sexual assault, motor vehicle accidents, natural disasters, physical assault, and even invasive medical procedures.

Slide 4: Posttraumatic Stress Disorder (PTSD): Overview

PTSD is one of many different ways a veteran can manifest chronic post-war adjustment difficulties. Those exposed to trauma may also be at risk for major depression, substance abuse, aggressive behavior problems, and the full spectrum of severe mental illnesses precipitated by the stress of war. In addition, some individuals may exhibit symptoms more consistent with medical problems, such as pain, gastrointestinal symptoms, headache, and present to the primary care clinician with these complaints.

Slide 5: Core Symptoms of PTSD

Symptoms of PTSD include intrusive memories, flashbacks, nightmares, and triggered emotional responses. There might be marked avoidance to discuss the event with others, or even to think about the event. Physiological hyper-arousal is also evident, and may reflect the continued alarm/fear system that the individual exhibited at the time of the trauma. This may be manifested in sleep problems, in over-exaggerated startle response, irritability, and general nervousness.

Slide 6: Accompanying Symptoms

Accompanying symptoms of PTSD may include survivor guilt, marked depression comorbid with PTSD, interpersonal difficulties such as an inability to relate to others, even close ones like family or spouse. Existential pain and conflict, really a sense of angst, a sense of loss of future, loss of a future orientation or hope about the future. As noted earlier, substance abuse is often comorbid with PTSD as the individual uses drugs, alcohol, pharmaceutical medications to damper the strong effects of the PTSD symptoms. And finally, physical health problems and complaints.

There's now growing literature to suggest that PTSD and trauma are very closely associated with some specific medical problems, and the individual may seek out the care from a primary care provider for these kinds of medical problems, and underlying these medical problems are PTSD symptoms. This is one of the rationales the National Center for PTSD has taken to built more treatment services within the primary care setting.

Slide 7: Example

The next is an example. A 23 year old US Army private returns home following his 2nd combat tour, is observed becoming agitated at his children while shopping at a local community market. Once at home, he remains unusually quiet throughout the evening until later that night, while watching the news, begins to cry and states "This is ALL so wrong!"

Slide 8: Example

After several hours of difficulty falling asleep, he awakes suddenly following a combat-related nightmare in which he is holding one of his children under one arm and an Iraqi child under the other, and they are frantically running for their lives. When his wife asks him if he would consider talking with a base doctor, he refuses and stomps out of the house. As you can see from this example, the individual exhibits many of the classic symptoms of PTSD, including nightmare, difficulties relating to others, irritability, and avoidance, marked avoidance to discuss or seek care for PTSD.

Slide 9: Putting the Soldier in Context

So let's put the soldier, the active duty soldier into context.

Slide 10: What is unique about current fighting force?

Well, despite a wide variation in age, many in the fighting force were born between 1983 and 1984, so the mean age is approximately 21 to 22. These are individuals that were born in an age of great technological advances and globalization, including instant access to information via the web, digital imagery, and cable television. There's been tremendous advances in military weaponry. This may have an influence on the kinds of injuries that individuals receive, including blast-related injuries. There's been constant conflict in the Middle East, in the Gulf War, and the end of communism, and September 11th. These are all events that will mark this generation of soldiers fighting in the current Iraqi conflict. This has also been an age of great wealth and growth in the United States. These individuals, the majority of individuals fighting in the marines and the army are, are very determined to succeed, are very ambitious, and well-informed. It's important to remember these kinds of attributes to this generation of soldiers as we develop interventions and have discussions with these individuals to understand how their belief systems about what they've gone through and the symptoms they have may affect the kinds of treatments that they are seeking.

Slide 11: Demands and Stress of the War Zone

The demands, stressors, and conflicts inherent in any combat operation can also be traumatizing, spiritually and morally devastating, and potentially transformative in damaging ways.

Slide 12: What unique aspects of the Iraq War are possible sources of stress?

We might think about combat stressors from three different levels. The first is direct. Those are the kinds of events where the individual has been directly affected by the event. The in-the individual has been, for example, injured. The individual has been sexually assaulted, or in a motor vehicle accident, or has fallen in a way that puts that individual at risk. These are examples of direct kinds of combat exposure. The individual may have witnessed the death or injury of another soldier, of an enemy combatant, or even civilians. And finally, vicarious. The individual has learned about another person being killed, another person being seriously injured, and just the knowledge of the loss of a buddy, the loss of someone close to them, has the ability to affect the individual in a traumatizing manner.

One would also want to consider the general stressors of combat, such as the deployment itself. What does that deployment, what does the prolonged separation mean to the individual? Are they leaving a spouse, a family behind? Are they concerned about the family's welfare? Are they concerned that they're unable to take care of their family during their absence, and how does this affect the individual's ability to cope to combat situations, as they consider their family and their children and their friends at home?

Also, what about environmental features? What I sometimes refer to as the low magnitude features. These may be the everyday stressors. The head, the dust, the wind. For Vietnam soldiers, it was often the, the rain that, on a daily basis, created havoc. It was a, a nuisance for Iraq, in terms of the desert warfare. It really might more be a focus on the heat and the dust and the sand that can affect the individual, and over time, reduce the individual's ability to cope with more high magnitude stressors. It's important to understand the individual's sense of the mission

objectives. For the Iraq war, sometimes the mission objectives have changed. How has the individual thought about their own role in the military, in relationship to the more global aspects of the mission objective?

Slide 13: Complex Interplay of Influences

These contribute to what I believe is a complex interplay of influences. The individual is coming to the combat event with specific pre-military risk factors, as well as resiliency factors. Some of the risk factors include family instability and conflict, early childhood trauma. But also, the individual comes to these events with resilient factors. Resiliency factors include their own hardiness, their own ability to be committed and determined and hopeful for positive events. The individual may also come from a, a very supportive background, in which they learn to cope with stressors, and they, they may also come from backgrounds that never allowed them to learn to cope with more extreme stressors when they occur. So each of these may contribute to either risk or resiliency.

As we discussed earlier, this, the, the stress of war, the traumatic stressors may include the combat itself, or injuries. Witnessing or participating in things that sometimes are referred to as atrocities. The perceived threat of injury or death, and as I just mentioned, everyday discomfort. And more and more, the unit culture, the military family, one's, one's battalion, one's unit, may provide comfort, support. It also may afford the individual a risk if their, if that unit culture has broken down.

What are the post-war risk and resiliency factors? Well, certainly research would suggest that social support is the strongest resiliency factor when the individual perceives the availability of a support system. People to talk to, people to, to discuss what has occurred. Distressing events, ongoing stressors following combat may, may serve to put the individual at great risk for PTSD. As they try to cope with returning home, and they face ongoing financial stress, family stress, occupational stress, these, these kind of ongoing stressors following combat seem to contribute to poorer outcomes for the individual.

Slide 14: What unique aspects of the Iraq War are possible sources of stress?

What unique aspects of the Iraq War are possible sources of stress? Traumatic events need to be seen in the context of the totality of roles and experiences in the war-zone. Research has shown convincingly that while exposure to trauma is a pre-requisite for the development of significant PTSD, it is necessary but not sufficient. There are a host of causes of chronic PTSD. In terms of war-zone experiences, perceived threat, such as "I thought I was going to die"), low-magnitude stressors, exposure to suffering civilians and exposure to death, have each been found to contribute risk for PTSD.

Slide 15: DSM IV Criteria for PTSD

Establishment of a Criterion A Stressor. Criteria A Stressor is the traumatic event, and we'll talk more about that in a moment. But the Criteria A Stressor, the trauma, is related to these three specific symptom criteria: intrusive memories, avoidance, and hyper-arousal. Two, there is an

emotional reaction, sometimes thought of as a fear-based reaction, in relationship to the traumatic event. That is, not only is the individual exposed to the trauma, but they have an emotional reaction at the time or around the time of the trauma. And finally, there is a significant change in global functioning related to the Criteria A Stressor, meaning this is a significant event for the individual in their development, and marks a shift in their ability to function.

Slide 16: PTSD: Diagnostic Criterion-A: Traumatic Event

Let's go over the actual Diagnostic Criteria. Criteria A states, the person has been exposed to a traumatic event in which both of the following were present. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the integrity of self or others. Criteria A two includes the person's response involved intense fear, helplessness or horror.

Slide 17: Components of Criterion-A

What are some components of Criterion A? It should be emphasized that the trauma of war is colored by a variety of emotional experiences, not just horror, terror or fear. Other emotions such as sadness about losses, or frustration about bearing witness to suffering, tremendous guilt about personal actions or inactions, and anger or rage about any number of facets of war, including the behavior of the enemy, or command decisions, may also meet Criteria A too, or as the emotional reaction.

Slide 18: PTSD: Diagnostic Criterion-B: Reexperiencing

Let's now turn to the symptom criteria. Criteria B Reexperiencing includes recurrent and intrusive distressing recollections, sometimes known as intrusive memories, intrusive thoughts. Nightmares, sometimes referred to as combat-related nightmares, may occur at any time during the sleep cycle, typically awaken the individual from sleep, and are very distressing when they occur. Flashbacks are almost a composite symptom. They, they include the sudden belief or, or perception that the individual feels that they are back in the actual traumatic situation. Intense psychological distress at exposure to reminders or the event, and intense physiological distress at exposure to reminders of the event, are the two triggered emotionally conditioned, conditioned emotional responses. Oftentimes referred to simply as triggers to the traumatic event.

Slide 19: PTSD: Diagnostic Criterion-C: Avoidance

Criteria C Avoidance involves persistent avoidance of stimuli associated with trauma and numbing of general responsiveness. These include efforts to avoid thoughts, feeling or conversations associated with the trauma, efforts to avoid activities, places, or people that arouse recollection for the trauma, inability to recall an important aspect of the trauma, oftentimes refer- referred to as psychogenic amnesia, diminished interest or participation, feelings of detachment or estrangement, restricted range of affect, and a sense of foreshortened future.

Slide 20: PTSD: Diagnostic Criteria-D, E and F

Criteria D includes difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and finally, an exaggerated startle response. The duration of the disturbance is more than one month. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Slide 21: Symptoms of PTSD

As noted earlier, some of the core symptoms of PTSD include difficulty falling or staying asleep, perhaps due to avoidance of nightmares, perhaps a function of staying hypervigilant. Quite possibly, it can be a self-learned technique for controlling symptoms, that is the individual attempts to exhaust themselves, exhaust their personal resources to a point where they are able to control some of the more exaggerated symptoms.

Slide 22: Symptoms of PTSD

As noted earlier, irritability or outbursts of anger may be from a sense of loss of control, sometimes coupled with fear of even greater expressions of anger or hostility. Sometimes these feelings of irritability or anger might be related to certain themes that arise for the individual, such as, such as a sense of betrayal, unfairness, or violation of rights. The irritability or anger can also be triggered by reminders of the traumatic event, and these reminders may be actual reminders or even symbolic reminders for the individual.

Slide 23: Symptoms of PTSD

Turning now to hypervigilance. Hypervigilance is really an excessive attention to external stimuli beyond that called for, given a realistic appraisal of the level of external threat. For an example, veteran, a veteran may never sit with his back to others in a restaurant, or an assault victim may constantly, constantly be looking around as they walk down the street. In evaluating hypervigilance, it's often important to distinguish between paranoid treads or ideation or generalized suspiciousness.

Slide 24: Communication Disconnects

There may also be what is sometimes referred to as communication disconnects. That is, there may be not only the presence of PTSD, but there may also be attention on broader implications or meaning for the individual of these continued symptoms. Sometimes this may bring about issues of stigma, for example.

There may be a disconnect between the acute symptoms, and the meaning or consequences of PTSD for the individual. There may be associations for the individual for having nightmares, having these flashbacks, having intrusive thoughts, which may bring up feelings of one's ability to tolerate stress, one's belief in one's own ability to have gone through combat and still have those memories or thoughts.

There may also be a communication disconnect between the individual in terms of their military unit as their family, and their spouse or parent as family. The individual may feel as if they're

unable to communicate about the PTSD to, for example, the spouse or the parent, because as many individuals who suffer through trauma will say, you can't understand my experience, or I don't want to talk about it because of the stigma associated with having such symptoms.

I believe that the communication disconnect, the inability to talk about it because of the stigma, because of a belief that one can't understand one's experience because others haven't been through it, one hasn't walked in another person's shoes, is actually an important aspect of the disorder that needs to be addressed.

Slide 25: Clinical Care for Returnees

So how do we provide clinical care for returnees? As is being done currently in the military, in the post-deployment health questionnaire, as well as within many VA settings, routine screenings are being provided in medical settings. Screenings include asking individuals in a brief format whether they are experiencing specific symptoms, specific core symptoms of PTSD. Brief interventions can be conducted by the primary care physician, and messages of support can be provided throughout the health care process. We recommend providing a blend of services throughout a continuity of care. These can include psycho-educational groups, providing informational pamphlets and resources, both in waiting room areas, directly to the individual and their family, as well as made available to other key persons in different, different or healthcare arenas. And more and more, we're recommending more intensive integrated clinical services that can include group therapy, family treatment, and individual treatment approaches.

Slide 26: Strategies to Assess PTSD

What are some strategies to assess PTSD? This largely depends on the context and the model of care delivery. Today, I'm focused on the medical care and primary care, or integrated care setting, but can include these other kinds of mental health care settings.

Slide 27: Strategies to Assess PTSD

Use of screens and detection and surveillance have different uses and reasons. One use may be to be able to take a population-based approach to care. A population-based approach to care assumes that in a population of healthcare-seeking individuals, that a certain percentage of those individuals may suffer from a specific disease or disorder, and that by providing more intensive screening for the disorder, that that issue can be addressed by the healthcare system. Further, by addressing that disease or disorder within the population, the reduction in those symptoms or that disease stay will benefit both the individuals who have the disease or the disorder, as well as the healthcare system itself, by addressing and reducing symptoms which may be causing healthcare-seeking behavior.

Screens and detection devices, such as 4 item screens that I'll be showing in a moment, should be brief and highly predictive. That is, individuals who endorse three symptoms or more might be referred to a behavioral health specialist for more intensive assessment and/or treatment.

Staff should be educated about the rationale for addressing and screening for PTSD. We have developed a 4 item screen that takes only a few moments for the individual to endorse or not endorse, and this may be used routinely for all individuals seeking healthcare in a primary care or medical setting. This may be advantageous over, for example, a more comprehensive PTSD scale that covers all the symptoms, and that it's brief. it's highly predictive of these 17 items, and the individual who endorses just a few of these items may be referred for more intensive assessment.

Slide 28: PTSD Primary Care Screen

So let's look at the PTSD primary care screen. The PTSD primary care screen was developed in Menlo Park by doctors Annabel Prins and Rachel Kimerling. The psychometric properties of this instrument, the screen, have been published, and the screen reads, the patient is considered a positive screen if they endorse three of the following questions. Have you ever had an experience that was so frightening, horrible or upsetting that, in the past month, you have had nightmares about it or thought about it when you did not want to? Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Were constantly on guard, watchful or easily startled? Or finally, felt numb or detached from others, activities or surroundings?

Slide 29: Single Item Screening in Primary Care

The next screening, you'll see a single item screening in primary care. This is a couple of questions that a primary care provider, even in their busy schedule, can ask an individual if they suspect PTSD. Have you been spending a lot of time thinking about your recent mission or operation? Or, do you get upset when you remember or think about things that have happened in the past? Even an endorsement of one of these single items may be appropriate to refer to behavioral health services for a more extensive screening.

Slide 30: Assessing PTSD

In addition, it's important to examine factors influencing symptoms, both within the individual's environment, as well as internally, such as thoughts, emotions, and listen for the reaction to these symptoms, as well. For example, what does it mean to the individual that they are having these symptoms? Again, going back to the communication disconnect between the individual symptoms themselves, and the meaning of those symptoms to the individual.

Ask the individual, what makes it worse? For example, are there external triggers, like watching the news, or performing duties that are part of the individual's normal routine, or even seeing the doctor? Are there internal triggers, such as poor sleep or anger or stress that are making these symptoms worse for the individual?

Inquire about what makes it better. Does spending time with the family, taking a walk, going to the beach, being with other people are these external features that help the individual to relax or be more positive in terms of their emotional state? What about internally? Does a good night's sleep, or replacing unpleasant thoughts with pleasant thoughts, make the symptoms better? And

being able to find out these kind of experiences from the individual is important to strategize for the individual in the primary care setting.

Slide 31: Brief Psycho-Education Intervention

Providing a brief psycho-educational intervention may be an important first intervention for the individual. These are some examples of what to say. Your symptoms seem to be a combination of having, for example, these nightmares or memories of combat, and your reaction to these memories. Other examples can be poor sleep or low mood, irritability, poor memory, poor concentration, stress, tension, or low libido. It seems that these are just as bad as the symptom itself. While we are working on improving these symptoms, you can begin working on your reaction to these symptoms by thinking about your goals and making plans for the future, exercising, and thinking about ways to reduce your stress.

Slide 32: Addressing Concerns about Disclosure

Also important is addressing concerns about disclosure. Asking the individual about previous positive or negative experience about talking to others, in relationship to painful experiences. Finding out about beliefs or expectations about discussing trauma with professionals and family. And also, finding out about beliefs the individual may have about their ability to cope with discussions surrounding traumatic events. Oftentimes, individuals who've experienced trauma-traumatic events will describe feeling that if they begin to open up, that they will lose control, that they will begin to cry, that they will not be able to stop or have control over the emotions once they begin.

Slide 33: Talking About One's Experience

Verbalizing feelings and thoughts about a potentially traumatic event is likely to impose a logical narrative structure onto memories that might otherwise be stored in a disorganized fashion, and to facilitate the integration of thoughts and feelings about the event. Self-disclosure is also likely to expose the discloser to the intense emotions associated with the experience, which may serve to facilitate the extinction of the strong affect tied to the event.

Slide 34: To Disclose or Not to Disclose?

To disclose or not to disclose? Self-disclosure about events to, for example, a partner or a spouse, family or friends, or other military personnel, has been related to lower levels of PTSD severity. The reactions to self-disclosure by partner or spouse, family, friends, or other military personnel were significant associated with PTSD severity. In each instance, more positive reactions were related to lower levels of PTSD symptoms. That is, individuals who provided a non-judgmental safe environment for the individual to discuss their experiences and, and felt supported, was related to lower levels of PTSD.

Slide 35: To Disclose or Not to Disclose?

No differences were detected in PTSD symptoms between veterans whose disclosure were met with an overall negative or non-validating response, and those who did not disclose at all. This later finding suggests that negative or non-validating responses by others to self-disclosure may negate the potentially beneficial effects of discussing the experience. However, it may also indicate that there are equally negative effects of not disclosing when the alternative is disclosure followed by a negative response.

Slide 36: Creating an Atmosphere of Safety

Most importantly, creating an atmosphere of safety is an essential ingredient to reduction in PTSD symptoms. Concerns about confidentiality should be and must be acknowledged, and steps taken to create the conditions in which a returnee will feel able to talk openly about their experiences, which may include difficulties with commanders or experiences with other soldiers, misgivings about military operations or policies, or possible moral concerns about having participated in the war.

Slide 37: State of Transition

The individual is going through what we refer to as a state of transition. The returnee is in a state of transition from war zone to home, and clinicians must seek to understand the expectations and consequences of returning home. Is he or she returning to an established place in society, to a supportive spouse or cohesive military unit? Or are they returning to financial stress? Are they returning to an American public thankful for his or her service, or are they feeling as if they are alone, and unable to talk to others about their experience? Are there concerns about redeployment? Given the current redeployment phases of many active duty soldiers, the time when they are stateside, this may be a good time for the individual to think about doing some of this recovery work, to discuss what has occurred during the more recent and previous combat experiences.

Slide 38: Key Points to Address in the Readjustment Period

Key points to address in the readjustment period. This is a quote from Yerkes & Holloway. “The deployment of the family member creates a painful void within the family system that is eventually filled (or denied) so that life can go on. The family assumes that their experiences at home and the soldier’s activities on the battlefield will be easily assimilated by each other at the time of reunion and that the pre-war roles will be resumed. The fact that new roles and responsibilities may not be given up quickly upon homecoming is not anticipated.”

Slide 39: Offer Practical Support

What can we do in primary care settings to help the individual to, through this state of transition? Returning soldiers may feel overwhelmed with problems related to family and friends, finances, and physical health concerns. The presence of continuing negative consequences of deployment may help maintain or even exacerbate war-zone stress reactions. Rather than treating these as distractions, clinicians can provide a valuable service by helping soldiers identify, prioritize, and execute action steps to address their specific problems.

Slide 40: Practical Support

Educating/assisting soldiers to disclose combat events with spouse, parents, children, friends, even strangers. Part of the work with a returnee is to develop stories that they can tell to each of these different individuals. For example, the individual may not want to disclose all of their combat experiences to the people in their life, and part of the work can be to develop a story that feels comfortable to share with parents and the spouse. being able to develop a story that one can share with one's children that is respectful for the child. For example, daddy was away for a long time serving in the United States Army. He's back now and he's okay. That is a, a story that can be shared with children that is respectful to the child, and helps the child to make sense of what their parent's experience has been, without necessarily exposing the individual, other individuals to, perhaps, some of the more grisly details of combat.

Encouraging full disclosure with trusted confidantes is also important, whether that be someone in the individual's immediate environment, or a clinician or therapist or chaplain. That, having people that one can discuss all the details of one's combat experience is vitally important to recovery.

And also provide education to spouse and families about expectations. The individual may return home to a honeymoon period. That is there may be a, a time in which there's so much excitement and relief about returning that, that any symptoms or problems or roles that, that may cause conflict are denied. But as, if this phase transitions into a later phase of the, the, the, the homecoming, problems may arise. And being able to handle conflicts and problem solving, and, and, and to address disclosure, may become more important topics.

Slide 41: Preventing Family Breakdown

Families have been stressed and experience problems as a result of their deployment. We should anticipate and prepare for family challenges, involve the families in treatment, provide skills training for patients and family members in relevant areas including communication about time away, renegotiating traditional family roles, managing anger in the couple relationship or with the children or between strangers, conflict resolution, and parents. Providing short term support for family members may, may also be an important part of the treatment as the stress may extend to family members as well. And linking families together for mutual support may be an important opportunity for the family members to be able to express and discuss their own stressors related to deployment combat and PTSD.

Slide 42: Methods of Care: Overview

What are some different methods of care, sometimes referred to as models of care? Education about post-traumatic stress reactions may occur in the primary care setting. Education may be one key component of care for those returning from war, and is intended to improve understanding and recognition of symptoms, reduce fear and shame about these symptoms, and normalize his or her experience. With such understanding, stress reactions may seem more predictable, and fears about long-term effects can be reduced. Reactions should be interpreted as

responses to overwhelming stress, rather than personal weakness or inadequacy, sometimes referred to as the appraisal of symptoms by the individual. Educating the returnee, the family and friends can also be helpful to identify “red flags”. These red flags may include any kinds of suicidal or homicidal gestures, increase use of substance abuse, road rage, or really any kind of other violent behavior the individual may be experiencing towards himself or anyone else. These kinds of red flags should be addressed to the primary care clinician, nursing, chaplains, or a behavioral health specialist

Slide 43: Methods of Care (continued)

Providing the individual training and basic coping skills is also an important educational intervention that can be included in the primary care setting by a primary care provider, nursing, or behavioral health specialist. These include relaxation therapy, deep breathing re-training, staying present in “here and now approach”, sometimes referred to as ground. Grounding can include becoming very aware of one’s immediate present environment. For example, just touching a table and feeling the table, feeling the temperature of the table, may shift the individual’s focus from their past trauma experiences or their symptoms to a tangible, present-oriented focus. Providing sleep hygiene and insomnia management are also key components to the individual’s recovery.

Staying positive, looking for the positive, asking “Has anything positive come out of this experience for you?” Typically, individuals, even who’ve gone through the most horrific of traumatic events, will be able to identify positive in their experience. Emphasize previous commitments, goals, or plans. As I mentioned earlier, these are typically ambitious, success-oriented individuals. These are individuals who have life plans and goals, and may feel as if these life plans or goals have been interrupted be, because of their traumatic experiences, and/or their, their symptoms, or PTSD symptoms. Reorienting the individual to those previous commitments, goals, and plans is an important part of the individual’s recovery. Finally, giving credit for everything the soldier has been through and has completed is important, as we, as we provide really constant source of support for the individual throughout the healthcare system.

Slide 44: Methods of Care (continued)

Individuals who exhibit more extreme forms of chronic PTSD may be referred to a behavioral health specialist for exposure therapy or cognitive restructuring. Both of these therapies have shown great effectiveness in reducing PTSD symptoms. Bryant and Harvey in 2000 noted that prolonged exposure is not appropriate for everyone. For example, those experiencing acute bereavement, extreme anxiety, severe depression, or those experiencing marked ongoing stress or at-risk suicide. But for those who are appropriate for exposure therapy, repeated exposure therapy includes thinking about the traumatic event in detail, and emotionally reliving the event in the presence of a clinician. Repeated trials of exposure therapy have been shown to reduce the intrusive memories, the marked avoidance, and some of the triggered emotional responses associated to the PTSD and the traumatic event.

Closely related is cognitive restructuring. There is evidence that people with acute stress disorder and PTSD exaggerate both the probability of future negative events occurring, and the adverse

effect of these events. Cognitive biases for events related to external harm, somatic sensations, and social concerns, may also contributed to these symptoms, and the ongoing nature of these symptoms. Cognitive restructuring may have wider applicability in that it may be expected to produce less distress than cognitive exposure.

Slide 45: Methods of Care: Building Resiliency

In addition to reducing PTSD symptoms is including in the treatment approach, promoting resiliency. I'm going to speak for a few minutes about ways to promote resiliency among individuals, and maybe a very important aspect of treatment for individuals who suffer from combat stress. So let's take just a few minutes to define resiliency, and think about ways to build resiliency.

Resilient people are optimistic. They maintain hope about future outcomes, and such optimism is associated with the use of active, problem-focused coping when dealing with stressful life events.

Resilient people have self-efficacy. They believe that they have the skills necessary to effectively manage or accomplish the task at hand, really resulting in sustained effort and greater likelihood of success.

Resilient people have a sense of mastery. They believe that they can exert positive control over their environment. They will break down complex problems into smaller, more accomplishable tasks and goals, which can result in a series of immediate successes that enhance the individual's feeling of mastery and control over the problem.

Slide 46: Methods of Care: Building Resiliency

Resilient people are hardy. Hardiness describes those who are actively engaged, who believe they can influence the course of events in their lives, and who accept change as a part of life, as a challenge rather than a threat, and know that it can be beneficial to their own growth. Evidence suggests that hardiness buffers the negative impact of stress, perhaps because it is associated with appraisal of events that minimize emotional distress and promote active coping.

Resilient people have a sense of coherence, which includes the expectation that life events will make sense, the belief that they have the necessary personal and social resources to meet the demands of these events, and the conviction that these demands are worthy of investment and commitment, and are meaningful.

Slide 47: Building Resiliency: The ties that bind

Resilient individuals use their social support network. They build and maintain close relationships with family and friends. They turn to their close relationships in times of need. They ask for help when they need it, even if it's just to talk or have someone to spend time with them. They also make themselves available to their close friends and family who need help, too.

And finally, they balance the things they can do on their own with the things that they need others for.

Slide 48: Finding Resources

No audio.

Slide 49: No title

I want to thank you, and thank to all those who have worn or are wearing the military uniform of our country. Thank you.

Slide 50: Contacts

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