

A Soldier's Trauma – Everyone's Trauma

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Abstract – Presentation Notes

The topic for my presentation is “A Soldier's Trauma – Everyone's Trauma” as traumatic events affect not only the lives of soldiers but also their families and others in their communities. Resolving the emotional impact of past traumatic incidents brings about a higher quality of life for all concerned. This talk is about resolving traumatic stress and Post-Traumatic Stress Disorder as efficiently and quickly as possible without negative side effects.

The Soldier's Journey

A soldier's trauma is shared by family and friends from mobilization to de-mobilization. Here's a brief summary of the journey.

The following information on the stages a deploying soldier goes through from mobilization to de-mobilization was supplied by Captain Stephen Baker, US Army.

Mobilization: This is often a difficult time for spouses and children because they are preparing for the deploying soldier to be gone for a certain length of time. Anxiety and pre-occupation with worry as to whether or not he/she will return can be overwhelming. The soldier may face financial burdens as well because with National Guard soldiers that deploy, especially the lower ranks, he/she may be making less money, which causes financial hardships regarding paying bills and taking care of their families' needs. This is a huge problem right now, according to Captain Stephan Baker, U.S. Army counselor for deploying soldiers.

Deployment: The soldier has arrived at the area of responsibility. He must adapt to an environment he/she is not used to, like the desert, which is very tough. It takes about two weeks to acclimate. After about a month, psychological paradigms start to develop. Sometimes acute depression may be visible, in that some soldiers start to long for home. The key here is that soldiers must keep a sense of awareness and not let his/her guard down, especially in a forward area with a high threat. This up and down of heightened awareness to keep him/her alive vs. longing for home leads to that “up and down” syndrome, which can lead to other psychosis if not coped with properly. This is called “Battle Fatigue.” The soldier simply gets psychologically tired.

Employment: The soldier is employed to his/her responsible lane. He/she may be stationed at a base upon arrival or, depending on the big scheme of things, may employ to the area he/she will be working at. Again, psychological fatigue may set in over time. Prolonged exposure to stress in the employment phase can be damaging depending on how close the soldier is to the traumatic event. Exposure to stress can be anything from the soldier seeing another soldier injured to actually being injured himself. There is a lot of inflow, outflow, and cross flow of activity in theatre. This can be quite stressing for anyone who is there for a prolonged period of time.

Re-deployment: The end of the tour of duty in the area of responsibility is drawing to an end. Soldiers start to see that home is getting closer. However, this presents some dangerous caveats for the soldier. Some become complacent and lose focus while they are still there. Also, and this is a big one, sometimes because of schedule delays in returning home, or extensions of those in place because the replacing unit cannot get there on time, there is additional distress and anger experienced by the soldiers preparing themselves to leave and now they have to wait even longer. Some soldiers start to try to find

ways to get home outside the normal channels. This causes a breakdown in morale. Morale and quality of life must be maintained in order for a soldier to be effective in his or her job.

De-mobilization: The soldier returns back to the states and is in processing back into home station. Re-entry into civilian life and seeing his wife and children for the first time in a year can be a little too much. This creates stimulus overload, that is, the soldier cannot actually integrate and assimilate the feelings associated with the prolonged absence. It is important to give the soldier some time to re-integrate. Another big problem or problems may arise at this stage: The soldier may be faced with a spouse who has not been paying the bills or who has created other financial problems. The kids may be getting into trouble due to their anxiety. The spouse who remained at home may leave or find someone else after the soldier's return. The soldier may find out that while he was gone there was no support system to help the family that stayed behind. The wife may have had to go to work, take care of three kids, and oh by the way, also had to be the handy man around the house. This can cause a breakdown in the traditional roles of marriage and create tension when the family gets back together.¹

Post-Traumatic Stress Disorder

Note: A combat situation elevates anxiety and can cause traumatic stress and Post-Traumatic Stress Disorder. If soldiers leave with mental baggage that is not resolved or dealt with, the condition that they usually leave with is exacerbated in some form. Pre-exposure to trauma in any degree before the soldier deploys, if not resolved, usually presents itself when he is in combat, when he gets back home, and/or it manifests itself years down the road. Military veteran, David W. Powell, tells of his personal experience with combat trauma and how it affected his life for many years in his 2006 book titled *My Tour In Hell: A Marine's Battle With Combat Trauma*. This is one of the most personal and gripping stories I have read about a soldier's journey to hell and back; and it validates the effectiveness of a technique called Traumatic Incident Reduction (TIR) that enabled David to finally get his life back.²

In addition to my other resources for information, I researched the Internet for some statistics. The numbers vary a bit from one report to another. According to a study by researchers from Walter Reed Army Institute of Research, nearly 10% of Iraq Vets screen positive for PTSD. 35% of troops who served in Iraq used mental health services in their first year home, although only one-third of them had received a mental health diagnosis.

Again, nearly 10% of Iraq vets screen positive for PTSD. This information was also drawn from the 3-page Post-Deployment Health Assessment (PDHA) given to all service members upon their return from any deployment. Researchers followed 303,905 Army soldiers and Marines for up to one year or until they left the service. That figure represents 85% of all returning troops. *Psychiatric News*, Vol. 41, No. 7, April 7, 2006.³

The need for mental health services by Iraq soldiers is due to a greater exposure to combat, according to the PDHA data. Compared with troops in Afghanistan, troops in Iraq more frequently saw comrades killed or wounded and were three times more likely to fire their weapons. Half the soldiers and Marines in Iraq had felt in great danger of being killed, twice the rate of those who served in Afghanistan.

Both the nature of the war and deployment practices may account for differences in mental health outcomes in the two theaters. There are no safe zones in Iraq, Col. Elspeth Cameron Ritchie, M.C., psychiatry consultant to the U.S. Army surgeon general, told *Psychiatric News*. "Danger can come from any direction, and it's hard to tell friend from foe."

Of the 35% of troops seeking mental health services, 12% were diagnosed with an ICD-9 (International Classification of Disease-9th Revision) mental disorder, but the other 23% received no psychiatric diagnosis. The fact that the 23% were willing to seek mental health services and tell about it could be an indication that the less specific codes that were used may have lessened the stigma of a

mental health diagnosis and helped the soldiers recognize that they should seek psychological help. This certainly is a move in the right direction of taking care of our military.

According to an April 2006 article in *Parade Magazine*, 15% of soldiers returning from Iraq were surveyed which revealed that they suffered from General Anxiety disorders, major depression or PTSD.

86% of the soldiers and Marines in Iraq reported knowing someone who was seriously injured or killed. Half said they'd either handled or uncovered human remains; more than half said they had killed an enemy combatant; and 10% said they'd been responsible for the death of a non combatant.

80% of those that suffered from a serious mental disorder acknowledged that they had a problem; of the 80% only 44% were interested in receiving assistance, and just 35% got help. The stigma of mental illness or weakness is still a significant factor in soldiers and veterans getting the help they need. Source: Dr. Joyce Brothers ⁴

Tips for Being Supportive

Anyone who is not familiar with, or used to using, mental health services before a crisis is not likely to seek such help during or after experiencing a crisis. I believe we need to keep the focus on our soldiers and veterans and do everything we can to help them resume a normal life. Simple common sense things can speed a soldier's recovery. The following are a few good tips for helping anyone who has experienced a traumatic event.

Give a vet some space. Most do not want to talk about the violence they witnessed right away.

Lend an ear. When the time comes, prepare to listen. The recollection may come out over the course of weeks or months, as your loved one reformulates the memories into meaningful stories. Baker: "To develop good coping skills, a vet needs to make meaning or rationalize the traumatic situation he has experienced. Talking about it helps him do this."¹

Recognize that things are different now. A spouse may have taken on new responsibilities. There may be some jealousy over what has been missed. Bring your vet up to date slowly, one issue at a time. Realize that you may have to renegotiate family routines.

Expect a period of adjustment. It can take 6 to 8 weeks to get back to something that approaches normal, both physically and mentally.

Understand that vets need to spend time with war buddies. Families need to know that the vet's lifeline to peers often makes the difference between coping and a withdrawal into isolation. Baker: "Certain core beliefs are violated along the time line of events whether directly exposed or tertiary. By talking to others who have experienced the same trauma, safety parameters can be formed. Safety is one of the big 'must haves' when dealing with PTS or PTSD."¹

Get help. If problems persist for more than three months, professional help may be needed. Mental health assistance may be obtained through your VA and DoD (Department of Defense) services. On-line screening test offered by the DoD, Office of Health Affairs, can help those who prefer anonymity. The test is called the *Mental Health Assessment*. This program allows every branch of the service (including National Guard and Reserve) and their family members to identify symptoms before problems become urgent. The program is assessable 24/7.

"Studies have found from 1 to 14 percent of people suffer from PTSD at some point during their lives."⁵ Anyone who experiences, or witnesses, a traumatic event may develop PTSD. When a loved one died, did you feel emotionally numb or detached. If you experience an event where you felt you were in serious danger (for example, during acts of violence, operations, accidents), you may have traumatic stress and have trouble concentrating, or feel depressed, or have sleep difficulties, or startle easily.

Traumatic Incident Reduction

If a person has experienced a traumatic event and the resulting emotional distress does not resolve naturally with time, Traumatic Incident Reduction (TIR) is a very powerful, effective technique for bringing one's suffering to an end. There are currently three versions of TIR in use by mental health professionals and lay practitioners trained in TIR.

- Basic TIR: Resolves known past traumatic incidents.⁶
- Thematic TIR resolves unwanted feelings, emotions, sensations, attitudes and psychosomatic pains resulting from past traumatic incidents even if those incidents are not initially within the client's conscious memory.⁶
- Future TIR handles anxiety a client has regarding a future event regardless of whether the event is likely or unlikely to actually occur.⁷

The TIR technique has specific steps and a unique session protocol. The basic 4-day TIR Workshop is a complete package of learning and experiential exercises which enable newly trained TIR facilitators to:

- 1) Create a safe environment and expertly manage communication in session.
- 2) Help clients locate an incident or theme (unwanted feeling, emotion, sensation, attitude, or pain) to address with TIR.
- 3) Facilitate the client's viewing of the traumatic incident from start to finish.
- 4) Facilitate the client's telling of what he has viewed and his reactions to it.
- 5) Facilitate the client's viewing of the traumatic incident repetitively to an end point (Extroversion, Positive Indicators) and recognizing when it is resolved.

TIR provides a means for

- 1) Contacting repressed memories – repetition brings forth state dependent memories.
- 2) Fully confronting painful incidents, no matter how long ago they occurred.
- 3) Experiencing the positive gain one would have had if he/she had been able to fully confront the traumatic events at the time they occurred.
- 4) Ending the cycle of secondary traumatization.

Although TIR represents a radical departure from traditional clinical procedure, it is at the same time firmly grounded in philosophic basics familiar to any therapist.

It is client centered as is psychotherapy. The TIR facilitator respects the senior authority of the client and does not invalidate or even critique the client's reality.

It is directive as is Rational Emotive Behavior Therapy. The TIR facilitator provides the structure for the session so that the client can focus on doing the work he needs to do.

Trauma is pure receptive learning. The person receives data but because of pain, unconsciousness, or insufficient time, is unable to integrate it, and the data becomes encapsulated as a trauma.

TIR is an integrated learning technique. The purpose of viewing (what a client does in a TIR session, hence why he is called a viewer) is largely to integrate data he already has. The *Rules of Facilitation and Communication Exercises* which a TIR practitioner learns in the basic 4-day TIR workshop not only create a safe space and time for the client but also an environment in which integration can take place.

TIR and Critical Incident Stress Management

TIR has a specific place in Critical Incident Stress Management and Debriefing: 1) To handle crisis responder's mental baggage making them better able to respond in a crisis situation rather than to react inappropriately or ineffectively, and 2) In the follow up stage to help crisis responders handle the trauma of the events they respond to and to help the victims return to normal or to a new normal as quickly as possible.

A,B,C's of EMT training are: A) making sure the airway is clear; B) breathing; and C) circulation

A,B,C's of crisis response are A) to weaken the intensity of early arousal; B) attending to basic needs (providing a warm blanket and a chair); C) compassion (let people know someone cares)⁸

TIR is not an "on-the-scene" crisis response method. Its specific purpose is to eliminate the negative effects of past traumas and to provide individuals with an opportunity for personal growth from past traumas.⁹

What TIR basic training has to offer the CISM team member:

1) In Preparation stage:

- a) to enhance a CISM team member's communication and listening skills
- b) to strengthen a CISM team member's ability to be fully present and to confront difficult situations with less chance of experiencing secondary traumatization

2) After the crisis has passed:

- a) TIR technique may be employed to fully resolve any lingering negative effects which have not fully resolved naturally with time.
- b) TIR may be employed to handle individual responder's reactions to the trauma in a timely manner, before the next crisis response, thus preventing PTSD and compassion fatigue.

No one who responds to war or to a mass casualty event is untouched by it. Profound sadness, grief, and anger are normal reactions to an abnormal event. Wanting to remain on the scene until the work is finished is normal. TIR is easy to learn and easy to use. Peer to peer use of TIR could solve the problem of the stigma of mental illness preventing people who need help from receiving help.

Development of TIR Protocols

Frank A. Gerbode, M.D., a psychiatrist, trained at Yale and Stanford is credited as the main developer of TIR. A dedicated team of certified TIR trainers work with Dr. Gerbode in the development of training materials. Dr. Gerbode's intention is to put into the hands of caring and competent helpers a structured technique for completely resolving PTSD, its consequences, and other trauma-related disorders. The technique had to be easy to teach, easy to learn, as well as highly effective in a short period of time. And he succeeded beyond all reasonable expectations with TIR, which is now the core technique of Applied Metapsychology.

Dr. Gerbode founded Applied Metapsychology International (AMI) in 1985, originally called the Institute for Research in Metapsychology (IRM), the certifying body for TIR. In 1986 he authored the first edition of "Beyond Psychology: An Introduction to Metapsychology", in which he outlines the theory and basic procedures underlying TIR and related techniques.¹⁰

Dr. Gerbode serves on the Applied Metapsychology International (AMI) Board of Directors and chairs the AMI Editing Committee, which is responsible for the evolution and development of metapsychology techniques, methods and training material.

Traumatic Incident Reduction is easy to learn. But, just as with anything else, the more experience you get, the more confident and competent you become. Post-workshop internships are available for

practitioners who want to become proficient in their newly acquired skills as quickly as possible, or who wish to become certified TIR facilitators.

For additional information on Traumatic Incident Reduction (TIR) and TIR professional skills training contact E-Productivity-Services.Net, 13 NW Barry Road, PMB 214, Kansas City MO USA, Phone 816-468-4945, E-Mail NLD@EPSN.NET. 4-day TIR workshops are presented in Kansas City and in other cities upon request.

REFERENCES

¹ Captain Stephen Baker, US Army, stationed at Jefferson Barracks VA Medical Center, in St. Louis, MO.

² *My Tour In Hell: A Marine's Battle With Combat Trauma*. David W. Powell 2006 ISBN-13: 978-1-932690-22-4.

³ *Psychiatric News*, Vol. 41, No. 7, April 7, 2006.

⁴ Dr. Joyce Brothers, April 16, 2006, *Parade Magazine*

⁵ Microsoft Encarta Library

⁶ *Traumatic Incident Reduction (TIR) Workshop Training Manual*, 5th Edition May 2006

⁷ *TIR Expanded Applications Workshop Training Manual*, 2nd Edition January 2006

⁸ Rocky Mountain Region Disaster Mental Health Institute Conference in Casper, Wyoming 2006 November 8-11

⁹ *Traumatic Incident Reduction and Critical Incident Stress Management: A Synergistic Approach* Ed. by Victor R. Volkman. 2007 ISBN-13: 978-1-932690-29-3.

¹⁰ *Beyond Psychology: An Introduction to Metapsychology*, 3rd Edition. Frank A. Gerbode . 1995 ISBN 1-887927-00-X.

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