The Experiences and Treatment of Veterans Living with PTSD

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Abstract

The purpose of this project was to create better access to an existing online community resource guide, and produce supplemental materials highlighting coping strategies, to enable counselors at the Tacoma Vet Center (TVC) to educate their clients, (veterans with Posttraumatic Stress Disorder [PTSD]) about resources and strategies that would empower them to participate fully in all areas of occupation and to increase their quality of life. This project included a document with hyperlinks to online saved searches, an instruction manual for navigating and customizing the saved searches, and a workbook of information, activities and strategies for clients to utilize. The counselors at TVC used the combination of the hyperlinks to saved searches and the instruction manual to find community resources for their clients, and found the workbook useful in helping their clients learn strategies to cope with symptoms of PTSD.

Context of Problem

Posttraumatic stress disorder (PTSD) is a mental health condition, defined as an anxiety disorder, that many veterans develop after being in combat or after military sexual trauma (MST). The National Center for Veterans Analysis and Statistics (2011) estimated that there were more than 23 million living veterans. Nationally, almost one-half million veterans are being compensated with disability benefits for PTSD (National Center for Veterans Analysis and Statistics, 2011). Many more are likely to have PTSD, but have not yet been diagnosed.

People's ability to function in virtually every area of occupation can be severely and negatively impacted when they live with PTSD. Alcohol and substance abuse, anhedonia, depression, domestic violence, hypervigilance, thoughts of suicide, sleep disturbances, and inability to socialize are common in this population (E. McSwain, personal communication, March 16, 2011). The Tacoma Vet Center (TVC), a storefront counseling office run by the United States Department of Veterans Affairs (VA), "guide[s] veterans' re-entry into civilian life" (Veterans' Outreach Center, 2010, p. 10) by offering counseling for PTSD, but does not have any role in assisting with veterans' more basic needs (E. McSwain, personal communication, March 16, 2011).

Elena McSwain, Special Field Operations Specialist for TVC, Tacoma, WA, indicated that her greatest need was for a well-organized, regularly updated, community resource guide that mental health counselors (henceforth, counselors) at her center could use to quickly provide information to clients about community resources for services that the TVC did not offer. The guide enabled counselors at the TVC to educate their clients, who are veterans with PTSD, about resources and strategies that would empower them to participate fully in all areas of occupation and to increase their quality of life. Strategies and exercises, drawn from Schiraldi (2009) and

Tull (2009), helped make the resource guide implementable. Specifically, the goal was "to use strategies to help them recover, compensate, or adapt so they can reengage with activities that are necessary for their daily lives" (American Occupational Therapy Association [AOTA], 2005, p. 845).

Purpose of the Project

The purpose of this project was to create better access to an existing community resource guide, and produce supplemental materials highlighting coping strategies, to enable counselors at the TVC to educate their clients, (veterans with PTSD) about resources and strategies that would empower them to participate fully in all areas of occupation and to increase their quality of life.

Overview of Project

This project modified the task of searching an existing online database, which counselors at the TVC became capable of using as their community resource guide, by creating pre-saved searches that made it easier for them to access the information. The staff identified a need for a statewide, organized, and regularly updated resource, but acknowledged that as a group they did not possess strong computer skills. The basic topics available through the database, and the statewide count of resources per topic heading were as follows:

- Basic Needs (3046)
- Consumer Services (667)
- Criminal Justice and Legal Services (1417)
- Education (1544)
- Environment and Public Health/Safety (595)
- Health Care (2462)
- Income Support and Employment (1124)
- Individual and Family Life (3720)
- Mental Health and Substance Abuse Services (1848)
- Organizational/Community/International Services (3230)
- Target Populations (7692)

These are the same topics identified by Elena McSwain as most needed by the veterans they

serve.

Additionally, supplemental printed materials supplied by the occupational therapy student provided information and strategies for issues within the scope of practice for occupational therapists. The following is a list of supplemental materials:

- Selecting an apartment that doesn't trigger symptoms
- Budget management
- Problem-solving
- Creating a meaningful life
- Relaxing
- Allowing happiness to return
- Sleep and dream management
- A return to sexual intimacy
- Employment accommodations

Targeted Population

The TVC, also known as the Veterans' Outreach Center, is operated by the VA. The TVC is operated as a storefront facility in a strip mall for ease of access and to create a more relaxed environment. Staffed by four mental health counselors, an outreach specialist, and a vocational counselor, the TVC assists veterans in readjustment to civilian life after trauma. Veterans are defined as men and women who have served in combat and are now separated from service, or are victims of sexual trauma, even if they were not deployed in a combat situation and may still be active duty (E. McSwain, personal communication, March 16, 2011). Counseling services are provided for substance abuse, relationship problems, PTSD, and sexual trauma. Additionally, vocational and benefits assistance, and referrals to community resources for services that are not provided by TVC are offered (Veteran's Outreach Center, 2011, p. 7).

The TVC Mission statement is as follows:

> The Tacoma Vet Center serves veterans and their families by providing continuum of quality care that adds value for veterans, families, and communities. Care includes professional readjustment counseling, community education, outreach to special populations, broker services

> with community agencies, and provides a key access link between the veteran and other services in the US Department of Veteran Affairs. (Veteran's Outreach Center, 2011, p. 4)

Key Player: Elena McSwain, MA, a Special Field Operations Specialist was a key player in providing information regarding what elements should be included in a resource guide to best fit the needs of the mental health counselors on staff, so they could serve their clients more effectively and efficiently.

Background

Posttraumatic stress disorder (PTSD) is an anxiety disorder first brought to many people's awareness after it was introduced into the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association) in 1980. Davis (2011) wrote, "PTSD has been diagnosed in individuals who have experienced a major stressor(s) or traumatic event that was perceived as life-threatening and involved intense emotions such as fear, helplessness , and horror" (p. 172). Combat veterans often repeatedly experience "terrifying or life-threatening event[s]" (Davis, 2011, p. 168), which is a hallmark of receiving a diagnosis of PTSD.

Psychosocial Perspective of PTSD

People's ability to function in virtually every area of occupation (American Occupational Therapy Association [AOTA], 2008, p. 630) can be severely impacted when they live with PTSD. Potentially impairing symptoms are difficulties with memory, judgment while driving, work, school, financial management, sleep, concentration, controlling irritability, anger, relationships, alcohol and substance abuse, homelessness, anhedonia, intrusive thoughts, depression, domestic violence (perpetration or victimization), a lack of social participation, and thoughts of suicide (Bremner, 2002; Brown, 2011; Classen et al., 2011; E. McSwain, personal communication, March 16, 2011; Pietzrak, Goldstein, Malley, Rivers, & Southwick, 2010;

Schiraldi, 2009; and Sue et al., 2005).

PTSD can be described by three symptom clusters: re-experiencing the traumatic event (often referred to as flashbacks), arousal symptoms, and avoiding reminders of the traumatic event. The loss of ability to process emotions may be the cause of much of the psychosocial impairment seen in those with PTSD (Pietzrak et al., 2010, p. 324). Davis (2011) wrote, "impairment [from PTSD] is often the result of re-experiencing the event either in dreams or flashbacks, or avoidance of specific places or situations" (p. 168).

Biological Perspective of PTSD

During flashbacks, the flow of blood to the prefrontal and frontal lobes decreases, which indicates decreased activity in the behavioral regulation system (Doidge, 2007, p. 233). Through his experiments, Kandel and colleagues showed that people can develop "'learned fear' and a tendency to overreact even to more benign stimuli" (as cited in Doidge, 2007, p. 219) when they are sensitized by exposure to stimuli they perceive as dangerous. Evidence suggests that the amygdala, involved in processing fear, becomes hypersensitized in those with PTSD (Schiraldi, 2009; Sue et al., 2005, p. 109), which means that otherwise benign stimuli could be perceived as dangerous.

Additionally, structural and chemical changes occur in the nervous system as sensitization to stimuli moves from short term memory to long term memory, doubling the number of synapses (Doidge, 2007, pp. 219-220). Memories born of trauma "seem to be processed and stored differently than [*sic*] normal memories . . . [and] be 'stuck' in the right hemisphere, split from the more logical left hemisphere . . . [accounting] for the speechless terror of PTSD" (Schiraldi, 2009, p. 380). Furthermore, the hippocampus, involved in memory integration, shrinks considerably, often affecting occupational performance (Bremner, 2002, pp.

61-63; also see Schiraldi, 2009). In short, the brain is both changed and damaged by the traumatic events that affect those living with PTSD (Bremner, 2002; Doidge, 2007). These brain changes may explain why PTSD makes such powerful changes in the personality, behavior, judgment, and ultimately in the quality of life of those living with it.

Behavioral Perspective of PTSD

Behaviorally speaking, some believe that PTSD is a form of classical conditioning because people react with fear or avoidance when they are exposed to situations that have aspects that are similar to the traumatic event they experienced, including smells, sounds, temperatures, or the angle or amount of light or shadows. "According to this perspective, the reason extinction does not occur is because the individual avoids thinking about the situation" (Sue et al., 2005, p. 109). Extinction occurs when a previously linked stimulus, or cue, and response are weakened to the point that the stimulus no longer causes the response. Exposure therapies work to thwart the avoidance reaction and allow extinction to take place. This is done by requiring a person living with PTSD to repeatedly imagine the traumatic event or to experience triggering stimuli (Sue et al., 2005).

Insider Perspective of Functional Impairment

To relay the degree to which occupational performance can be impaired by PTSD, Shay (1998) related the account of one of his patients, a Vietnam veteran, who stated, "I haven't really slept for twenty years. I lie down, but I don't sleep. I'm always watching the door, the window, then back to the door. I get up at least five times to walk my perimeter" (p. 20). Out of fear of harming his wife, he has slept on the couch for the past 10 years and has been asexual for the past four years. He graphically described sudden, physically violent attacks on his family members, vivid nightmares, hypervigilance verging on paranoia, a complete inability to

socialize, alcoholism combined with bouts of workaholism, and the high emotional cost this has had on him and his relationships. He expressed the loss of meaning in his life and anhedonia this way, “I don’t care if I live or die. I’ve been waiting to die ever since I got back from Vietnam” (Shay, 1998, p. 22). Additionally, he vomited daily, experienced stomach pains, extraordinarily high blood pressure, and cracked and oozing skin; the causes may be a combination of PTSD, jungle rot and Agent Orange exposure.

PTSD and Comorbidity

PTSD co-occurs with a number of other diagnoses, such as substance abuse and depression, and can cause impairments in functioning in virtually every area of occupation (AOTA, 2008, p. 630). “The likelihood that a patient with PTSD will meet diagnostic criteria for at least one other psychiatric disorder is 80%” (Kessler, Sonnega, Bromet, Hughes, & Nelson, as cited in Friedman, 2006). Back et al. reported that the co-occurrence of mental disorders and substance use disorders is much higher than chance. . . . “A high proportion, or 20% to 30%, of individuals with substance abuse disorders meet criteria for PTSD” (Back et al., as cited in Moyer, 2011, p. 213).

In any given year, approximately 1.1% of the total population is homeless (National Coalition for the Homeless, 2009b, U. S. Census Bureau, 2011). Veterans represent “between one fourth and one-fifth of all homeless people. Three times that many veterans are struggling with excessive rent burdens and [are therefore at an] increased risk of homelessness” (National Coalition for the Homeless, 2009a). The National Coalition for the Homeless (2009a) published the following statistics for homeless veterans:

- 76% experience alcohol, drug, or mental health problems,
- 47% of homeless veterans served during the Vietnam Era,
- 67% served three or more years.

Studies looking at aggression in veterans suggests that when PTSD is coupled with depression, elevated feelings of anger and more limited ability to control their anger may be experienced. Additionally, violence and aggressive behavior may be a way to cope with, and relieve tension associated with unpleasant feelings such as anxiety, shame, and guilt (Beckham, Moore, & Reynolds, 2000; Bushman, Baumeister, & Phillips, 2001).

Health Risks Associated with PTSD

Bremner (2002) discusses the high correlation of health risks associated with stress in general, and PTSD, as an anxiety disorder, in particular. Smoking, drinking, and eating in excess are common behaviors of people living with PTSD, and often impede participation in exercise, which can lead to anxiety and depression. Heart disease is an established risk of smoking, drinking, and obesity, but is also a risk for those living with depression or anxiety. Smoking may also increase the risk of developing cancer. Studies show that chronic stress accelerates arteriosclerosis due to increases in cortisol in the bloodstream, and damages the lining of blood vessels, which increases the risk of heart attacks. “New evidence suggests that PTSD, apart from the influence of stress per se, may increase the risk of several other physical disorders, including diabetes, ulcers, asthma, and possibly cancer” (Bremner, 2002, p. 13). Stress may also lead to an increased risk of developing osteoporosis (Kumano, 2005).

Sleep disturbances, both a cause and symptom of anxiety and depression, are common in people living with PTSD. Sleep, widely understood to be essential for our health and wellbeing, has been denied to prisoners of war as a means of torture. Those who experience insomnia and disturbed sleep are, in essence, being tortured by the lack of sleep. Katz and McHorney (2002) reported insomnia was present in approximately 50% of the 3445 people with chronic illness

(including mental health issues) that they tested. Insomnia is associated with a decrease in health-related quality of life measures in all domains that were tested, "especially mental health, vitality, and general health perceptions" (Katz & McHorney, 2002, p. 229).

Gradus et al. (2010) found that those with a PTSD diagnosis committed suicide nearly twice as often as those without a PTSD diagnosis. Having a dual diagnosis of PTSD and depression raised the risk of completing suicide even more. Peake (2008) found that nearly twice as many veterans committed suicide as the general population.

Who Is At Risk for Developing PTSD

People more likely to develop PTSD after experiencing trauma:

- Were directly exposed to the traumas a victim or witness
- Were seriously hurt during the event
- Went through a trauma that was long-lasting or very severe
- Believed [they] were in danger
- Believed a family member was in danger
- Had a severe reaction during the event, such as crying, shaking, vomiting, or feeling apart from [their] surroundings
- Felt helpless during the trauma and were not able to help [themselves] or a loved one. (VA, 2011, ¶ 5)

Additionally, women, non-whites, those who are younger or poorly educated, who drink to excess, or who "had an earlier life-threatening event . . ., another mental health problem, . . .[or] have family members who have had mental health problems" (VA, 2011, ¶ 6) are at greater risk for developing PTSD (also see Davis, 2011; Schnurr & Lunney, 2008).

Prevalence and Statistics

Experiencing traumatic events is somewhat common, with over 50% of the U. S. population having "at least one trauma in their lives" (VA, 2011, ¶ 2). It is estimated that approximately 7% of all Americans will develop PTSD at some point in their lives (Kessler et al., 1999). "The estimated lifetime prevalence of PTSD among . . . [Vietnam] veterans was

30.9% for men and 26.9% for women" (Kulka et al., 1990). The current prevalence rate for Gulf War veterans and those in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) is more than double the estimated lifetime prevalence for all Americans (Kang, Natelson, Mahan, Lee, & Murphy, 2003). Shen et al. (2010) found that men sent to Iraq or Afghanistan were up to 10 times more likely to develop PTSD than those never sent on missions in the current wars.

Veterans are estimated to experience military sexual trauma (MST) at rates from as low as 38% for males, and as high as 75% for females. Of these, one-third to two-thirds developed PTSD at some point after being raped (Katz, Bloor, Cojucar & Draper, 2007; VA, 2011).

Over one-half million veterans currently live in Washington state. Tom Schumacher, Director of Behavior Health for the Washington State VA, estimates that statewide, nearly 40,000 veterans of our current two wars, OEF and OIF, live with PTSD. Not all veterans living with PTSD have been formally diagnosed and accurate numbers have not been established nationally, statewide, or countywide (T. Schumacher, personal communication, March 21, 2011).

Some develop more mild cases. Owens, Steger, Whitesell, and Herrera (2009) found that lower severity in PTSD symptoms was related to having a purpose in life. Having a purpose in life may protect against depression and feelings of guilt. Regardless of the severity of the initial trauma, as healing and recovery from the incident occur, some individuals experience posttraumatic growth (Calhoun & Tedeschi, 2006).

Herman (1997) noted,

> A study of ten Vietnam veterans who did not develop post-traumatic stress disorder, in spite of heavy combat exposure, showed . . . the characteristic triad of active, task-oriented coping strategies, strong sociability, and internal locus of control. These extraordinary men had consciously focused on preserving their calm, their judgment, their connection with others, their moral values, and their sense of meaning, even in the most

chaotic battlefield conditions. (p. 58)

Treatments

Pharmaceutical. Although PTSD can be successfully treated, it can become a chronic, lifelong disability (Friedman, 2010). Typical treatment includes symptom management, psychotherapy, discussing the traumatic event, correcting dysfunctional thinking regarding the event, and PTSD education (Dryden-Edwards, 2010). Veterans living with PTSD who seek treatment often receive medication. Many medications have been tried, with variable success, including selective serotonin reuptake inhibitors (Stein, Seedat, van der Linden, & Zungu-Dirwayi, 2000), Cognitive Behavioral Therapy combined with a pharmacological approach (Humpreys, Westerink, Giarratano, & Brooks, 1999) off-label use of antipsychotic medications (Hamner, Deitsch, Brodrick, Ulmer, & Lorberbaum, 2003; Leslie, Mohamed, & Rosenheck, 2009; Sokolski, Denson, Lee, & Reist, 2003), adrenergic-inhibiting medications and antikindling or mood stabilizers (Antai-Ontong, 2007).

Psychotherapeutic. Psychotherapeutic options include anger management training (Gerlock, 1994), combinations of exposure therapy and cognitive restructuring (Biedel, Frueh, Uhde, Wong, & Mentrikoski, 2011), Eye Movement Desensitization and Reprocessing (EMDR), Trauma Focused Cognitive Behavioral Therapy (TFCBT) (Bisson et al., 2007; Schnurr et al., 2003), Imagery Rehearsal, (Cook et al., 2010), and hypnosis, (Friedman, 2010). Studies have not shown these to be successful treatments for veterans with chronic PTSD. Further research is needed to determine whether these interventions hold any promise as earlier interventions.

Alternative approaches. Alternative approaches to symptom management include sending veterans with chronic PTSD to the Outward Bound Experience (Hyer, Boyd, Scurfield, Smith, & Burke, 1996), and a walking therapy that emphasizes the importance of bilaterality while intentionally bringing painful memories into conscious awareness to process and integrate

them (Hartmann, 2006). Nonstandardized, subjective measures for the Outward Bound Experience (OBE) and narrative comments from participants suggest that OBE may hold some promise, however standardized assessments found no significant change in symptoms.

Although medication is often prescribed for sleep issues, evidence demonstrates the benefits of implementing non-pharmacological interventions for both higher quality sleep and reduction of PTSD symptoms (Dryden-Edwards, 2010; Pierce & Summers, 2011). "Specifically, rehearsing adaptive ways of coping with nightmares (imagery rehearsal therapy), training in relaxation techniques, positive self-talk, and screening for other sleep problems have been found to be particularly helpful in decreasing the sleep problems associated with PTSD" (Dryden-Edwards, 2011, bullet 18; also see Schiraldi, 2009).

Meaningful occupations and activities. While pharmacological and psychological treatments are important parts of PTSD treatment, they do not have occupational therapy's emphasis on meaningful occupations and activities as therapeutic interventions, taking into account the person's needs and desires, an analysis of the task, and the impact of the environmental context on creating goals and treatment plans. Occupational therapy (OT) practitioners have a uniquely client-centered, activity-based approach to addressing functional impairments regardless of the cause, and extend this perspective into their treatment with veterans living with PTSD (Baum & Michael, 2008). "The therapeutic use of occupations includes opportunities for *mastery experiences*, in which occupational engagement allows the client to demonstrate abilities, recognize assets, and understand and adapt to continuing challenges" (Kannenberg, Amini, & Hartmann, 2010, p. 378). The goal of OT treatment is to assist veterans in returning to having meaningful lives by helping them to reintegrate into their families and communities, by returning to military service or adjusting to civilian life (Baum &

Michael, 2008).

Baum and Michael (2008) wrote that occupational therapists work with veterans with PTSD at every level of impairment, including helping them learn to manage a household, medicines, and their financial affairs; learn coping strategies for management of symptoms such as flashbacks, social isolation, anger, depression, anxiety or memory deficits; by assessing the home to determine modifications to respond to physical impairments; or by providing driving simulations to help overcome combat driving behaviors. The ultimate goal is for those served by OT to regain functional, meaningful lives with the greatest level of physical, mental, and emotional health possible.

The World Health Organization (WHO) described mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004, p. 12). The primary therapeutic tenet for OT practitioners in helping veterans with PTSD overcome disabilities and regain the greatest overall function is to engage them in meaningful occupation. Finley (2011) corroborated these findings and added that service to others brings the greatest success of all.

According to Baum and Michael (2008) occupational therapists help veterans with PTSD

> through a graduated series of desensitization experiences within the *context of daily activities* . . . to reduce the reaction to disturbing thoughts and images; strengthen a person's general coping skills . . . by identifying the activities and behavior associated with positive outcomes; to engage in activities that will help them manage or ameliorate depressive symptoms and/or excess anxiety and address issues of substance abuse; [and who have issues with] cognitive executive function, such as memory, planning or organization . . . by using cognitive behavioral strategies and assist the individual with learning and developing compensatory strategies to improve performance and maximize independence. (p. 5)

Barriers to Treatment

A primary barrier to treatment is the message the military sends those whom it sends into battle. An injured soldier speaking of his military training said he was led to believe he was "larger than life, almost like a superhero" (National Public Radio, 2011). He believed that anything less than that was "weak-minded" (National Public Radio, 2011). Therefore, combat veterans may not seek out help at all, or may halt treatment when they begin experiencing emotions that might be seen as weak-minded.

Common barriers to "effective medication treatment for PTSD" (Jeffereys, 2009) include misuse or difficulty managing medications, combining prescription medication with recreational drugs or alcohol, and fears surrounding becoming addicted or experiencing sexual (and other) side effects. Davidson (2000) and Foa (2000) noted that SSRIs are "associated with side effects such as insomnia, diarrhea, nausea, fatigue, and depressed appetite. Because of this, discontinuation rates are twice as high as those of behavioral treatments" (cited in Sue et al., 2005, p. 110).

Prazosin, an alpha-blocker used to treat high blood pressure by blocking some of the receptor sites for adrenaline, is used off-label (a non-approved use per the Food and Drug Administration) to treat nightmares and sleep disturbances associated with PTSD. Because the half-life (the time it takes for half of the medication dose to be deactivated) of prazosin is only 2-3 hours, missing a single dose caused these symptoms to return quickly (Taylor & Raskin, 2002; Van Liempt, Vermetteni, Geuze, & Westenberg, 2006; Venes, 2005).

Leslie, Mohamed and Rosenheck (2009) found limited benefit to veterans living with PTSD who were given a popular treatment option of prescribing off-label antipsychotic medications typically given to those with schizophrenia. Just as those living with schizophrenia have experienced, many veterans living with PTSD have experienced permanent, and potentially

serious, extrapyramidal side effects such as tardive dyskinesia. These side effects, if experienced, create a secondary set of problems that may make quality of life and ability to participate in all areas of occupation (AOTA, 2008, p. 630) even more challenging than if the veteran were *only* dealing with PTSD symptoms.

Serving Veterans' Needs

Elena McSwain, Special Field Operations Specialist for the TVC explained the need for a community resource guide by referencing Maslow's Hierarchy of Needs, which is a model of motivation. She pointed out that working on personal growth or mental health become unimportant when people are cold and hungry. Maslow stated that "consciousness is almost completely pre-empted" (as cited in Best, Day, McCarthy, Darlington, & Pinchbeck, 2008, p. 306) by basic physiological needs, such as hunger or shelter. "Clients may find it difficult to participate in a therapy session when they feel threatened . . . or are dealing with other basic physiological needs such as lack of sleep or pain" (Brown, 2011, p. 331). The TVC's clients diagnosed with PTSD often have challenges meeting basic physiological needs.

Although the TVC does provide counseling and assistance in applying for other VA benefits, it does not provide direct services for any of the more basic needs their clients may have. In these cases, counselors at Tacoma Vet Center refer clients to community organizations to assist with providing for these needs. The resource guide identifies local community resources statewide.

The ultimate purpose of this community resource guide is to enable counselors at the TVC to educate their clients, who are veterans with PTSD, about resources and strategies that will empower them to be able to participate fully in all areas in occupation and to increase their quality of life.

Goals and Objectives

The following objectives were selected because they represented the most basic of basic needs:

Goal 1: Upon accessing sections of this guide during in-service, counselors at the TVC who worked with veterans with PTSD were educated about how to access information about community resources to assist their clients in providing for their basic needs.

Objective 1.1: After counselors at the TVC accessed the section of this guide dedicated to housing and shelter, they were able to select three community resources to aid veterans with PTSD in improving their participation in obtaining shelter.

Objective 1.2: After counselors at the TVC accessed the section of this guide dedicated to food, they were able to select three community resources to aid veterans with PTSD in improving their participation in obtaining food.

The following goal was selected to allow a concrete, measurable outcome after providing an in-service of limited time to the counselors at TVC:

Goal 2: During an in-service, counselors were educated on how to access sections of the supplemental materials, covering 9 topics listed on page 4 of this thesis, to provide veterans with PTSD strategies for coping with the symptoms of PTSD.

Objective 2.1: After counselors at the TVC accessed the section of the supplemental materials dedicated to housing, they were able to provide three strategies to aid veterans with PTSD in seeking housing that minimizes triggers for PTSD symptoms.

Objective 2.2: After counselors at the TVC accessed the section of the supplemental materials dedicated to employment accommodations, they were able to provide employment

accommodation strategies to aid veterans with PTSD.

Project Outcome

Success of the project was determined by the TVC counselors' ability to find appropriate resources for hypothetical clients by using the supplemental materials and education provided to them during an in-service training by the occupational therapy student. To improve the likelihood for success, the occupational therapy student provided counselors at the TVC an opportunity to access the guide, preview supplemental materials, and provide feedback regarding the utility of the information and format. This project is sustainable because the resource information is updated regularly and the strategies provide useful information for the foreseeable future. By utilizing this guide, counselors at the TVC provided veterans with PTSD community resources and strategies that allowed them to participate more fully in areas of occupation, increased their quality of life, and therefore were more able to focus on healing from the traumas that caused their PTSD.

Implications for OT

The driving force for this project was to assist the counselors at the TVC efficiently and effectively provide the highest quality community resources to veterans living with PTSD. This project provided counselors with the best tool for this task, which was a pre-existing online database that was currently not user-friendly. This project honored The Centennial Vision's desire to maximize occupational therapy's service to society.

The features of this project were a direct outgrowth of concepts articulated in the Occupational Therapy Practice Framework: Domain & Process, 2nd edition (the Framework-II) (2008). Assisting clients, with or without disabilities, to engage in their chosen occupations is at the heart of the Framework-II. The counselors' occupation was, and is, to help their clients

develop greater internal and external resources to live fuller lives. One of the external resources they provided their clients was information about basic services available in the community. The goal of this project was accomplished by adapting the context and tasks related to accessing information from the online database, that were barriers to the occupational performance of counselors at TVC.

Model

The Ecology of Human Performance (EHP) is a holistic model that embraces the concepts of a connection between the body, mind and spirit, and the uniqueness of individuals. EHP emphasizes the dynamic relationships between person, task, and context and illustrates how each of these affects performance. When the *press* of environmental demands is too great and overwhelms the person's skills and ability to adapt, the model deems this a poor fit. A good fit is one where there is a match between the person's adaptive behavior and the environmental press. The EHP model provides five intervention strategies to improve occupational performance: establish/restore, adapt/modify, alter, prevent, and create. Each strategy takes the person, task and environment into account and allows for varying degrees of change to occur to each to make a better fit. However, the EHP model encourages OT practitioners "to use more interventions directed at the environment" (Brown, 2009, p. 438).

After performing a needs assessment it was determined that the best solution was to adapt the environment and the task to assist with the population's occupational performance. The EHP model provided excellent guidance, because it specifies the adapt/modify approach for these issues. To best support busy counselors with weak computer skills in providing community resources to their clients, simplifying the task and modifying the virtual environment improved

the counselors' occupational performance because it improved the fit.

Occupational performance is defined as "the outcome that is associated with the confluence of the person, environment, and occupation factors" (Brown, 2009, p. 438). Therefore, the counselors' (i.e., EHP's person) occupational performance was defined by the challenges of barriers created by the confluence of their somewhat limited computer skill and knowledge, the unfamiliar task of performing multiple-step database searches, and the virtual environment of an unfamiliar and somewhat non-intuitive online database. Besides the virtual environment described above, there was an inability to update antiquated internet browsers and internet connections. This created a barrier to occupational performance by making navigation to and within websites slow and cumbersome, with the inability to bookmark oft-used websites in an organized way that allowed for easy retrieval of information. Last, there was the cultural environment of the workplace, which de-emphasized the value of developing greater levels of computer skill.

This project addressed the poor fit between the person, environment and task at TVC. The information the counselors wanted was housed many layers deep on a website that did not have clear directions, and within a database system that required many more steps, which ultimately made it challenging enough to be inaccessible for the counselors. The role of an occupational therapist using the EHP model to support the occupational performance of the counselors included understanding that "it is often more efficient and effective to change the environment" (Brown, 2009, p. 440). Therefore, saved searches were created and stored on the unofficial TVC website, on the database website, and in a Microsoft Word document with hyperlinks, to allow for whichever method was the best match between the counselors and the environmental press.

Application of the OT Practice Framework

The Framework-II provides information about the profession's scope of practice: its domain. The domain of OT includes the following aspects: areas of occupation, client factors, activity demands, performance skills, performance patterns, and context and environment. Each of these aspects impacts the others. If one of these aspects is weak, all other aspects are impacted (AOTA, 2008). The Framework-II guides OT practitioners in helping their clients to participate in meaningful activity by assisting OT practitioners in framing their clinical reasoning.

In the second section, the Framework-II addresses the OT process. The process is separated into three continually interacting aspects: evaluation, intervention, and outcomes. During the evaluation phase, an occupational profile and analysis of occupational performance occurs. OT practitioners identify who the client is, where the problems lie, the client's desired outcomes, the environmental supports or barriers, and then use this information to begin making an intervention plan. During the intervention phase, OT practitioners decide on a plan and implement it, re-evaluating and modifying it as needed.

The portions of the Framework-II that informed this project most substantively were the work aspect of areas of occupation for the TVC counselors. For the TVC counselors' clients, the portions of the Framework-II that informed this project were all areas of occupation, aside from activities of daily living (ADL) and play. Additionally, the project was informed by the consultation, advocacy and education processes identified as *types* of intervention and the *modify* approach detailed in the intervention approaches section (AOTA, 2008).

The target population was counselors at the TVC who provided counseling to veterans with PTSD. The Framework-II helped frame the student therapist's clinical reasoning to best support the target population's engagement in occupation. The area of occupation where

counselors required support was work, specifically work skills supporting job performance. The counselors, who described themselves as having weak computer skills, were all veterans – some were living with PTSD. They asked for a community resource guide that allowed them to quickly provide their clients accurate information about community support for areas of occupation that their clients were unable to provide for themselves. At the start of the project, the counselors each had their own small collection of old photocopies and brochures that they used for this purpose. The TVC had no unified source of accurate, organized, and regularly updated information.

Initially, I had intended to create something akin to the Yellow Pages, but was concerned that it would quickly become outdated as provider information changed, and realized that the counselors did not have the time to maintain and redistribute a corrected document, even if it were in an electronic form. I found a far superior community resource; a continually updated, online database that provided nearly all of the information the target population wanted for the entire state—but in a format that was challenging.

Acting in a *consultancy* role, I interviewed the counselors to understand their needs, problems they encountered, and possible solutions. The Framework-II describes the collaborative process as "identifying the problem, creating possible solutions . . . and altering them as necessary for greater effectiveness" (AOTA, 2008, p. 654).

Acting in a *advocacy* role, I worked with the database manager to create pre-made searches for the most needed information, and worked with the webmaster of TVC's unofficial website to create a user-friendly resource page on the website that linked to these searches. These changes were an excellent example of the *modify* approach; modifying both the task and the virtual environment thereby grading the "activity demands to support performance in the natural

setting" (AOTA, 2008, p. 658).

Acting in an *educator* role, I provided an in-service with the counselors. This process "involves imparting knowledge and information about occupation . . . that does not result in the actual performance of the occupation" (AOTA, 2008, p. 654). I went a step further by creating a short, printed guide that explained how to navigate and print once inside a database search, and helpful hints to performing and saving their own customized searches. Additionally, an in-service provided an opportunity for practicing the steps in the written guide and to familiarize them with using the database. Supplemental materials for TVC's counselors to give to their clients provided coping strategies and information also fell within the educator role.

Last, the indirect population benefitting from this project were the clients of the TVC and anyone accessing the unofficial website for resource information. Virtually all areas of occupation can be affected by the symptoms of PTSD, and the database addressed support for most of these areas. Acting in *advocacy* role for the indirect population, this project "promote[d] occupational justice and empower[ed] clients to seek and obtain resources to fully participate in their daily life occupations," (AOTA, 2008, p. 654) by increasing the accessibility of the database by placing it in a user-friendly format and more convenient location.

Project Procedure and Product Description

- A fellow student identified TVC as an agency needing a resource guide and wanting the help of an occupational therapy student.
- The home agency was contacted via email to see if they were interested in this project.
- Several meetings were held with the key contact at TVC to discuss their needs.
- A sustainable community resource guide was found to already exist. It was the WIN211 database housed online at http://www.crisisclinic.org/ .

- Several phone conversations were conducted with Sarah Marshall, Resource Center Supervisor for the King County portion of the WIN211 database. She provided tips for navigating the website and she explained to acknowledge WIN211 for its free availability.
- A needs assessment was conducted in order to find out the best way to implement the project.
- After performing a needs assessment it was determined that the best solution was to adapt the environment and the task to assist with the population's occupational performance.
    - A list of saved searches with hyperlinks was completed and saved to a Microsoft Word document, in an account created on the Crisis Clinic WIN211 database website, and on the unofficial TVC website.
        - The occupational therapy student had to learn how to make hyperlinks within the text of a Microsoft Word document by seeking out the assistance of the Technical Services Help Desk on campus, and further detailed explanation from a technically savvy friend, Carlin Buchanan.
    - Additionally, a printed navigation tool to customize searches was created (see Appendix A). It contained screenshots of actual pages of the online database, and many color-coordinated arrows and word descriptions showing what buttons, arrows, and icons to select at any given juncture in the navigation process. The final product was a spiral bound, color printed book, 21 pages in length, with a clear plastic cover and hard stock back cover. Ten copies needed to be made, at a cost of $110.
    - To perform the advanced formatting this segment of the project required, the occupational therapy student had to get tips from the Technical Services Help Desk on campus, and experiment for many hours.

- To create supplemental materials a book and a website were read. They were:
    - Schiraldi, G. R. (2009). *The post-traumatic stress disorder sourcebook* (2nd ed.). New York, NY: McGraw Hill.
    - Tull, M. (2009). *Rates of PTSD in veterans.* Retrieved from http://ptsd.about.com
- After a draft of the supplemental materials, which were created as short (2-5 page hand-outs) was supplied to the project chair in January, 2012, the project chair suggested they be turned into a single workbook, with pictures. The occupational therapy student had purposely avoided pictures because of the complex nature of copyright laws, challenges with proper attribution, and the advanced formatting knowledge required to work with linked object boxes in Microsoft Word and move them without accidentally blocking out desired text. To create the workbook, the occupational therapy student needed to:
    - enlist the help of the Technical Service Helpdesk on campus, and practice the skills learned,
    - meet with the librarian to talk about copyright laws, how to identify the proper attribution methods for pictures found on the internet, and pitfalls to avoid.
- Supplemental printed materials (sample supplied in Appendix B) supplied by the occupational therapy student became a workbook with chapters for each of the 9 topics listed below. The workbook was color printed, was spiral bound, and was over 50 pages long. The chapters provided information, activities, and strategies for:
    - Selecting an apartment that doesn't trigger symptoms
    - Budget management
    - Problem-solving
    - Creating a meaningful life
    - Relaxing
    - Allowing happiness to return
    - Sleep and dream management
    - A return to sexual intimacy

    - Employment accommodations
- A 45 minute in-service was completed to walk the counselors and other staff at TVC through using the saved searches and the navigation tool.
- Questions were asked of the group throughout the presentation to see if they could use the information they just learned to help a hypothetical client.
- Questions were asked at the end of the presentation to measure the effectiveness of the presentation.

Special Circumstances or Considerations for the Project

Since this project began, the key contact left the organization and moved to the east coast. Having no specific "key contact" made communication challenging. Additionally, since some of the counselors at the TVC described themselves as having weak computer skills, they were concerned that an online resource was beyond their capabilities and enthusiasm for the project was low.

There were several potential "fixes" for these challenges. First, the OT student set an appointment to teach a counselor, who self-identified as having the weakest computer skills in the group, how to access and use the database. Saved searches were created, along with a printed navigation tool to customize searches. Finally, an in-service was completed to walk the entire staff at TVC through using the saved searches and the navigation tool.

Limitations

Even though this project was successful, there were limitations. Having changes in personnel that also caused understaffing caused severely limited communication. Due to conflicts in schedules between the occupational therapy student and staff at TVC, there were time limits and constraints on when the in-service could be presented and how long the

presentation could take.

Because of the timing in the changes in personnel, and the challenges with getting a document with live hyperlinks onto the computers at TVC, it was difficult to ascertain before the in-service if the hyperlinks to the saved searches would work at their location. Using the occupational therapy student's laptop, the links did not work. It was later discovered that the link's pathway required the same browser that created the links (Mozilla Foxfire) to be available at TVC. It was not available. However, the occupational therapy student prepared for this potential by saving this information in two other locations, the TVC unofficial website and in an account created on the online database's website. Both options worked well.

Making a change in the format of the supplemental materials (from short handouts to a workbook with photos on each of the 9 topics) delayed their timely completion. Although the counselors were able to see an abbreviated version of the two sections of the supplemental materials required for them to reach the goals the occupational therapy student identified for them, the counselors at TVC were not able to see the completed supplemental materials before printing. Therefore, they were not able to provide input into this portion of the project. If this project were being done again, the supplemental materials would have been completed, approved, and printed before the in-service took place.

Future Steps/Sustainability

This project is sustainable because the resource information is updated regularly by those who manage the regional segments of the WIN211 database housed online at http:www.crisisclinic.org. Additionally, the activities and strategies provided in the supplemental materials provide useful information for the foreseeable future. The supplemental materials were provided in printed and electronic format (for ease of reproduction) to the counselors at TVC and

they will independently provide them to their clients for use as they see fit. The counselors and staff have all been educated about the information on the online database and how it can be used. No future steps are required of the student occupational therapist to sustain this project.

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Appendix A

The following are the hyperlinks to saved searches that allowed counselors at the TVC to access the online database quickly to search a specific topic.

Links to Saved Searches

- **Basic Needs**
  - Food
    - All Food - Statewide
    - Food Banks - Statewide
    - Food Banks - Pierce County
    - Meals – Pierce County
    - Meals - Statewide
  - Utilities
    - Utility Assistance - Statewide
  - Clothing
    - Clothing Banks – Statewide
  - Shelters
    - Shelter - Statewide
    - Shelter - Pierce County
- **Housing**
    - Supportive Housing – Statewide
  - Low Income
    - Low Income Housing Subsidy – Pierce County
  - Expenses
    - Housing Expense Assistance – Statewide
    - Housing Expense Assistance – Pierce County
  - Home Improvement
    - Home Improvement Assistance – Statewide
  - Counseling
    - Housing Counseling – Statewide
    - Housing Counseling – Pierce County
  - Eviction
    - Eviction Assistance – Statewide

- Relocation
  - Relocation Assistance – Statewide

- **Health**
  - General
    - General Medical Care – Statewide
    - Community Clinics – Statewide
  - Prescription
    - Prescription Medication Services
  - Dental
    - Dental Expense Assistance – Statewide
  - Eye
    - Eye Care – Statewide
  - Pregnancy
    - Pregnancy Testing - Statewide
    - Mother and Infant Care - Statewide
  - Psychological
    - Mental Health Eval - -Statewide
    - Mental Health Expense Assistance - Statewide
    - Supportive Therapy - Statewide
    - PTSD - Statewide
  - Physical Fitness
    - Physical Fitness - Statewide
  - Veterinary
    - Veterinary Care Assistance - Statewide
  - Sex Ed
    - Safer Sex - Statewide
  - Contraception
    - Contraception – Statewide
    - Emergency Contraception – Statewide
  - Drug/Alcohol
    - Drug Courts – Statewide
    - Detox – Statewide
    - Substance Abuse Counseling – Statewide

    - Health Insurance
        - Health Insurance Premium Assistance – Statewide

- **Legal**
    - Criminal
        - Crime Victim Assistance – Statewide
        - Family Violence Protection – Statewide
        - Alternative Sentencing – Statewide

    - Psycological
        - Mental Health Courts - Statewide

    - Bullying
        - Bullying Prevention – Statewide

    - Driving
        - Traffic Court - Statewide

    - Mediation
        - Mediation Services - Statewide

- **Education**
    - Financial Aid
        - Student Financial Aid - Statewide

- **Recreation**
        - Recreational Facilities – Statewide

- **Burial**
        - Burial Assistance – Statewide

Appendix B

The following is an excerpt of the Instruction Manual to assist in navigating the online database.

Instruction Manual
for
Community Resources Online

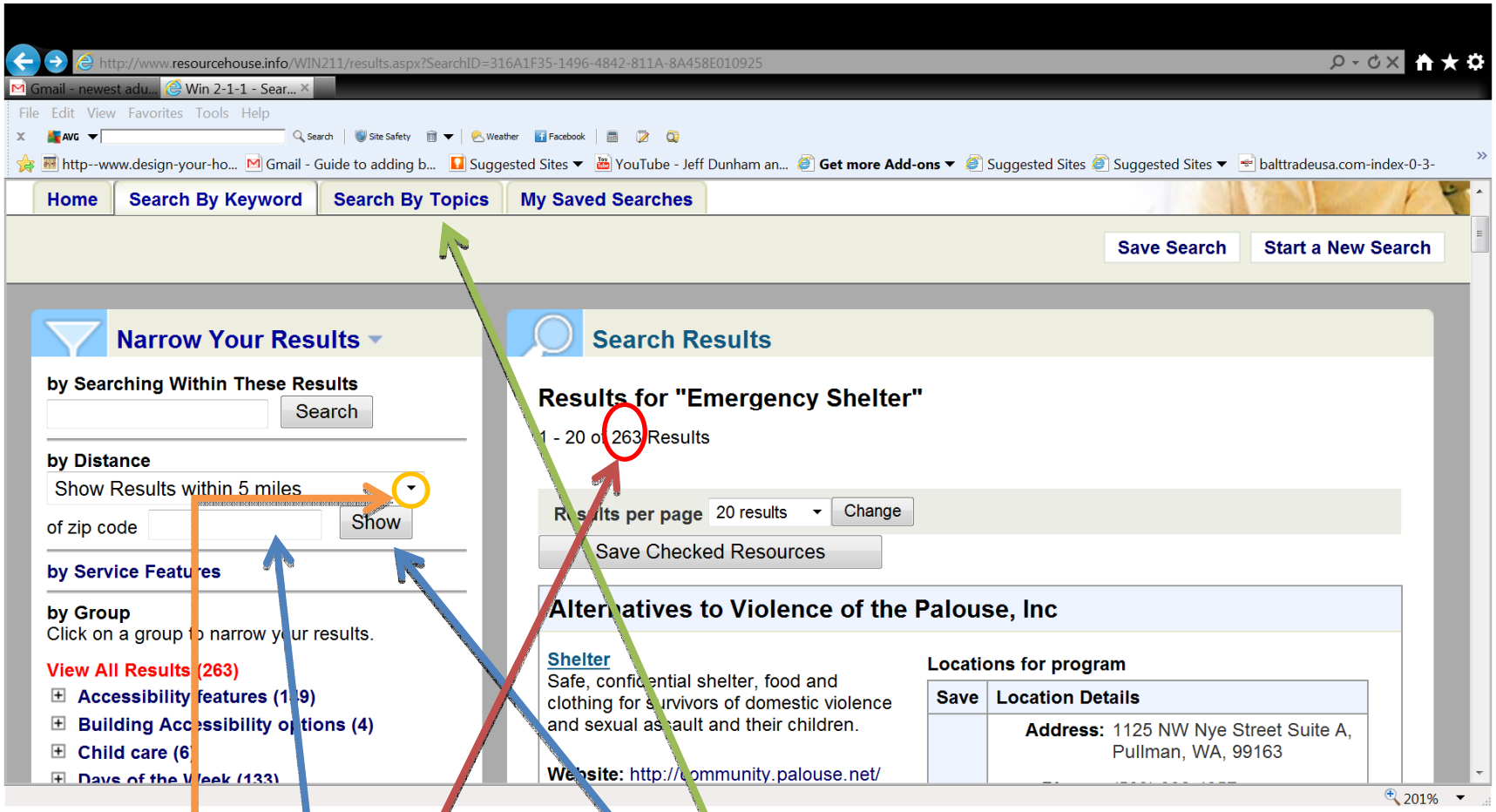
Created by
Wendy Schonwetter
Graduate Student
University of Puget Sound
Occupational Therapy Program

This online database is owned by:

Washington State 2-1-1 Get Connected. Get Answers.

Washington Information Network 2-1-1

CUSTOMIZING STATEWIDE SAVED SEARCHES

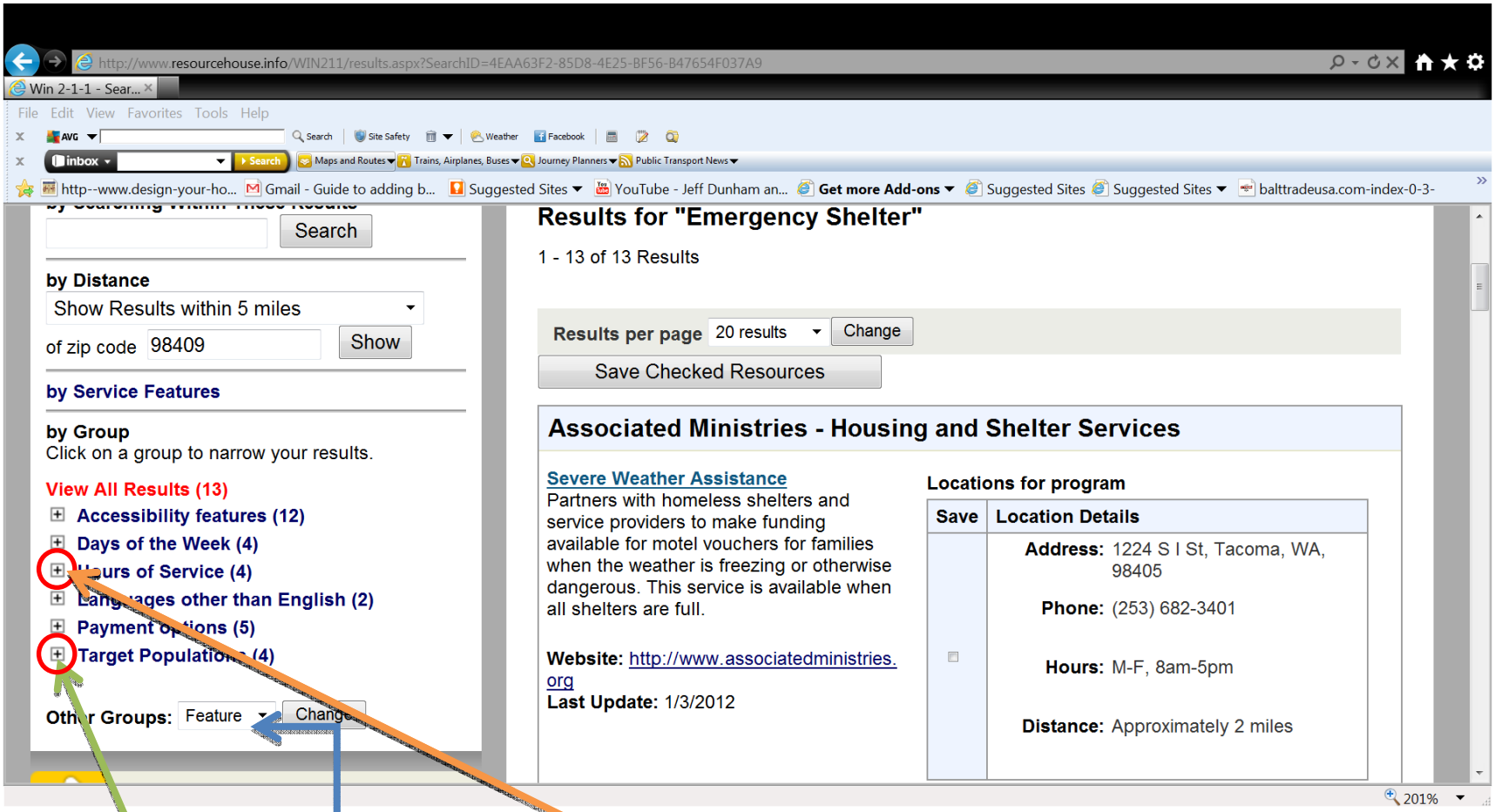


Click this arrow to set the distance from the area you are looking in **IF you want to search by zip code**, to reduce the number of results. In this example there are **263** shelters statewide.

For example, if you enter **98409** into the zip code box and click **Show**, 13 results are within 5 miles of that zip code. Give it a try and see what you get! If you want to **narrow the search you just created**, *turn to the next page …*

If you want to search by county or city name… Click the *Search by Topic tab at the very top…then TURN TO PAGE 10*

NARROWING A SEARCH BY ZIP CODE

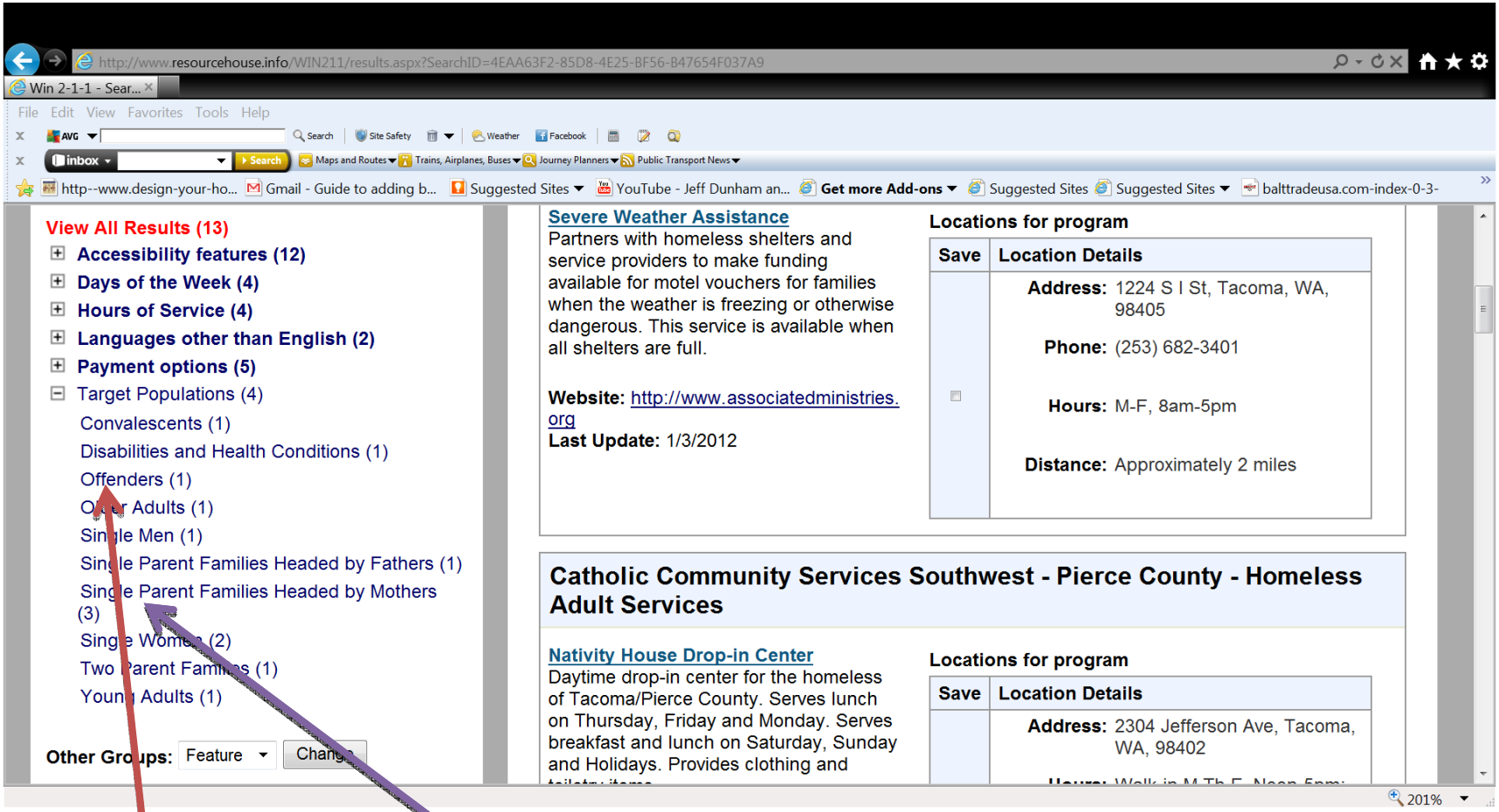


This indicates that there are 13 Emergency Shelters within 5 miles of the 98409 zip code (Tacoma).

To find out the **target populations** they serve, or the **hours of service,** click on **the + sign** to the left of those choices. These are just two of the six **Features** listed for this zip code. Statewide (the previous page) had 11 Features listed. **Features** is the default setting for "Other Groups", so you will see this every time you search.

To see the **Target Populations**, *turn to the next page…*

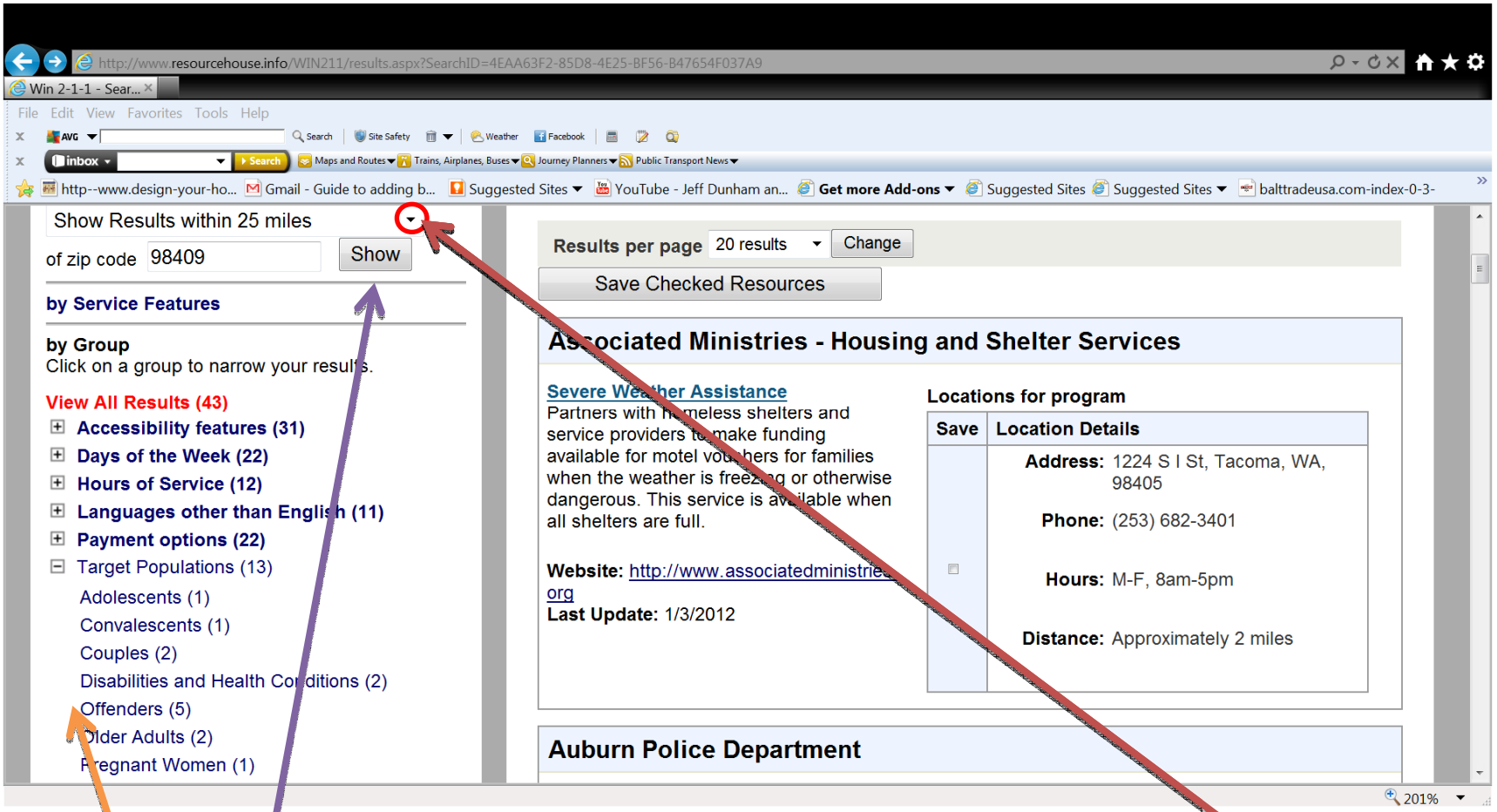
EXAMPLE OF TARGET POPULATIONS SERVED



If your client is a **single mother with children**, there are three choices available **within 5 miles of the 98409 zip code**. If your client is an **offender**, there is one choice available **within 5 miles of the 98409 zip code.**

But what happens if your client can't or doesn't want to use the one offender facility available? *Turn to the next page….*

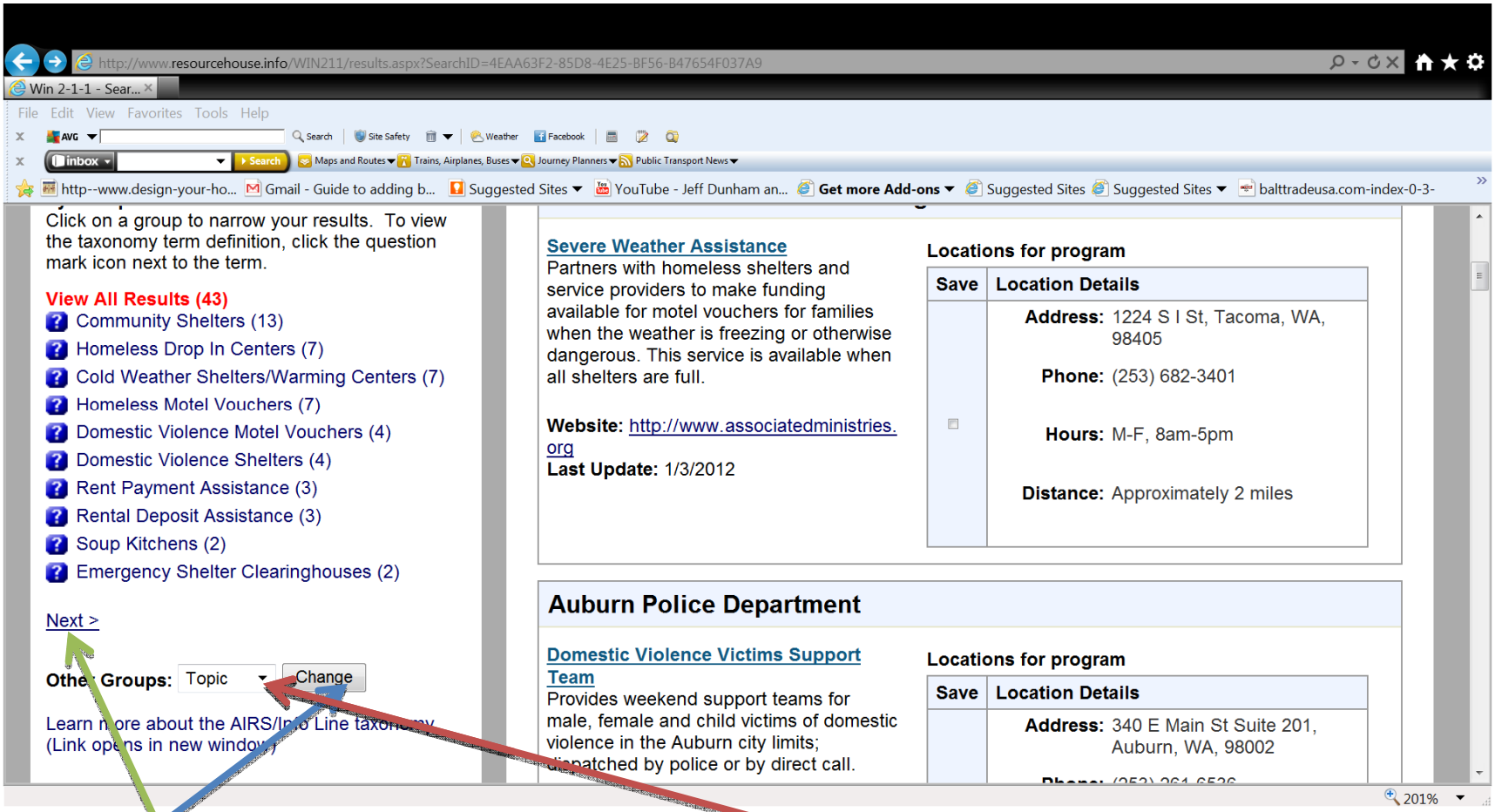
EXPANDING A SEARCH BASED ON THE MILES FROM THE ZIP CODE



To expand the search to a broader area from a starting point of a zip code, click the **arrow to the right of Show Results** and make a selection. Then click **Show**. In this example, the **search is now within 25 miles of the 98409 zip code,** and there are now **5 options for offenders.** Just click on the word to bring up the locations on the right.

What if you want to know **what types of shelters** are offered**?** *Turn to the next page…*

BREAKING DOWN A SEARCH BY TOPIC



To see what type of shelters are available, click on the arrow to the right of **Other Groups,** select **'Topic'**, and click on the **Change** button.

Notes: there is a **'Next'** page with more listings.
Just click on the words to bring up the locations on the right.
If you want to expand your search to the entire county, or the whole city, click **Search by Topic** at the top of the page **(turn to page 5, green arrow).** *See the next page for results…*

Appendix C

This is an example of one chapter of the workbook provided to TVC.

FINDING HOUSING THAT DOESN'T TRIGGER YOUR PTSD

Your home should be a safe place that you can count on to feel safe and relaxed enough to get the rest you need to continue healing. Being able to recognize triggers that cause disturbing memories, sensations, emotions, and behaviors is a step toward controlling PTSD's symptoms.

The following exercised, drawn from *The Post Traumatic Stress Disorder Sourcebook (second edition), by Glenn Schiraldi, Ph.D.,* are meant to help you to make the connection between the original trauma/s you have experienced and your current triggers, and help you think about choosing less stressful housing.

Schiraldi suggests processing memories like these in a safe place. These exercises may be good to do with a friend, support group, or your therapist. If you choose to do them alone, take it slow.

If you notice yourself beginning to get anxious or upset, stop doing the exercise and breathe slowly. Take a few minutes to focus on beauty – birds in the trees outside your window, calming music, or cup of tea.

It’s okay to do the exercise for short periods of time, if you need to. There’s no rush.

Ready? Turn the page to get started.

Look at this list of common triggers and the traumatic memories they can stir up. Feel free to add, circle, or cross out things to make it reflect your experience.

TRIGGER	ORIGINAL TRAUMATIC EVENT
Firecrackers, cars backfiring, 'war games' at nearby military bases	Combat, gunshots
Campfire, cooking, barbecuing	Burn victims
Warm, damp, humid weather	Vietnam
Lover's naked body	Bodies of civilians killed by terrorists
Smell of diesel fuel, traffic	Airplane crash, roadside bomb in Iraq
Popcorn popping, noise from shooting range	Helicopter, small arms fire
Rushing, feeling overwhelmed, stress	A rushed decision with a tragic outcome
Police, security guards, others in uniform	Being in uniform during the event
Door noisily shutting	Explosions
Aging or hospitalization	POW camp (loss of freedom or purpose, helplessness)
Entering subway or tunnel	Fighting in trenches

Perhaps reading this list has made you more aware of some of your specific

triggers. Write them below while they are fresh in your mind. If you can remember a specific part of the event/s you experienced it, write that in the column to the right.

This is hard work! Schiraldi suggests getting help and support from a counselor or support group members to help filling this out. Making ourselves think about traumatic memories brings up a lot of feelings of discomfort. Asking ourselves to remember, rather than working so hard to forget, is very healing.

TRIGGER	ORIGINAL TRAUMATIC EVENT

Dr. Schiraldi suggests that some people are able to better identify triggers by thinking about the following twelve categories, which start on the next page.

As you see each of the categories, scan your memory for each specific category, one at a time, to see if things having to do with this category trigger you.

After each category, there will be a short list of everyday items, sensations, behaviors, or thoughts that have triggered other veterans.

As you come up with your triggers, ask yourself, “What does it remind me of?” Write the triggers and events that come to mind.

Remember, this doesn’t have to be perfect, in full sentences, neat, or complete. It is okay if you report things in the “wrong” spot. Just getting it into your conscious mind and awareness is a very good, and healing, activity.

Dr. Schiraldi suggests that one of the greatest challenges is thinking about painful memories, because we think that if we avoid them we’ll feel better.

But trying to avoid thinking about them makes our lives worse, because the memories intrude in the form of flashbacks, dreams, anxiety, or a feeling that we aren’t really in our bodies or feel as like everything is a dream.

This is a work in progress. Take it a little bit at a time.

Rest when you need to.

Come back to it. Do some more.

Rest. Get support.

Breathe…

Turn the page to begin. There are 12 pages, one for each category.

#1—Sight

Courtesy of Ilana Blackmore

blood,
black garbage bags,
a boss standing over you,
certain colors,
TV shows featuring war or violence

#2—Sound

Courtesy of Wendy Schonwetter

a car backfiring,
popcorn popping,
planes flying overhead,
plane taking off or landing,
foghorns,
whispering,
crying or moaning …

#3—Smell

Courtesy of Natsumi Nozaki

diesel,
body odors,
meat cooking,
the way the air smells when it's hot…

#4—Taste

specific medicines,
blood,
cigarettes,
alcohol…

Courtesy of Wendy Schonwetter

#5—Body

Courtesy of Wendy Schonwetter

The feeling of running, falling, throwing, tripping, sweating, laying on your stomach or back…

Being held, carried or pinned down, being touched when sleeping, touching certain shapes, textures, or temperatures, for example a cold metal handle or canvas

nausea, headache, feeling drugged or drunk, exhaustion, racing heart, out of breath, etc.

#6—Weather, dates, seasons, lighting

Courtesy of Wendy Schonwetter

hot/humid/still air,
hot, dry, sunny, windy,
leafless trees,
cloudy skies,
dark of night,
a certain angle of sunlight

#7—Stressful events

participating in or overhearing an argument,
visiting a hospital,
receiving criticism,
having a nightmare,
participating in a competition…

#8—Strong emotions

Courtesy of Ilana Blackmore

anything that brings up feelings of anxiety,
feelings of being out of control
(such as the feeling of not knowing the answer,
or being drunk or high),
physical pain (such as PMS cramps),
feeling scared or confused…

#9—Thoughts

Courtesy of Evah Paterek @ forevahphotography.com

negative thoughts
negative self-talk
(such as “I’m no good”…)

#10—Behaviors

Courtesy of Ilana Blackmore

Driving on dirt roads…

#11—Out of the blue

Courtesy of Wendy Schonwetter

Sometimes you are triggered seemingly out of the blue, like when you are relaxing or are tired, or something outside your unawareness. Use the categories to guide you—what were you tasting, smelling, seeing, feeling, what was the weather, time of day, etc. You may have an “aha moment” where you realize the connection between your original trauma and what triggered you.

#12—Combinations

Courtesy of Ilana Blackmore

Often triggers contain several memory categories at the same time. An example would be experiencing the sound and smell of fireworks, and if you threw them it would include the kinesthetic body awareness of throwing.

Congratulations! This is a hard exercise. Don't judge yourself on how long it took you, or how far you got during each attempt. You are moving in the right direction!

Did this exercise help you able to see more clearly what triggers you and when? Sometimes something that will trigger you when you are tired, won't when you are well rested.

DO YOU NEED A CHANGE?

Now that you have done this exercise, does your current housing situation provide you the safety and ability to relax enough to support your recovery and well-being?

When thinking of a move, you can begin by calling or visiting apartment complexes, or talking to real estate agents. They can tell you if they are near firing ranges, noisy traffic, slaughterhouses, or other troubling triggers from your list.

Before you decide on a new place to live:

- visit the area,
- drive around,
- and if it's an apartment complex, ask to sit in the apartment quietly for awhile, and
- come back at different times of day, both weekday and weekend.

You'll learn a lot about if it is suitable for you or not.