

**ROADMAP TO RESILIENCE: A TOOLKIT FOR RETURNING SERVICE MEMBERS
AND THEIR FAMILY MEMBERS®**

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**TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL PROBLEMS AND
AGGRESSIVE BEHAVIOR (COST \$60)**

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I. RESEARCH FINDINGS ON RETURNING MILITARY SERVICE MEMBERS

(Gleaned from Burkett & Whitley, 1998; Dean, 1997; Friedman et al., 2007; Grossman & Christensen, 2007; McNally, 2003a; Ruzek, 2003 and Rand Report <http://veterans.rand.org>)

Data on Veterans from Iraq and Afghanistan Wars

More than 1.6 million U.S. military personnel have been deployed to Iraq or Afghanistan since the start of military operations in 2001. As of February 2008, military operations in Iraq and Afghanistan have claimed 4400 lives and more than 30,800 soldiers have been injured according to the Department of Defence.

70% of Reservists and 66% of active duty soldiers report exposure to potentially traumatic experiences during their deployment (direct combat experiences, uncovering and handling human remains, death of one's buddy, civilians) (Milliken et al., 2007).

One-third of deployed soldiers have served at least two tours of duty. 70,000 have been deployed three times. 20,000 having been deployed at least 5 times.

In Florida, where the Melissa Institute is located, there are approximately 80,000 active duty personnel, 42,000 military spouses and 33,000 school-age dependents. In Miami-Dade County there are approximately 4000 veterans who have returned from deployments in Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom from Iraq who are enrolled in VA programs. Approximately 10%-15% of these veterans have children. Most of these children are of preschool age because of the relative youth of the veterans. However, an estimated 7% of the veterans who are Reservists are between 40 and 60 years of age and 20% of them have school age children or older. Of particular concern is the impact of the veteran's distress and psychological difficulties (e.g., PTSD, Traumatic Brain Injury) on the children and their spouses.

Impact of Combat Service

(See Hosek et al, 2006)

Most soldiers adapt well following combat deployment, returning without problems and readjust successfully.

Estimates are that between 25% and 33% of recent combat veterans are grappling with psychological problems.

A recent telephone survey by the RAND Corporation of 1965 veterans indicated that in the previous 30 days, 14% screened positive for PTSD, another 14% screened positive for Major Depression and 19% screened positive for a probable Traumatic Brain Injury during deployment (RAND, 2008, <http://veterans.rand.org>).

They estimate that as many as 300,000 returning veterans have PTSD and/or Depression and 300,000 experience TBI. In up to 50% of cases, veterans experience symptoms of all three

conditions. Only about 53% of those who meet diagnostic criteria had sought help within the past year. Of those who received help, only half received quality care.

More than 100,000 combat veterans have sought help for mental disorders since the start of the Iraq and Afghanistan wars in 2001. Nearly 50,000 VA documented PTSD cases, nearly 4000 of them are women. Soldiers often suffer more mental distress in the transitions to life at home than they show upon leaving the combat zone.

3 to 6 months after returning from Iraq, 17% of soldiers meet the criterion for PTSD (Hoge et al. 2004) and 10% screen positive for depression (Milliken et al., 2007). Rates of mental health problems varied by deployment site: Iraq 19.1%, Afghanistan 11.3% and other locals 8.5 % (Hoge et al. 2006).

Mental health risk indices are highest at 4-10 months post-deployment than they had been at homecoming. The overall rate of mental health risk (anxiety, PTSD, depression, substance abuse) increased from 17% to 27% in the active duty soldiers and from 17% to 35% in the Reservists, from the time of homecoming to the 10 month follow-up period. Milliken et al., (2007) propose that the higher symptom rate among the Guard was due to the stress of transitioning back to civilian employment, reduced access to services and diminished peer support. However, more longitudinal studies over longer periods of time indicate a general decline in the prevalence of mental disorders and improved adjustment (Toomey et al., 2007).

Studies of veterans with PTSD indicate that they have poorer perceived health, more chronic health conditions and higher health utilization costs. Many returning combat veterans often have difficulty and conflicts with family members and friends.

Veterans in the general U.S. population, whether or not they are affiliated with the VA care system, are at an elevated risk of suicide. The VA suicide telephone hotline are receiving over 1500 calls a week from veterans and family members.

The Veterans Health Administration estimates 1000 suicides per year among veterans returning from Iraq and Afghanistan and as many as an additional 5000 per year among all living veterans. Male veterans have double the suicide rate as their civilian counterparts.

Compared to civilian men who died by suicide, veterans were 58% more likely to use a firearm to end their lives. Approximately 12,000 veterans under VA care attempt suicide each year (Kaplan et al., in press).

Among deployed army soldiers, the committed suicide rate of 121 in 2007 increased by 20% over the year before. There were 89 confirmed suicides the year before and 32 additional suspected suicides that are still under investigation. There is a need to convey to soldiers that *“It takes the courage and strength of a warrior to ask for help”*.

Anger and hostility are particularly salient problems in veterans suffering from PTSD. In fact, the relationship between anger and PTSD is higher in samples with military war experience than in samples that had experienced other types of traumatic events. Anger is substantially associated

with PTSD severity and the relationship between anger and PTSD becomes stronger with increasing time since the event (Orth & Wieland, 2006). Chemtob and his colleagues (1997) have demonstrated the value of treating both anger and PTSD in an integrative fashion.

There is a need to highlight for families with PTSD that the overall prognosis is positive, as complete recovery occurs within 3 months in approximately half the cases. (See *Guide to recovery from PTSD for families* by Lanham, 2005 and Matsakis, 1996, 1998). As Lyons (2008, p. 16) highlights, research demonstrates “the resilience and strength in military couples in overcoming the challenges of deployment separation and war trauma” (Lyons, 2008, p. 16).

Factors that Influence Reactions to Combat

Soldiers who served in Iraq longer than 6 months were 1.5 to 1.6 more likely to screen positive for mental health problems, more likely to have marital concerns and more likely to plan for marital separation and divorce (Lyons, 2008). Soldiers on a 3rd or 4th redeployment have the highest incidence of mental disorders.

Multiple deployments were associated with a 50% greater prevalence of mental health problems (9% among repeaters versus 6% among first time deployers).

High (versus low) combat exposure is associated with 2.4 times more cases screening for anxiety, 2.6 times more depression and 3.5 times more PTSD. (See <http://www.scribd.com/doc/134591/mbat-iv-report>)

Veterans age 24 or younger were found to be at significantly increased risk for mental disorders (Seal et al., 2007).

Exposure to combat atrocities is most associated with increased mental health risk and PTSD is one of the best predictors of relationship problems and marital distress. There is also more distress in spouses of soldiers with PTSD. The more severe the PTSD in the returning soldier, the greater the perceived burden on the spouse (Lyons, 2008). If the wives had a more secure attachment style and a challenge appraisal style, rather than an insecure/avoidant attachment style and a threat appraisal style, they were more capable of coping with their PTSD spouse. Negative domestic home experiences can entrench PTSD symptoms (Tarrier et al., 1999). PTSD symptom of emotional numbing and withdrawal are particularly associated with relationship problems, as well anger and threatening behavior (Lyons, 2008). The avoidance symptom cluster included constricted affect, detachment and loss of interest in pleasurable activities.

In addition to the length and intensity of combat duty and the number of deployments, combat experiences that are associated with an increased risk for mental health problems and post-military adjustment difficulties include the perception of threat to life, physical injuries, exposure to brutality and mutilated bodies, death of children, loss of a friend, engaging in atrocities, being physically deprived (POW), high rates of wounds and fatalities in one's combat unit, perceived responsibilities and meaning attendant to such military duties as Body Identification and Grave Registration and bomb removal, and the experience of Acute Stress Disorder and Combat Stress Reactions in the aftermath of trauma exposure (peritraumatic dissociation and intense arousal).

As Ruzek (2003) observes, veterans may experience the war as “senseless and they lack conviction of its moral correctness” and they accuse their military leaders of having mismanaged the war” (p 193). Such an outlook leads to mistrust of authority and hostility toward government that could undermine seeking treatment.

A number of premilitary and postmilitary risk and protective factors have been identified. Among the premilitary risk indicators are an unstable family life during childhood, a family history of anxiety or mood disorders, early trauma history, having been sexually abused during childhood, a developmental history of antisocial behavior, negativistic personality traits, lower intelligence and lower cognitive ability and a history of neurological soft signs. Post military risk indicators contributing to poor adjustment include low levels of social support and high levels of homecoming stress.

Bad homecoming experiences (indifference, insults, ridicule from civilians) and difficult transition into work, school, family roles, all increase the risk of adjustment difficulties.

Impact of Comorbid Disorders

33% of Veterans of Iraq and Afghanistan who were treated at the VA were given a comorbid diagnosis of an another mental health disorder with PTSD. For example, last year the Veterans Affairs started screening all Iraq and Afghanistan war veterans who came for clinical help. Since April 2007, 33,000 of 727,015, or about 15% have been screened positive for mild brain injury since April 2007.

Mild traumatic brain injury (e.g. concussions) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems 3 to 4 months after the soldier's return home (Hoge et al., 2008). PTSD and depression are important mediators of the relationship between mild traumatic brain injury and physical health problems.

Rutland-Brown et al. (2008) indicated that TBI is the leading cause of death and one of the most common causes of injury in bomb blasts. TBI are associated with approximately two kinds of fatalities and occur among 12% to 31% of immediate survivors of bombings. TBI symptoms often overlap with acute stress disorder symptoms. (See *CDC Heads Up: Preventing Injury in your Practice Toolkit* available at <http://www.cdc.gov/ncipc/pub-res/tbi.toolkit/toolkit.htm> and *Military Acute Concussion Evaluation-MACS* available at <http://www.dvbic.org/pdfs/DVBIC.pocket.card.pdf>)

Rutland-Brown et al. (2008) observe that symptoms such as the immediate occurrence of headache, nausea, vomiting and balance problems are more commonly associated with TBI, whereas the development and nightmares are more suggestive of ASD and PTSD. Confusion, disorientation and memory problems may be associated with both conditions. See Warden, (2006), Schrab et al. (2006) for a description of a brief TBI scale, Vasterling and Brewin (2005) for a discussion of the neuropsychology of PTSD.

Hopewell and Christopher (2007) indicated that many persistent difficulties shown by returning veterans are more related to PTSD issues than due to the original concussion resulting from explosive devices.

Patients with concurrent PTSD and Substance Abuse Disorders (SUD) benefit less from treatment than those with either disorder alone. A diagnosis of PTSD limits the effectiveness of conventional SUD treatment.

Comorbid veterans with PTSD and SUD have a greater number of problems in living, including legal problems, social conflicts, violent behavior, assault charges and suicide attempts. They also have practical problems in living than those veterans with either disorder alone. They are more likely to be unemployed, financially challenged, lack routine family contact, relatively socially isolated and devoid of daily purposeful activities.

Women and the Military

More than 160,000 women have been deployed to the wars in Iraq and Afghanistan. They have experienced more lethal attacks than American women did in Vietnam. In addition, many female soldiers have reported being sexually assaulted, harassed and raped by fellow soldiers and officers (Corbett, 2007).

1 in 10 U.S. soldiers in Iraq are female. As compared to the 160,000 Iraq female deployment, 75,000 women served in Vietnam and 41,000 were dispatched to the Gulf War in the early 1990's.

Women in the military are at greater risk for having adverse reactions to combat deployment than men (Castro et al. 2006).

Female veterans deployed overseas in the first Gulf War reported high levels of sexual abuse from their male comrades: 66% experienced verbal harassment; 33% endured physical harassment; and 23% were sexually assaulted. This sexual abuse increased the likelihood of developing PTSD more than did their combat experiences. The more severe the sexual abuse suffered, the more likely they were to develop PTSD.

Thus, the Iraq War is leaving a large number of women with a “double whammy” of military sexual trauma and combat exposure.

Gang rapes tended to last longer and involve more physical trauma than lone assailant assaults.

More specifically, physical sexual assault has been reported by 23%-41% of female troops/veterans.

Military sexual assaults led to PTSD in more cases (60%) than other types of trauma (42%). Women who experienced military sexual assault were three times more likely to have PTSD than women who were sexually assaulted in other contexts (childhood, civilian), and nine times more likely than women who had no sexual history. 69%-90% of sexual assaults in the military go

unreported and in many instances, reports of sexual abuse were rebuffed by military officials, further exacerbating the distress (Hunter, 2008; Lyons, 2008).

Rape is the traumatic event that is most likely to lead to PTSD in women and in men, although it is much rarer in men. One third of a nationwide sample of female veterans seeking health care through the VA said they experienced rape or attempted rape during their service. Of that group, 37% reported that they were raped multiple times and 14% reported they were gang-raped (Corbett, 2007).

Corbett (2007) described the pressure of being a woman in the military. As one female veteran reported, “You're one of three things in the military—a bitch, a whore, or a dyke. As a female, you get classified pretty quickly and you are subjected to crass jokes, ridicule and sarcasm”.

The rate of sexual assault is underreported. Estimates are that only 10%-30% of women soldiers who were assaulted report it to military officials. Many victims felt that they would be mistreated by the military if they reported assaults.

Only 10% of those reported sexual assaults resulted in a court-martial of the perpetrator.

Female veterans who reported being sexually assaulted in the military were found to be twice as likely to screen positive for symptoms of alcohol abuse than those who were not assaulted.

Women with PTSD and Alcohol Abuse are more likely to report a history of childhood sexual abuse and they report having experienced a greater number of childhood traumas.

Childhood sexual abuse, sexual assault and gender-based stressors, rather than the level of exposure to traditional war stressors appear most related to the development of concurrent PTSD and alcohol abuse problems in female soldiers.

Male victims of sexual assault (some 9%) often score higher on measures of trauma than do female victims. Half of servicemen who were sexually assaulted by comrades, often more than once, were so distressed by the experience that they sought discharge from the military.

Family Stress and Child Care Stressors in the Military

(See Caliber Associates

http://www.cfs.purdue.edu/mfri/pages/military/2005_Demographics_Report.pdf and

Presidential Task Force on Military Deployment

<http://www.apa.org/releases.MilitaryDeploymentTaskForceReport.pdf>)

One in five soldiers deployed report marital concerns and problems.

38% of women and 44% of men in the active duty force have children.

11% of women in the military are single mothers, compared to 4% of single fathers.

10% of women and 2% of men are in dual military marriages.

Approximately 700,000 children in America have one parent deployed away from their family in military service.

Issues of child care represent an important concern, especially for single moms in the military. Women service members with children, more so than single women and their male counterparts, report a more substantial decline in health and well-being after deployment and their children report more emotional distress during their mother's absence.

(see <http://www.jec.senate.gov/Documents/Reports/MilitaryMoms05.11.07Final.pdf>)

The U.S. military provides health care for nearly two million children.

Boys tend to experience more adverse reactions to deployment than girls. Younger children (under 6) and younger families are more affected by parental deployment (Mabe, 2008).

Research on military families have found an increased rate of child maltreatment during deployment, than during nondeployment, primarily in the form of child neglect. There is an increase in rates of child maltreatment of up to three fold by civilian mothers, although this rate of maltreatment is lower than the civilian rate of maltreatment (Gibbs et al., 2007; Rentz et al., 2007).

The impact of deployment on the spousal relationship has yielded varied results. Some studies have found modest increases in spousal violence, while other researchers have not supported this conclusion. Survey data indicates that 58% of military spouses believed that deployment had strengthened their marriage, 31% believed it had no effect, and only 10% felt deployment had weakened their marriage (Caliber Associates Website).

Mabe (2008) has described intervention programs designed to help families deal with the stress of deployment. The interventions focus on ways to help families deal with loss, ambiguity, perception of lack of control and on ways to bolster resilience.

Reger and Moore (2008) highlight the value of developing intervention programs designed to address predeployment, deployment and postdeployment challenges. The predeployment coping activities include staying connected, planning for separation, considering possible injury and mortality; deployment coping activities include learning ways to cope with environmental, physiological, cognitive and emotional stressors; postdeployment coping activities include learning to cope with homecoming stress such as transitioning and adjusting to new roles, problem-solving important decisions and accessing social supports and needed assistance. Also see <http://www.battlemind.org/soldier-battlemind.html#>

See the discussion of how to conduct Battlemind checks for self and buddies.

Lessons from Research with Vietnam Veterans and Veterans from other Combat Experiences

(See Meichenbaum's *Handbook on Treating Adults with PTSD*, pp. 57-69; Kulka et al., 1990).

More recent analyses of the National Survey of Vietnam Veterans (NVVRS) have raised suspicions about the PTSD figures originally reported and the view of the so-called “dysfunctional veteran”. (see Burkett & Whitley, 1998; Dohrewend et al. 2006; Grossman & Christensen, 2007). For example, Burkett and Whitley (1998) showed that the vast majority of Vietnam veterans were as well-adjusted, or even more successful, than their non-serving civilian peers.

The number of patients diagnosed with PTSD from Vietnam had been inflated threefold, with the number of severe cases at 18.7% and the number of cases remaining 12 years after the War was 9.1%. This is in sharp contrast with the estimate of 30.9% which had been reported previously (Dohrewend et al. 2006).

The number of veterans diagnosed and compensated for PTSD grew to more than double the number of total service members known to be involved in actual combat operations in Vietnam.

In fact, psychiatric casualties following the Vietnam War were lower than other wars. McNally (2003a) reports that the rate of breakdown was 12 cases per 1000 men for Vietnam veterans, as compared to 37 per 1000 psychiatric breakdowns during the Korean War, and during W.W. II it ranged from 28 to 101 per 1000 (see Dean, 1997).

In the U.S., while men are more likely to be exposed to traumatic events than women, women are two to three times more likely to develop PTSD and related psychiatric problems. However, among combat veterans the gender differences are more attenuated. For example, 30% of male Vietnam theatre veterans (VTV) and 27% of female VTV met lifetime criteria for PTSD.

As many as 94 % of Vietnam veterans with PTSD applied for financial compensation for their illness. A veteran who obtains a service-connected disability rating of 100% for PTSD can earn more than \$36,000 per year tax free which is indexed to inflation for life (Burkett & Whitley, 1998). “The financial loss is substantial should they recover from PTSD” (McNally, 2003a).

McNally (2003a) highlights the need to obtain military records directly from National Personnel Records Office in St. Louis in order to verify self-reports of combat exposure. There is a danger of individuals exaggerating symptoms or fabricating their histories of combat.

Up to 50% of Vietnam veterans who develop PTSD may continue to have it decades later. It is critical to intervene early before symptoms become entrenched.

“Male Vietnam War veterans in VA settings are a particularly chronic and treatment-refractory cohort who appear unlikely to benefit from pharmacotherapy or from psychosocial treatments. These findings are a strong argument for early detection and treatment of PTSD, because decades of chronicity appear to reduce the prognosis for a favorable outcome”. (Friedman & Davidson, 2007, p. 396).

73% of male Vietnam veterans who met diagnostic criteria for PTSD also qualified for a lifetime diagnosis of alcohol abuse or dependence and 25% to 56% have a lifetime drug abuse/dependence. Such lifestyle behaviors exacerbate chronic PTSD.

Some of the distress associated with war-related memories may involve feelings of guilt. Nearly 66% of Vietnam veterans reported moderate or greater guilt-related reactions to war experiences. Among Vietnam veterans, commission of atrocities predicted risk for PTSD beyond that attributable to combat exposure alone. (See Kubany, 1997).

Finally, it is important to keep in mind that research has continually shown that from the time of W.W.I to the present, veterans as a group, are less likely to be incarcerated, have higher levels of education, and generally have more success upon return to civilian life than do their civilian counterparts (Moore et al., 2008).

Treatment Services for Returning Soldiers

Almost 300,000 veterans from the conflicts in Afghanistan and Iraq have sought care in VA medical centers. About 120,000 have been diagnosed with mental health problems, with PTSD being the most commonly seen diagnosis (nearly 60,000). (Katz, 2008). But this represents only a small proportion of those in need.

In fact, only 25%-40% of soldiers with mental health problems get help. Hoge et al. (2004) found that only 38%-45% of those soldiers who met screening criteria for a mental disorder indicated an interest in receiving help. Concerns about treatment not being kept confidential, being stigmatized, appearing “weak”, being defensive and ambivalent about discussing problems and fear of change concerns about side-effects of treatment and doubts about whether treatment would be effective, resentment against authority figures and the VA system, unfavorable views of mental health care, fear of negative career impact, and other practical barriers interfere with their seeking services. To complicate matters, the VA has a reported backlog of 400,000 benefits claims.

Female veterans may be hesitant about seeking help and seeking treatment because they have fears that they (1) will be blamed for what happened (“You should have known better.”); (2) will only be seen as the “stereotyped” woman veteran; (3) jeopardize future job advancement, particularly in the military. These fears may be compounded by the fact that women veterans are often subject to experiences of isolation both within and outside of the military. Thus female veterans can benefit from a peer group network and gender-specific interventions.

As of 2007, of some 1400 VA hospitals and clinics, only 27 house inpatient PTSD programs, and of these, just two serve women exclusively. There are 232 vet centers.

Ethnoracial minority populations differ, not only in the amount of trauma exposure they experience, but they also differ in their help-seeking behaviors. As Pole et al. (2008) and Ford (2008) highlight, there is a need for treatments to be ethnoculturally-sensitive and therapists need to be culturally competent.

20% of active-duty soldiers and more than 40% of Army Reservists could benefit from treatment. Only a small percentage of veterans choose to receive health care in VA facilities.

The number of all veterans compensated by the VA for PTSD (as of 09/30/07) was 299,672. But 75% of veterans do not get their health care through the VA system.

Female Vietnam veterans with PTSD showed a lifetime rate of 29% for alcohol disorder, higher than those without PTSD; 10% of female veterans with current PTSD had a current alcohol use disorder, compared with less than 2% of women without PTSD. There is value in providing an integrated treatment program for veterans with comorbid PTSD and SUD (Najavits, 2004).

Treatment for PTSD can enhance treatment outcomes for substance abuse. The amount of treatment used following completion of inpatient substance abuse treatment is a major predictor of substance abuse outcome.

There is a significant overlap between symptoms of PTSD and opiate withdrawal. Such withdrawal symptoms may be associated with an increase in traumatic memories, exacerbation of PTSD symptoms and possibly increased suicide risk. There is a need to conduct a polysubstance abuse assessment.

There is a need to develop integrative treatment programs that address patients with comorbid disorders such as PTSD and SUD, PTSD and anger-control problems, PTSD and depression/guilt reactions. For example, see Abueg et al, 1995; Donovan et al., 1999, 2001; Chemtob et al., 1997; Kubany et al., 2006; Novaco & Chemtob, 1988; Ouimette et al., 1997, 1998, 2000; Reilly et al., 1994.

These treatment programs are designed to reduce trauma-related guilt, reduce substance abuse and anger, interpersonal conflicts and violence, and help patients confront avoided situations and contacts, develop more social contacts and intimacy with others, reduce hypervigilance behaviors and manage related PTSD symptoms and improve their quality of life. The treatment is designed to help them anticipate (plan ahead) and learn to cope with commonly occurring relapse triggers.

Murphy (2008) highlights that the evidence for the treatment effectiveness of combat-related PTSD is still limited (see Fontana & Rosenheck, 2004 and Schnurr et al. 2003). Murphy (2008) describes ways to incorporate Motivational Interviewing procedures that include collaborative goal setting and problem-solving, relapse prevention procedures so soldiers do not get “blindsided” by internal (emotional) and external (reminders) triggers, and ways to anticipate and address potential road blocks to maintaining treatment improvements. (See Meichenbaum, 1994, 2002, 2006a,b, 2007 for examples of ways to employ a patient-centered intervention approach with distressed traumatized individuals).

Benish et al. (2008) have conducted a meta-analysis of various psychological treatments for adult individuals (some 15 studies with 958 patients and they found no differences between various interventions including exposure-based treatments and treatments designed explicitly to exclude exposure such as present-centered therapies. Moreover, dismantling studies have failed to

identify the validity of specific ingredients (e.g., the eye movement component of EMDR). Their results suggest that is the common factors to all treatments that are likely responsible for the benefits of treatment.

Even though the Benish et al. Meta-analysis should give pause to those who advocate a specific treatment approach, there are a number of cognitive-behavior therapists who have advocated specific treatment procedures such as prolonged exposure, cognitive processing therapy, coping skills and mindfulness training.

A number of Clinician guidebooks on the application of cognitive-behavior therapy are available. See Follette & Razek, 2006; Institute of Medicine, 2007; Taylor, 2006; Zayfert & Becker, 2007. In regard to treat children with PTSD see Cohen et al. (2006) and www.musc.edu/tfiht; www.netsnet.organdmodelprograms.samhsa.gov

EVIDENCE OF RESILIENCE IN RETURNING SERVICE MEMBERS AND THEIR FAMILY MEMBERS

- Most returning veterans (approximately 70%), are **RESILIENT**. The typical service member today is healthier, fitter, better educated and more resilient than the typical civilian. Indeed, only 25% of the young adults in the U.S. would make the grade were they inclined to volunteer for the military.
- From the time of World War I to the present, veterans as a group have resumed “normal” lives and are well adjusted. They are more likely to get a higher education, achieve more job success as civilians, get arrested less often than their peers who never served.
- Veterans of war and peacekeeping efforts who had been deployed reported more positive than negative effects. They indicated that deployment had an overall positive meaning on their lives, contributed to better psychological adjustment and to higher levels of life satisfaction and higher occupational attainment.
- The majority of veterans (70%) judge the impact of their service on their present lives as “very meaningful” and that their service to their country was still highly important in their lives. Veterans have positive feelings of making a significant contribution. They feel part of a greater cause for their country having helped to protect their family and community.
- Veterans report that their combat experience taught them how to cope with adversity, to be self-disciplined and instilled feelings of greater independence, honor and accomplishment. For example, among aviators shot down, imprisoned and tortured for years by the North Vietnamese, 61% said that they had benefited psychologically from their ordeal. They reported that imprisonment had produced favourable changes, increasing their self-confidence and teaching them to value the truly important things in life. The more severe their imprisonment experience, the more likely the POWs were to report “posttraumatic growth.”
- Military training facilitated the veterans’ ability to establish and maintain healthy relationships both in and outside of the military. For example, the divorce rate among returning service members is lower than the divorce rate in the general population.
- Many returning soldiers report enhanced meaning and comradeship (“Band of Brothers/Sisters”) as a result of their service. They take pride in their service.
- They have learned many things while serving that they can apply positively in their civilian life.
- Currently, 71% of officers and 50% of enlisted personnel are married. 42% of all service members have children. About 10% of the Armed Forces are dual-career marriages, being married to another member of the military. A common saying in the military is that “when one person joins, the whole family serves”.

- Like returning service members, military families are generally **RESILIENT** and a healthy and robust group. Most military spouses and military children rise to the occasion and do well. This level of **RESILIENCE** is impressive given the recurrent separations, difficult reunions, threat of injuries or death, and for active duty military personnel multiple moves every two to three years, long and often unpredictable duty hours.
- Among the more than 700,000 members of Reserve and National Guard who have been activated since 9/11, they constitute 35% of all military children. Their families face specific challenges of living off base among civilians and as a result are less integrated into a military community with less access to military support systems and programs. Many have had to leave or put on hold their civilian careers because of their sudden military status. These challenges may put Reserve families (spouses and children) at greater risk, as they receive less support from peers and teachers than families of active duty members. Specific interventions across the full deployment cycle can help bolster resilience in Reserve families. Like returning service members, military families are generally **RESILIENT** and a healthy and robust group. Military families who function most effectively are active, optimistic, self-reliant and flexible. They can keep things in perspective and embrace change and adaptation as necessary. They find meaning in military life and identify with the work of their uniformed family member. They maintain good relationships with family, friends and neighbors who welcome and support them.

“If the family as a whole adjusts well to deployment, so do their children. Family and children well-being are closely connected”. (N. Park, 2011)

- Most spouses of returning service members believe that deployment has strengthened their marriages. Only 10% felt that deployment weakened their marriages.
- Deployment contributed to the development of new family skills and competencies, a sense of independence and self-reliance. The majority of military spouses reported that deployment of their mate provided them with opportunities for personal growth such as becoming more self-confident in handling problems and stressors.
- Military families were found to be comparable with civilian families in terms of physical and mental health despite having to deal with the unique demands of military life such as moving often, foreign residence and deployment.
- For Active Duty military personnel, family-specific resiliency factors include access to comprehensive health care, education, consistent employment for active duty soldiers, legal assistance and social support services such as Yellow Ribbon, Military One Source, Family resilience campaign and activities, Spouse Battlemind Training, writing projects, child supports.
- Since the start of the conflicts in Iraq and Afghanistan, over two million children have been directly affected by the deployment of a parent.

- Children in military families are also typically resilient, even after experiencing significant traumas and losses. Military children typically function as well as or even better than civilian children on most indices of health, well being and academic achievement. They have similar or lower rates of childhood mental disorders, lower rates of juvenile delinquency, lower likelihood of alcohol or drinking abuse, better grades and higher IQs than their civilian counterparts. Military children are in general healthy, have good peer relationships, are engaged in school and community activities and are satisfied with life, having high optimism and a positive self-image. They evidence more respect for authority. They are more tolerant, resourceful, adaptable, responsible and welcoming of challenges. They are more likely of befriending and knowing someone who is “different”. They show lower levels of impatience, aggression and disobedience and higher levels of competitiveness.

“Most military children are happy to embrace the term ‘military brat’ which comes to stand for being brave, adaptable, responsible, independent, proud, trustworthy, and RESILIENT” (N. Park, 2011).

- These findings take on a greater significance when we learn that nearly 900,000 U.S. children have had at least one of their parents deployed since 2001. Currently, 234,000 children have one or both parents at war.
- Following combat exposure, somewhere between 10% and 30% of returning soldiers may evidence PTSD, (or symptoms of PTSD), depression, anxiety and related readjustment problems. But, the majority (over 70%) do not.
- There are effective, short-term treatments to help those who have readjustment problems.
- *“Overall, military experience is a positive experience for most who serve. Time spent in the military allows many individuals to develop deep bonds with others who serve beside them, fosters feelings of pride and fulfillment in serving one’s country, and it may also provide a broader perspective on life.” (Selby et al. 2010, p. 304)*
- Finally, if you want to understand what Resilient Service Members do, consider the research findings of Drs. Dennis Charney and Steven Southwick. They studied 250 American Prisoners of War during the Vietnam War who were held captive for up to eight years and subjected to torture and solitary confinement. Remarkably years after their release, they had lower-than-expected incidence of depression and PTSD. To determine how these men handled such a dire experience, yet in many cases came out stronger than before, they studied them intensely and came up with the following prescription for a **RESILIENT LIFE**. As you consider this list of attributes, research has indicated that the same markers were found in women who had suffered severe trauma, especially sexual and physical abuse and combat exposure.
 - **Establish and nurture a supportive social network** - - Emotional strength comes from close meaningful supportive relationships.

- **Be optimistic** - - Optimism is strongly related to resilience.
- **Develop cognitive flexibility** - - ability to reframe stressful events. Resilient POWs regard their years in captivity as horrendous, but they learned valuable things about themselves that they would not have learned in any other way.
- **Develop a personal “moral compass” or shatterproof set of beliefs.** Use one’s faith or sense of spirituality as a guiding force. Many POWs never lost their faith and prayed every day of their captivity.
- **Be altruistic** - helping others and being part of a group who survived together aided their coping abilities with extreme stressors. The belief in a survivor’s mission can be a lifesaver to traumatized people.
- **Find a resilient model in a mentor or heroic figure.** Role models can be inspiring and provide valuable coping tips.
- **Learn to be adaptive in facing your fears.** Recognize that fear and other intense emotions like sadness, grief, anger are “normal” and can act as a guide. It is not that one has such intense feelings, but it is what one does with these emotions that is critical to adjustment.
- **Develop active coping skills.** Resilient individuals have a broad repertoire of coping skills that they can call upon to meet the demands of the situation. Sometimes they use direct action problem-solving coping skills and sometimes they use emotionally palliative acceptance coping strategies. Resilient Service Members also express confidence in their abilities to adapt to stressful situations.
- **Have a sense of humor and laugh frequently.** Positive emotions fuel resilience.
- **Keep fit.** Exercise is good for physical and psychological well-being and also enhances brain health and plasticity.

This **ROADMAP TO RESILIENCE** Handbook takes a page out of the playbook of Resilient Service Members and spells out in detail what they do to bolster their Resilience and deal with post-deployment stress effects. Resilience can be developed through focused training and by stress-inoculation training procedures. You can learn to recognize your own strengths and engage them to deal with challenging situations. We all have things we can do very well. The idea is to build on them when you are faced with stressful situations. You can learn to leverage your RESILIENCE into life changes.

QUOTABLE QUOTES

“The number one thing you should know about OIF/OEF Veterans is that they are not the same people they were before they were deployed. But do not assume that is a bad thing. The Service Member may come home more confident, with better problem-solving skills. He or she

may return with a deeper sense of gratitude for the comforts he used to take for granted or she may have found a greater sense of purpose or direction than she ever had before. Yes, there are maybe many unseen wounds of the soul and spirit, but there are tremendous resources to help heal these 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."

*Alison Lightfield, Former Captain, US Army Nurse Corps
www.hand2handcontact.org*

"Veterans returning from Iraq and Afghanistan often show amazing courage and survival skills, not only in war, but also at home."

*Armstrong, Best and Domenici
(Courage after fire, 2006)*

WHAT IS RESILIENCE?

RESILIENCE is the capacity of people to effectively cope with, adjust, or recover from stress or adversity.

RESILIENCE is the process and outcome of successfully adapting to difficult or challenging life experiences and the ability to rise above one's circumstances.

RESILIENCE reflects the ability to confront and handle stressful life events, ongoing adversities and difficulties, and traumatic experiences, both while deployed and also when reintegrating into civilian life.

RESILIENCE reflects the ability to maintain a stable equilibrium and relatively stable healthy level of psychological and physical functioning, even in the face of highly disruptive stressful and traumatic events.

RESILIENCE reflects the ability to

- bounce back
- beat the odds
- transform one's emotional and physical pain into something "positive"
- evidence a relatively stable trajectory of healthy functioning across time
- move from being a victim to being a "survivor" and even to becoming a "thriver"
- be "stress hardy" adapting to whatever life sends, and for some, even evidencing "post- traumatic growth"

As a result of experiencing traumatic events, some individuals will experience **POST-TRAUMATIC GROWTH (PTG)**. PTG is the ability to experience positive personal changes that result from the struggle to deal with trauma and its consequences. PTG highlights that strengths can emerge through suffering and struggles with adversities. Individuals may develop a renewed appreciation of life and a commitment to live life to the fullest, valuing each day; improved relationships with loved ones; a search for new possibilities and enhanced personal strengths and new spiritual changes. This **ROADMAP to RESILIENCE** project provides practical tools to increase your ability to develop Post-traumatic growth. Not only to **LEARN IT**, but **LIVE IT**.

Perhaps, the concept of **RESILIENCE** was best captured by Helen Keller who was born blind and deaf when she observed,

"Although the world is full of suffering, it is also full of overcoming it".

As one returning Vet commented:

"Resilience is moving from taking orders or completing other people's missions to creating your own missions and bringing on-line your own decision-making abilities. I have a deeper meaning of life as a result of my deployments."

As often observed:

"Man has never made a material more resilient than the human spirit."

SOME FACTS ABOUT RESILIENCE

Following a natural catastrophe or a traumatic event no one walks away unscathed by such events, but neither do most survivors succumb in the aftermath to despair. Most show remarkable levels of resilience.

The ceiling for harmful effects is about 30% of those exposed.

People are much more resilient under adverse conditions than they might have expected.

A person may be resilient in some situations and with some type of stressors, but not with other stressors.

Resilience is more accessible and available to some people than for others, but everyone can strengthen their resilience.

Resilience may be available and more accessible to a person at one period of time in his/her life than at other times in his/her life. Individuals may go through periods of extreme distress, negative emotions and poor functioning and still emerge resilient.

Resilience (positive emotions) and negative emotions can co-occur side-by-side.

Research indicates that individuals who have a ratio of 3 times as many experiences of positive emotions to 1 of negative emotions on a daily basis (3-to-1 ratio) are more likely to be resilient and have a successful reintegration.

Resilience does not come from rare and special or extraordinary qualities or processes. Resilience develops from the everyday magic of ordinary resources. Resilience is not a sign of exceptional strength, but a fundamental feature of normal, everyday coping skills.

There are many different pathways to resilience. A number of factors contribute to how well people adapt to adversities. Predominant among them are:

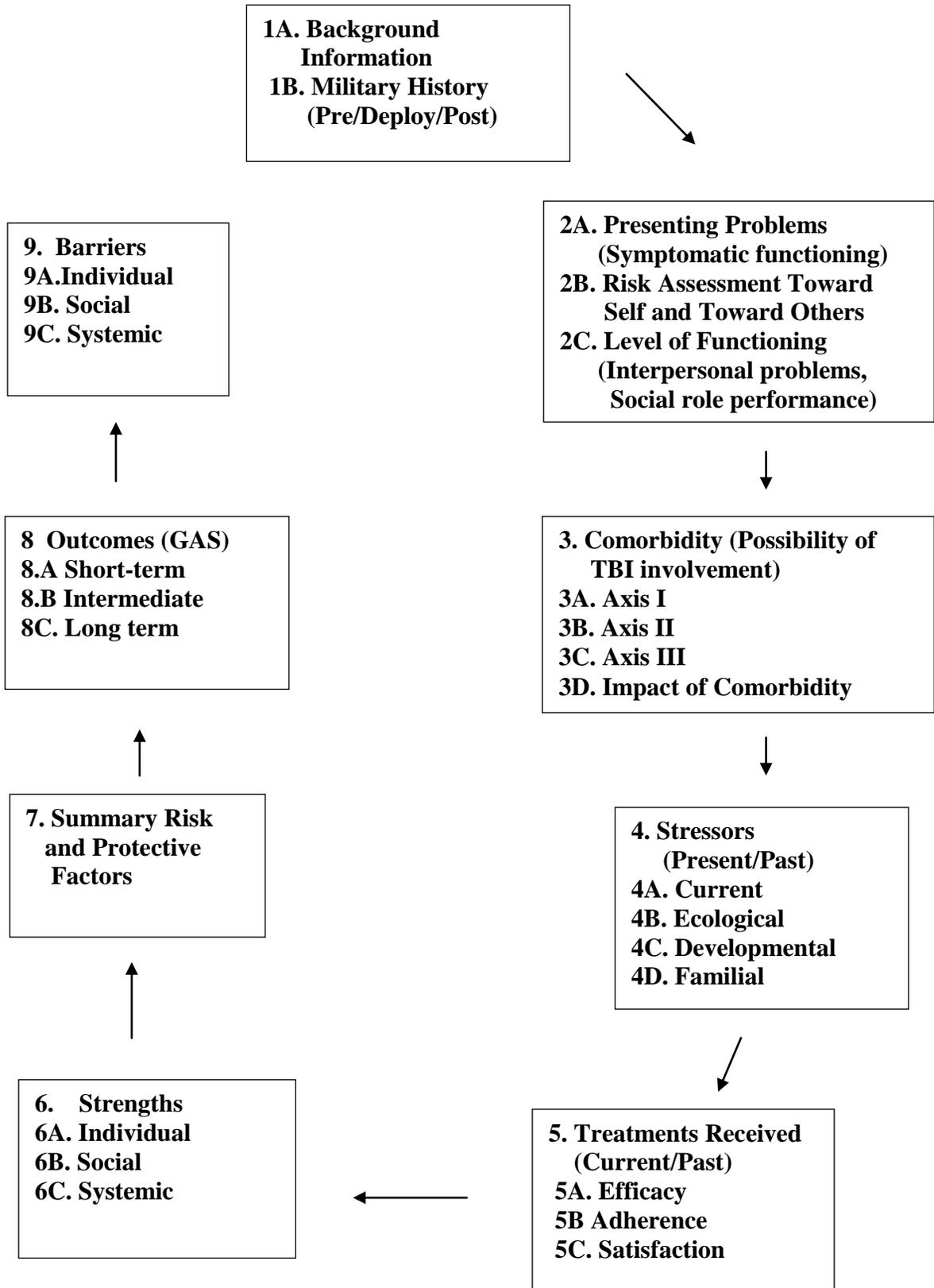
- a) the perceived availability of social relationships and the ability to access and use social supports;
- b) the degree of perceived personal control and the extent to which individuals focus their time and energies on tasks and situations over which they have some impact and influence;
- c) the degree to which they can experience positive emotions and self-regulate negative emotions;
- d) the ability to be cognitively flexible, using both direct-action problem-solving and emotionally-palliative acceptance skills, as the situations call for;
- e) the ability to engage in activities that are consistent with one's values and life priorities that reflect a stake in the future;

There are many roads to travel and many forks along the pathway to resilience. It is possible to change course at many points.

Individuals who are low in resilience are at risk for experiencing stress, depression, anxiety and interpersonal difficulties.

A RESILIENCE REINTEGRATION PROGRAM can promote subjective well-being.

GENERIC CASE CONCEPTUALIZATION MODEL TAILORED TO RETURNING SERVICE MEMBERS
(A Multiple-focused Assessment Strategy)



FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS AND RELATIONSHIP TO MILITARY EXPERIENCE

“What brings you here...? (distress, symptoms, present and in the past)
 “And is it particularly bad when...” “But it tends to improve when you...”
 “And is it affecting you (how...in terms of relationship, work, etc)”
 “Would it be okay if we discussed how your present reactions are tied into your military experiences?”
 (Review information from 1B)

BOX 3: COMORBIDITY

“**In addition**, you are also experiencing (struggling with)...”
 “And the impact of this in terms of your day-to-day experience is...”

BOX 4: STRESSORS

“Some of the factors (stresses) that you are currently experiencing that seem to **maintain** your problems are...or that seem to **exacerbate** (make worse) are... (**Current/ecological stressors**)
 “And it's not only now, but this has been going on for some time, as evident by...” (Review impact of Military experiences and Developmental stressors)
 “And it's not only something you have experienced, but your family members have also been experiencing (struggling with)...” “And the impact on you has been...” (**Familial stressors and familial psychopathology**)

BOX 5: TREATMENT RECEIVED

“For these problems the treatments that you have received were-note type, time, by whom”
 “And what was **most effective** (worked best) was... as evident by...
 “But you had **difficulty following** through with the treatment as evident by...” (Obtain an adherence history)
 “And some of the difficulties (barriers) in following the treatment were...”
 “But you were specifically **satisfied** with...and would Recommend or consider...”

BOX 6: STRENGTHS

“But **in spite of**...you have been able to...”
 “Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situations are...”
 “Moreover, some of the people (resources) you can call upon (access)are...” “And they can be helpful by doing...” (**Social supports**)
 “And some of the services you can access are...” (**Systemic resources**)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“Have I captured what you were saying?”
 (Summarize risk and protective factors)
 “Of these different areas, where do you think **we** should begin?” (Collaborate and negotiate with the patient a treatment plan. Do **not** become a “surrogate frontal lobe” for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

“Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
 “How are things now in your life? How would you like them to be? How can **we** work together to help you achieve these short-term, intermediate and long-term goals?”
 “What has worked for you in the past?”
 “How can our current efforts be informed by your past experience?”
 “Moreover, if you achieve **your** goals, what would you see changed?”
 “Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

“Let me raise one last question, if I may. Can you envision, can you foresee, anything that **might get in the way**- any possible obstacles or barriers to your achieving your treatment goals?”
 (Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
 “Let's consider how we can anticipate, plan for, and address these potential barriers.”
 “Let us review once again...” (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.

“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Thinking Level

Engage in self-focused, “mental defeating” type of thinking. Perception that one has lost autonomy as a human being, lost the will to exert control and maintain identity, lose the belief that one has a “free will.” See self as a “victim”, controlled by uninvited thoughts, feelings and circumstances, continually vulnerable, unlovable, undesirable, unworthy. Use dramatic metaphors that reinforce this style of thinking. “I am a prisoner of the past”, “Entrapped”, “Contaminated”, “Damaged goods”, “A doormat”, “An outsider.” Experience a form of Mental exhaustion, mental weariness.

Hold erroneous beliefs that changes are permanent, the world is unsafe, unpredictable and that people are untrustworthy. Hold a negative, foreshortened view of the future and the belief that life has lost its meaning.

Engage in self-berating, self-condemnation, self-derogatory “story-telling” to oneself and to others (i.e., self blame, guilt-engendering hindsight, biased thinking; anger-engendering thoughts of viewing provocations as being done “on purpose”).

Engage in upward social comparisons, so one compares poorly in one’s coping abilities. Be preoccupied with what others think of you. Engage in comparison of self versus others; before versus now; now versus what might have been.

Ruminate repeatedly, dwell on, focus upon, brood, pine over losses, “near miss” experiences. Replay over and over your concerns about the causes, consequences and symptoms related to negative affect and losses. Use repetitive thinking cycles (“loss spiral”).

Engage in contra-factual thinking, repeatedly asking “Why me” and “Only if” questions for which there are no satisfactory answers.

Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation.

Have an overgeneralized memory and recall style which intensifies hopelessness and impairs problem-solving. Difficulty remembering specific positive experiences. Memories are fragmented, sensory driven and fail to integrate traumatic events into autobiographical memory or narrative.

Engage in “thinking traps”. For example, tunnel vision as evident in the failure to believe anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one’s self-identity; or recall any positive coping memories of what one did to survive, or what one is still able to accomplish “in spite of” victimization; do mind-reading, overgeneralizing, personalizing, jumping to

conclusions, catastrophizing; “sweating the small stuff”, and emotional reasoning such as viewing failures and lapses as “end points”.

Evidence “stuckness” in one’s thinking processes and behavior. Respond to new situations in post-deployment settings “as if” one was still in combat (misperceive threats).

At the Emotional Level

Engage in emotional avoidance strategies (“Pine over losses”, deny or shift your feelings, Clam up, bury your emotions and do not consider the possible consequences of doing so).

Magnify and intensify your fears and anger.

Experience guilt (hindsight bias), shame, complicated grief, demoralization.

Fail to engage in grief work that honors and memorializes loved ones or buddies who were lost.

Fail to share or disclose feelings, process traumatic memories. Focus on “hot spots” and “stuck points.”

At the Behavioral Level

Engage in avoidant behaviors of trauma-related feelings, thoughts, reminders, activities and situations; dissociating behaviors.

Be continually hypervigilant, overestimating the likelihood and severity of danger. Act as if you are on “sentry duty” all the time; Act like a faulty smoke detector that goes off at the slightest signal.

Engage in safety behaviors that interfere with the disconfirmation of emotional beliefs and the processing (“restoring”) of trauma-related memories and beliefs.

Engage in delay seeking behaviors. Avoid seeking help. Keep secrets and “clam up”.

Engage in high risk-taking behaviors; chasing the “adrenaline rush” in an unsafe fashion; Put self at risk for revictimization.

Engage in health-compromising behaviors (smoking, substance abuse as a form of self-medication, lack of exercise, sleep disturbance that goes untreated, poor diet, dependence on energy drinks, abandonment of healthy behavioral routines).

Engagement in self-handicapping behaviors (“excuse-making”), avoidance behaviors.

Use passive, disengaged coping behaviors, social withdrawal, resigned acceptance, wishful thinking and emotional distancing.

At the Social Level

Withdraw, isolate oneself, detach from others.

Perceive yourself as being unwanted, a “burden”, thwarted belongingness, distrusting others. (“No one cares”, “No one understands”. “No one can be trusted”).

Associate with peers and family members who reinforce and support maladaptive behaviors. Put yourself in high-risk situations.

Experience an unsupportive and indifferent social environment (i.e., critical, intrusive, unsympathetic- - offering “moving on” statements).

Fail to seek social support or help, such as peer-related groups, chaplain services, or professional assistance.

At the Spiritual Level

Fail to use your faith or religion as a means of coping.

Have a “spiritual struggle” and view God as having punished and abandoned you.

Use negative spiritual coping responses. Relinquish actions to a higher power, plead for miracles, or divine intervention; Become angry with God; Be demanding.

Experience “moral injuries” that compromise values. Lose your “moral compass” and “shatter” your deeply held beliefs in safety, trust, self-worth; experience a “soul wound.”

Avoid contact with religious members who can be supportive.

HOW TO CREATE A “HEALING STORY”
 (“Beware of the stories you tell, you will be lived by them.”)

*Every year of our lives, we add well over half a million minutes to our banks of experience. How we organize, chronicle, interpret, imbue them with meaning, share these experiences and weave them together into “stories” will influence how **RESILIENT** we become.*

We don’t just tell stories, stories tell us. The tales we tell hold powerful sway over our memories, behaviors and even identities. Stories are fundamental to our being. Once you tell a story, it is hard to get out of that story’s framework. Over time, the stories we tell tend to get more dramatic. The stories we tell others and to ourselves grip our imagination, impregnate our hearts and animate our spirit.

1. Following exposure to traumatic events, up to 30% of individuals may evidence chronic distress, and even develop Post-traumatic Stress Disorder and related problems. For such distressed individuals, their memories are over-generalized (lacking in detail) that intensify their sense of hopelessness and impairs their problem-solving abilities. Their traumatic narrative is inadequately integrated into their autobiographical memories. Their stories have an inflated sense of responsibility with accompanying excessive guilt and shame. They misperceive their distressing reactions as signs that they are “going crazy” and that they are “worthless” and that they are a burden on others. Their stories convey the belief that the world is unsafe and unpredictable, unjust, and that people are unappreciative of their sacrifices, untrustworthy and unsympathetic. They may feel marginalized, isolated and rejected.

For those who are struggling, their stories are filled with “hot spots” and “stuck points” and their thoughts and accompanying feelings are viewed as unwanted, uninvited and involuntary, poorly controlled, nor accepted.

In their attempt to stop or suppress such thoughts and feelings, and in their efforts to avoid reminders, they may paradoxically experience even more intrusive distressing thoughts, images and intense feelings and urges. Their coping efforts actually **BACKFIRE** and act like a **BOOMERANG**. They may try to cope by self-medicating (using alcohol, drugs), by trying distraction or engaging in high-risk reckless behaviors (withdrawing, isolating themselves, being hypervigilant, on “sentry duty” all the time) that inadvertently, unwittingly and perhaps unknowingly, make their level of distress even worse.

2. **In contrast, RESILIENT** individuals and Service Members are psychologically agile and flexible in how they tell their stories. They include in their story-telling examples of what they did and how they coped and survived. They tell the “rest of their story.” They weave into their story-telling the upside of what happened, as well. They view any traumatic events that they experienced as a “turning point”, a “fork in the road”, a “temporary detour” on their personal journey. Their stories are rich with healing metaphors, mottos, and examples of pain, but also survival.

3. Resilient individuals may take some time to experience grief or unhappiness, distress, anger and loss, sadness and anxiety which improves their abilities to better appreciate the world in all of its complexity and richness.
4. Resilient individuals tend to tell stories that have redemptive sequences in which bad events have good outcomes, as compared to contamination sequences when the reverse happens.
5. Resilient individuals slow down how they tell their stories and break their experiences into pieces. They examine the pieces in terms of all the complexities and then they connect the dots. They do not act like a “Monday morning quarterback,” who has hindsight bias, blaming themselves for things they did not know at the time.
6. Resilient individuals are on the lookout for unexplored “open spaces” in their narrative that act as a guide to new goals and alternatives. Redemption stories bolster hope, strengthen self-confidence that their efforts will bear fruit. They strengthen the belief in the possibility of positive outcomes. Changes in story-telling provide access to new solutions.
7. Resilient individuals tend to tell **COHERENT STORIES** that create meaning out of their stressful life experiences and in which they see themselves as “personal agents” often with the assistance of others, of the positive changes that they have been able to bring about. These **COHERENT NARRATIVES** are clearly articulated, detailed, logical and well organized. Such **COHERENT** stories are salutary and help reduce distress. They increase the survivor’s sense of control over his or her experiences, reduce feelings of chaos and increase the sense that the world is predictable, orderly and beneficent. Coherent story-telling can provide a degree of “closure” by helping make sense of what happened and how people responded. Narrative coherence conveys feelings of personal self-efficacy and points a direction to the future. It is not enough to help individuals create a trauma narrative, but it is also essential to help individuals integrate such thoughts and feelings into a consistent coherent meaningful experience and story. Trauma is only one part of an individual’s life, rather than the defining aspect.
8. Resilient individuals have the ability and penchant to tell their fragmented stories in a chronological narrative with before, middle and post-trauma exposure or post-deployment parts. They are able to integrate what happened during deployment into their autobiographical memory and let the “past be the past.” As one Resilient individual stated: “I have no interest in going back to the past and getting stuck again.” Resilient individuals refuse to allow the “trauma stories and images” to become dominant in their narrative and take away their sense of identity. They can disentangle themselves from the influence and lingering impact of traumatic events. They engage in a narrative healing process.
9. Resilient individuals avoid “thinking traps” that can derail their story-telling (**See item 64**). Instead they incorporate in their story-telling “cherished recollections”, “fond memories”, a “heritage of remembrances”, “change talk” (**See item 65**), “RE-verbs”, (**See item 62**). Resilient individuals tell stories that enrich their lives and help them get past their personal

challenges. They tell stories that they can pass onto the next generation, as “lessons learned.”

10. Resilient individuals tell their stories first and then they live their way into them. They may act “as if” they are characters in the stories that they tell. There may be a certain amount of “fake it, until you make it.”
11. **Listen to the stories you tell others and that you tell yourself. Do your stories include:**
 - a) **Redemptive (positive ending) sequences;**
 - b) **RE-words and change talk action verbs;**
 - c) **Goal statements and “how to” pathways thinking;**
 - d) **Problem-solving strategies, Action Plan with “if...then” statements and expressions of self-confidence and “GRIT” (dogged persistence);**
 - e) **Expressions of optimism, including statements of benefit finding and benefit remembering (“Silver lining” thinking), downward comparisons (“Could have been worse”) statements;**
 - f) **Meaning-making statements (“Making a gift”, “Sharing lessons learned” statements)?**

Ask yourself and others, if the stories you tell are elaborate, organized, coherent (having a beginning, middle and end) that are now integrated as part of your autobiographical memory? Does your story open up new possibilities for change and provide a positive blueprint for the future? If not, how can you begin to change your story? How can you develop a **RESILIENT MINDSET**?

SUMMARY

Psychological Characteristics of Resilient Individuals

Experience Positive Emotions and Regulate Strong Negative Emotions

Be realistically optimistic, hopeful, ability to laugh at oneself, humor, courage, face one's fears and manage emotions. Positive expectations about the future. Positive self-image. Build on existing strengths, talents and social supports.

Adapt a Task-Oriented Coping Style

Ability to match one's coping skills, namely direct action present-focused and emotionally-palliative acceptance with the demands of the situation. Actively seek help and garner social supports. Have a resilient role model, even a heroic figure who can act as a mentor. Have self-efficacy and a belief that one can control one's environment effectively. Self confidence. Seek out new and challenging experiences out of one's "comfort zone" and evidence "GRIT" or the perseverance and passion to pursue long-term goals.

Be Cognitively Flexible

Ability to reframe, redefine, restory, find benefits, engage in social problem-solving and alternative thinking to adaptively meet changing demands and handle transitional stressors.

Undertake a Meaning-Making Mission

Create meaning and a purpose in life; survivor's mission. Use one's faith, spirituality and values as a "moral compass." Be altruistic and make a "gift" of one's experience. Share one's story. General sense of trust in others.

Keep Fit and Safe

Exercise, follow a routine, reduce risks, avoid unsafe high-risk behaviors (substance abuse, chasing "adrenaline rush" activities).

**SUMMARY OF WAYS TO SUCCESSFULLY REINTEGRATE AND BECOME MORE
RESILIENT - - DO's AND DON'Ts**

<u>AREAS OF FITNESS</u>	<u>DO's</u>	<u>DONT's</u>
PHYSICAL	Take care of your health and body Engage in health-promoting behaviors	Overlook health and abuse your body Avoid exercise
INTERPERSONAL	Nurture positive relationships (Reconnect, Share, Renegotiate roles)	Isolate, withdraw, avoid help
EMOTIONAL	Experience Ratio 3 positive to 1 negative emotion (3:1) Take Steps to Emotional Fitness (Use opposite actions, Acceptance/Mindfulness, Face fears, Grieve)	Behave in ways that escalate and maintain a “negative emotional spiral”
THINKING	Adopt a Resilient MINDSET Be psychologically flexible Be optimistic, hopeful (benefit finding and remembering) Avoid “thinking traps”	Engage in negative thinking
BEHAVIOR	Restore regular safe routines Access information, Show Gratitude, Use “Action Plans” Show GRIT, Seek assistance	Engage in “high-risk” activities
SPIRITUAL	Use POSITIVE spiritual/religious ways of coping. Engage in a meaning-making mission, Reset your “moral compass”, Forgive self and others, Use your faith and religion as an aide	Use NEGATIVE spiritual/religious coping strategies

APPENDIX A

RESILIENCE CHECKLIST

MY PERSONAL RESILIENCE PLAN

Creating A Vision of the Future

In each of the following **FITNESS** areas, identify the specific things you plan to do in order to improve your level of **RESILIENCE**. How much confidence do you have that you will be able to follow through on each Resilience-Bolstering Behavior?

P - - PHYSICAL FITNESS

- ___ 1. Take care of my body.
- ___ 2. Exercise regularly.
- ___ 3. Get good sleep.
- ___ 4. Eat healthy.
- ___ 5. Avoid mood-altering drugs, overuse of alcohol.
- ___ 6. Manage pain (physical and emotional).
- ___ 7. Avoid high-risk dangerous behaviors.
- ___ 8. Other examples of ways I can **KEEP PHYSICALLY FIT**.

I - - INTERPERSONAL FITNESS

- ___ 9. Recognize deployment changes everyone and that readjustment takes time.
- ___ 10. Reconnect with social supports.
- ___ 11. Lean on others and seek and accept help.
- ___ 12. Give back and help others. Share my "islands of competence" with others.
- ___ 13. Participate in a social network.
- ___ 14. Share my emotions with someone I trust.
- ___ 15. Strike a balance between my war buddies and my loved ones.
- ___ 16. Overcome barriers to seeking help.
- ___ 17. Renegotiate my role at home.
- ___ 18. Use my communication (speaker/listener) skills and my social problem-solving skills.
- ___ 19. Use my cultural or ethnic traditions, rituals and identity as a support aide.
- ___ 20. Find a role model or mentor.
- ___ 21. Use community resources such as Websites, telephone hotlines.
- ___ 22. Be proud of the mission that I served with my "Band of Brothers/Sisters."
- ___ 23. Use pets to maintain and develop relationships.
- ___ 24. Other examples of ways to **DEVELOP AND USE RELATIONSHIPS**.

E - - EMOTIONAL FITNESS

- ___ 25. Cultivate positive emotions (hobbies and pleasurable activities).

- _____ 26. Engage in an **UPWARD SPIRAL** of my positive emotions, thoughts and behaviors.
- _____ 27. Make a “**BUCKET LIST**” of emotional uplifting activities and then **JUST DO IT!**
- _____ 28. Show “**GRIT**” - - ability to pursue with determination long-term goals. (“*Choose hard right, over easy wrong.*”)
- _____ 29. Use positive humor.
- _____ 30. Cope with intense emotions by using opposite actions.
- _____ 31. Give myself permission to experience and share emotions (feel sad, cry, grieve, become angry).
- _____ 32. Face my fears.
- _____ 33. Engage in constructive grieving (memorialize and honor those who have been lost).
- _____ 34. Share my story and the “rest of my story” of what led me to survive (share lessons learned).
- _____ 35. Allow myself to share my “emotional pain” with someone I trust.
- _____ 36. Journal - - use “writing cure.”
- _____ 37. Use creative and expressive activities to work through my feelings.
- _____ 38. Enjoy the benefits of self-disclosure.
- _____ 39. **RE STORY** my life and share evidence of my **RESILIENCE**.
- _____ 40. Take specific steps to **EMOTIONAL FITNESS**.
- _____ 41. Change my self-talk.
- _____ 42. Engage in non-negative thinking and become more **STRESS-HARDY**.
- _____ 43. Show gratitude.
- _____ 44. Other examples to improve my **EMOTIONAL FITNESS**.

T - - THINKING FITNESS

- _____ 45. Be psychologically flexible.
- _____ 46. Use constructive thinking and consider alternative solutions/pathways.
- _____ 47. Establish achievable goals.
- _____ 48. Establish realistic expectations.
- _____ 49. Look at things differently.
- _____ 50. Use hope to achieve goals.
- _____ 51. Be realistically optimistic.
- _____ 52. Bolster a sense of self- confidence and self-efficacy.
- _____ 53. Engage in benefit-finding. (“*Search for the silver lining.*”)
- _____ 54. Engage in benefit-remembering.
- _____ 55. Engage in downward comparison. (Consider those less fortunate.)
- _____ 56. Go on a meaning making mission. List and share positive military experiences with others.
- _____ 57. Engage in altruistic (helping) behaviors.
- _____ 58. Find meaning in my suffering and move toward “post-traumatic growth.”
- _____ 59. Consider lessons learned from my deployment that I can share with others.
- _____ 60. Be mindful- - stay in the present.
- _____ 61. Maintain my “moral compass.” Stick to my key values.
- _____ 62. Use my Change Talk.
- _____ 63. Control my self-talk.

- _____ 64. Avoid “**THINKING TRAPS.**”
- _____ 65. Nurture a positive view of myself, others and the future.
- _____ 66. Create a “**HEALING STORY.**”
- _____ 67. Other examples of ways to improve my **THINKING FITNESS.**

B- BEHAVIORAL FITNESS

- _____ 68. Develop safe regular routines.
- _____ 69. Stay calm under pressure. Keep my cool.
- _____ 70. Prepare for possible high-risk situations.
- _____ 71. Break tasks into doable subtasks.
- _____ 72. Get unstuck from the past.
- _____ 73. Improve my “people-picking” skills. Avoid people, places and things that get me into trouble.
- _____ 74. Take a “news holiday.”
- _____ 75. Co-exist with my difficult memories and use positive emotions to **UNDO** negative memories.
- _____ 76. Self-disclose to a trusted person.
- _____ 77. Join a social group that gives my life a sense of purpose.
- _____ 78. Renegotiate my role and responsibilities.
- _____ 79. Adopt a **CAN DO** attitude.
- _____ 80. Read to find comfort.
- _____ 81. Gather information (visit websites).
- _____ 82. Avoid making things “worse.”
- _____ 83. Continue my “journey of healing” and view setbacks as “learning opportunities.”
- _____ 84. Use my **ACTION PLANS** and **BACK-UP PLANS.**
- _____ 85. Other examples of ways to improve my **BEHAVIORAL FITNESS.**

S- SPIRITUAL FITNESS

- _____ 86. Use **POSITIVE** religious/spiritual ways of coping.
- _____ 87. Avoid using **NEGATIVE** religious/spiritual ways of coping.
- _____ 88. Maintain **HOPE.**
- _____ 89. Visit the Chaplain or some other Clergy person for assistance.
- _____ 90. Use some form of spiritual/religious/devotional activities.
- _____ 91. Participate in a spiritual and religious group.
- _____ 92. Engage in spiritual/religious rituals.
- _____ 93. Engage in commemorative services.
- _____ 94. Forgive others and also forgive myself.
- _____ 95. Address my “moral injuries” and “soul wounds”.
- _____ 96. Use my religious beliefs and traditions.
- _____ 97. Share the spiritual lessons learned from my deployment.
- _____ 98. Reset my “moral compass” and refocus on my core values and attributes that I brought home from my deployment.
- _____ 99. Walk away from **HATE** and the desire for **REVENGE** and use Compassion Meditation.

_____ 100. Recognize that life is short and make the most of every moment.

_____ 101. Other examples of ways to improve my **SPIRITUAL FITNESS**.

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