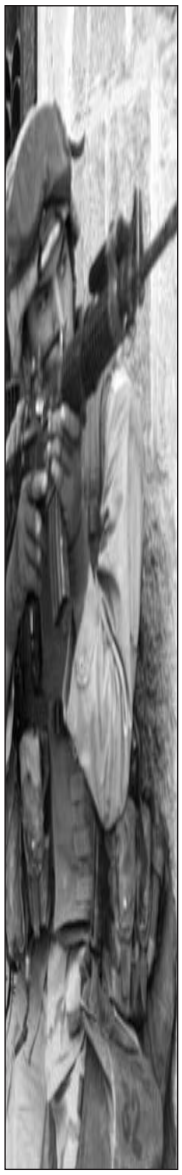
__Anita Dale__ describes the highly positive findings of her research into the experiences of veterans who received treatment for post-traumatic stress.

How human givens therapy is helping war veterans

THERE are currently about four million forces veterans in the UK and how many of them suffer post-traumatic stress disorder (PTSD) is anyone's guess. The King's Fund Centre for Military Health Research, which carried out a meta-analysis of 15 years research into military health, asserts that the incidence is low, with alcohol misuse, anxiety and depression much more problematic.[1,2] But it is recognised that under-reporting is likely, as serving personnel tend not to report symptoms[3] and this reluctance persists into the veteran population.[4] In contrast, US veterans report a substantial increase in mental disorders following forces discharge, including PTSD.[1]



I shall use the term post-trauma stress (PTS) to describe the significant difficulties experienced by a large number of veterans, whether or not they have officially been diagnosed with PTSD (see box, below right), which is associated with a range of adverse outcomes, including poorer general health, more physical, psychological and behavioural symptoms[5] and relationship problems.[6] Obtaining a diagnosis of PTSD has legal and political connotations and potentially many veterans may be suffering many of the characteristics of PTSD without actually being diagnosed.[7] UK veterans with mental health problems *during* service are an especially vulnerable group of the veteran population, as they seem to be at higher risk of ongoing mental health problems, social exclusion and unemployment after discharge.[8] Also, on leaving the forces, some veterans struggle to adjust to civilian life without the routine, support and camaraderie that they have grown used to.[9]

Just as there is lack of agreement about the degree of PTSD suffered by veterans, there is no consensus as to what constitutes the best therapy, with some experts arguing that trauma-focused treatments, where the focus is on the memories of the traumatic events and the personal meanings of the trauma, are superior to non-trauma-focused treatments.[10] The leading proponents of this view chaired the group that developed the National Institute for Clinical Health and Excellence (NICE) guidelines for best PTSD treatment: in essence, trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprogramming (better known as EMDR).[11] And while therapeutic differences are still being debated [12,13] the NICE guidelines continue to dominate in primary care.

While human givens therapy for trauma has yet to be investigated through randomised controlled studies, many elements are already approved within NICE guidelines. There are similarities with many trauma-focused CBT approaches, such as imaginal exposure, although relaxation *before* the imaginal exposure is a distinctive element of human givens therapy. And, as we know, human givens therapy goes further, including a strong focus on using a client's existing resources to create hope and a sense of empowerment. Human givens trauma therapy can be described (in NICE-approved terms) as using trauma-focused, imaginal, graded exposure during applied relaxation (the rewind technique – see box on page 19), with cognitive restructuring (rehearsal, during relaxation, of successful coping).

I decided to carry out a study of veterans' experience of human givens trauma therapy, as delivered by the charity PTSD Resolution, set up in 2007 to offer this treatment free to veterans,

Criteria for PTSD, summarised

The experiencing or witnessing of an event involving death, threatened death or serious injury, causing intense fear, helplessness or horror (or, in children, disorganised or agitated behaviour). Experience of one of the following: recurrent intrusive images, thoughts or dreams; a sense of reliving the event; or intense mental or physical distress when something triggers often unconscious associations with the event [such as significant anniversaries, hearing a particular sound, the sensation of intense bodily heat]. Experience of three of the following: persistent avoidance of anything associated with the trauma, such as thoughts, feelings, activities, places or people; amnesia for aspects of the event; sense of detachment; loss of warm feeling; or sense of foreshortened future. Experience of two of the following: difficulty falling or staying asleep; irritability and outbursts of anger; difficulty in concentrating; hypervigilance; and exaggerated startle response. Symptoms must have occurred for at least a month and have significant adverse effects on work, social or daily functioning.

the Territorial Army, reservists and dependants. I wanted to find out what did or did not work for them and whether changes experienced through therapy were maintained over time. I also wanted to explore participants' subjective experience of participating in the therapy. In particular, I was interested in:

- how HG therapy differed from any previous treatment for the same symptoms
- if any part of the therapy was experienced as particularly helpful or unhelpful
- what participants perceived as different, physically, mentally and emotionally, after treatment
- whether the military or non-military background of the therapist affected, or was perceived to affect, the effectiveness of the therapy.

Trauma assessment

Prior to starting therapy with PTSD Resolution, and then again at completion, all veterans contacted had filled in the Impact of Events, Extended Scale (IES-E),[14] the most widely used trauma assessment questionnaire. For the study, former clients of the charity who had completed treatment between March 2008 and March 2011 were invited to fill in a follow-up IES-E questionnaire; the time interval between completing the end of therapy questionnaire and being asked to fill in the follow-up questionnaire varied between six months and three years. It was important that treatment had been completed, so that there was no ongoing relationship with the charity, and no potential gain from participating in the study that might bias results.

The charity's database listed 43 veterans who had had treatment during the required period. Of these, there were 30 eligible clients for whom current contact details were available and all were contacted by letter, with a stamped addressed envelope enclosed. Thirteen veterans did not reply. (It is possible that the initial paperwork seemed daunting and a short initial enquiry, with the option for telephone contact and form completion at the interview stage, might have improved willingness to participate. However, some veterans might simply have been unwilling to re-examine the topic of trauma). Of the 17 that did reply, 11 completed the questionnaire and agreed to be interviewed; four agreed to the questionnaire completion only.

IESE-E results

The IES-E scores collected before and after treatment for the original 43 veterans showed that 41 rated themselves as having improved after therapy and two considered that they had deteriorated. The data from the 15 veterans who completed the follow-up questionnaire showed statistically significant improvements in symptoms of PTS, largely maintained over time. The effect size was large and compared very favourably with published research findings, for which the shorter IES 15 question instrument was used to assess symptom levels at follow-up.[15]

All those who agreed to be interviewed were white British males, aged between 21 and 63. They had variously served in Afghanistan, Bosnia, Cyprus, the Falklands, the Gulf, Iraq and Northern Ireland, amongst other places. Only two had an official diagnosis of PTSD and received a disability benefit from the Ministry of Defence. The interviews were semi-structured, so as to allow participants freedom in their responses to enhance the richness of the data – and a great deal of very useful information did emerge.

Getting started

There was a common thread of reluctance among the veterans to acknowledge the PTS symptoms at first, especially if it was a family member who pointed them out. As one veteran put it, "When I first came back from the Gulf, my family told me I'd changed and I didn't believe it". Keeping very busy at work to distract from the symptoms was typical, with four participants directly or indirectly mentioning overworking as a way to mask or escape the PTS. ("My way of dealing with it towards the end of my Army career was working ridiculously long hours to mask it." "I just used to bury myself and wear myself out, to make sure I slept.")

Four participants mentioned minimising symptoms while serving, either to avoid discharge or the potentially negative effect on their careers.

"I did a couple of [therapy] sessions," said one, "and it got to the point where [the medical officer] said well I think you've got depression. I can get you out of the Army as soon as you want. And I said but I don't want out of the Army; I want to stay in. And he said okay, well, see how you get on. And we had a couple more sessions and I basically said, yeah, I'm fine and basically glossed over it, and sort of pushed it off to one side."

Another said, "The Army I served in was not one where you said to somebody 'I'm having problems'. Maybe you'd get away with it now but you certainly wouldn't then. They might say it wouldn't hurt your career but I knew it would."

When participants did finally seek help it was often on the advice of military friends or precipitated by a crisis at home. One said, "I had a massive argument with my wife, and it was the closest I've ever come to hitting her. I had to literally – it was everything in my power – to walk away. I ran out of the door and grabbed my car keys and just [cleared] off down the road. I pulled over in a layby and I was in tears – I'm going mad here. Then, right ... that's it, and I rang the number, because I needed help."

Some participants reported that it was difficult to ask for help, either because they felt others were worse off than them or because it was embarrassing to need help. Two reported the devastating effect when, having plucked up the courage to ask for help, they were met with an answer phone. "Getting the answer phone – that

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was like my whole world had turned upside down. And I thought, holy shit, right when I need this, it's not there. So I sat there and I was pretty much – this is horrendous." However, the effect of this was offset by a call back within 10 minutes. All participants rated the PTSD Resolution staff and telephone responses as helpful. In contrast, two people had previously rung another national veterans' charity, where they had also been greeted by an answer phone, but had received no response at all to the messages they had left, asking for help.

Experience of therapy

Starting therapy felt alien or embarrassing to some participants but most embraced the human givens approach of addressing traumatic events through relaxation and the rewind technique. Only one person found the idea of speeding back and forth through the trauma memory (see box on page 19) as too strange to engage with. However, two who had initially been reluctant to seek therapy found it, to their surprise, helpful.

Comments on the treatment included the following. "Those two sessions, I'd say, are worth their weight in gold and there's probably still a lot of people out there who still aren't getting that help that probably need it." "All I know is that it worked for me."

Some particularly appreciated the fact that the human givens approach to resolving trauma does not require people to talk about their traumatic experiences during therapy. (Some veterans, however, wanted to talk about their experiences, and that was accommodated.) Overall, therapy was an easier experience than expected for most:

"I thought it would be a bit more intense, but it wasn't, it was more relaxed … I thought it was going to be bang on it, but it … was more chilled."

"He sat me down in a nice comfy chair, and he managed to get me, for the first time in years, to shut my mind down. Actually shut it down completely. He did something by just talking to me that made my body go ffftt, stop, basically."

The detraumatising method itself was described by participants as highly effective.

"It seemed to work. I mean, my wife said to me, really from the first set of treatment, that I started calming down quite a lot. And I started being less of a dick when I was at home."

"[After two sessions] I was calm, and I could sleep … and know that, when I woke up, it would be the alarm or the kids that woke me up, and not a nightmare."

"I could put hand on heart and say I'm not troubled by war experiences, things that happened in 1982, at all." (See panel below for other responses.)

Most participants said they had made continuing use of relaxation and calming techniques that they had been taught in the therapy sessions, with relaxation skills and physical exercise the most popular. As one commented, "[The] breathing techniques and other different techniques … I've found them to be lifesavers, quite frankly."

Experiences of the rewind technique

"The thing I noticed most of the time was that the dream had gone. I still occasionally have the beginning of the dream but it never gets to the really nasty stage – I wake up basically. And I don't feel so bad about it either, too. To my mind it [the therapy] was almost like a magic pill."

"I still feel emotional about it because there was a dreadful incident, but the emotions are in proportion."

"I haven't had the big red rages for years; I just haven't had the uncontrollable rages."

"It's quite easy [to talk about the traumatic events] since [the therapist] managed to sort it for me. Before, if I'd so much as thought about it I'd have nightmares for a week."

"[The traumatic event] is not difficult to cope with now. I've got it firmly boxed away, and I can bring out if I want to... I can bring it out and have a look at part of it, then shut it up and put it away, and then bring it out a day later and have another look ... I know it's there but it doesn't scare me."

"The therapy, without question, was the only therapy – and I'm quite cynical of therapy – that really did help."

"Your mind is doing it all for you and you're looking at something so frequently... And before you know it the next one's gone, and that one, it was gone. It was happening so quickly. Eventually it was happening so fast it was gone. Your mind was doing it. You weren't doing it, he wasn't doing it, your mind was doing it and it's basically put it back into long-term memory, rather than being in short-term memory, at the front all the time."

"Once you split the emotion off from the event it became a lot easier to handle. With those two mixed together it was just a mess."

"It doesn't seem so bad now, the guys losing their legs in front of me. I can describe it really well, it's like it was only yesterday, but it doesn't bother me."

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2 *King's Centre For Military Health Research (2010/11).* KCMHR Newsletter. *Kings College, London.*

3 *See, for instance, Iversen, A, C, Van Staden et al (2009). The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study.* BMC Psychiatry, *9, 68.*

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5 *Hoge, C W, Terhakopian, A et al (2007). Association of post-traumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans.* American Journal of Psychiatry, *164, 150–3.*

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Nine participants had had experience of other therapies. Aspects that individuals specified as most helpful were relaxation training, regression (but this was experienced as distressing at the time), mindfulness and meeting others who were experiencing PTS. Distraction techniques, CBT, anger management, prescribed medications and group sessions were viewed by different people as only partially helpful while EMDR, talking about feelings, attempts to induce forgetting, group sessions, the therapist waiting for the client to come up with answers, and strictly time-limited sessions were mentioned, by different individuals, as not helpful at all. The positives cited about the human givens therapy provided by PTSD Resolution, as compared to other treatments, were the prompt availability of treatment, the small number of sessions (generally just three to five), the ability to process the traumatic events privately, without needing to discuss them, and the tools to reduce emotional arousal.

Therapist background

All except one of the 11 interviewees thought it was unnecessary for their therapist to have a military background, though half said that an awareness of military matters or particular experience of trauma would be helpful. In the case of one person, who thought it advantageous that his therapist did not have a military background, and another, who was clearly in favour of his therapist having been in the forces, both views reflected their own therapist's particular background. One person incorrectly assumed his therapist was ex-military and attributed the success of the therapy to that. These data indicate that a good level of rapport is more important than a shared military background.

Follow-up

Although participants appreciated therapists' invitations to contact them in the future if necessary, the majority expressed the view that it would be helpful for the therapist to take the initiative in checking in with them post-therapy, to see whether any further therapy might be required. A number were reluctant or embarrassed to ask for further help themselves.

Coping strategies

All participants reported character changes due to PTS symptoms, which human givens trauma therapy had helped them to address. These PTS coping strategies included alcohol abuse and aggression, whether verbal or physical, and also overworking and medication. One mentioned overspending. Four mentioned depression and three had made suicide attempts or had had suicidal thoughts.

Alcohol misuse was the most commonly mentioned coping strategy, with seven participants identifying their misuse of alcohol as uncharacteristic and describing it as a blocking mechanism. As one vividly put it, "I just thought I was a lad going out and getting drunk and doing rubbish things, getting involved with loads of horrible things. But it was actually totally out of character. Because I'd gone from this happy-go-lucky, good-at-sports sort of lad, and I'd come out and I was just sort of wasting my life really … I didn't see [alcohol] as a problem as I was just going out with my friends who are doing similar things. But some of them knew when to stop and I would probably just drink until I would fall down – over the top. I found out later that it was probably me just numbing … blocking things out." Another was very clear that "I did not have a problem with alcohol until I had a problem with PTSD". It is interesting that the King's Centre for Military Health Research notes the extent of alcohol abuse among veterans but has not made any observations about its uncharacteristic nature, as reported here, or its link with PTS, even though earlier research from at least as far back as 1983 has identified such a link.[16,17,18,19,20]

Uncharacteristic anger, aggression and violence were also common. One said, "I lost my appetite, my sex drive; my aggression really went up, I got very aggressive … I was looking for a fight at every opportunity and I'm not that type of person, I prefer to walk away from a fight and not get involved. People noticed it in me."

Another reported, "I was always terrified, right up until I had this treatment, I was always terrified that I was going to do something illegal, because my temper was so violent, verbally violent, but I just felt that one day I'm going to pick something up, because I had lot of … frustration. And an inability to express this frustration properly."

After therapy, participants reported an improved ability to manage emotional arousal, recognising the early signs and taking action to avoid unreasonable responses, usually through physical exercise, and relaxation techniques.

Ongoing effects of therapy

All the participants that were interviewed reported improved coping abilities after therapy. Nine of the 11 said that they had found the sessions helpful and that the traumas dealt with were no longer troublesome to them. Two said the sessions were partially helpful but that they would have liked more sessions to address service

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8 *Iversen, A, Nikolaou, V et al (2005). What happens to UK veterans when they leave the armed forces?* European Journal of Public Health, *15, 2, 175–84.*

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issues, and one would have welcomed a refresher. Overall, the responses indicated that participants experienced greater mental and emotional balance and felt more able to direct the course of their lives after therapy, but the therapy did not necessarily equip veterans to manage the rest of their lives easily. As one veteran observed, "The Falklands is not so intrusive any more. It is maybe my childhood, my past, and my marriage, now …" Another said, "A lot of what happens with me is that it's just mixed up with other things. But the general pattern of my moods is similar to what was happening 20 odd years ago – isolation, depressed a little bit, just things like that – which I can't link to anything in particular. And it may be that the 1982 [Falklands] side of things has been resolved. If you took away everything that's going on currently in my life, it might be just fine and I'm normal like everyone else. Everyone's got issues."

Six veterans referred to potentially problematic current non-service related issues. Even though therapy had previously been helpful, few considered using the same therapy to address the current issues – some of which were apparently traumatic. This raises the question of whether the experience of living with PTS had sensitised them and affected resilience in managing subsequent stressors[21] or whether unhelpful behaviour patterns that had developed before the original traumas were treated were still continuing. This, combined with the previously highlighted reluctance to seek further help, clearly indicates a potential role for follow-up human givens therapy to help veterans address unmet essential needs, draw on personal resources and keep using the strategies to manage emotional arousal, whatever its context. Human givens therapy provided by PTSD Resolution now routinely includes follow-up of treated veterans.

I identified three overarching themes from the interview data: disconnection, lack of control, and return of control after effective therapy.

Disconnection

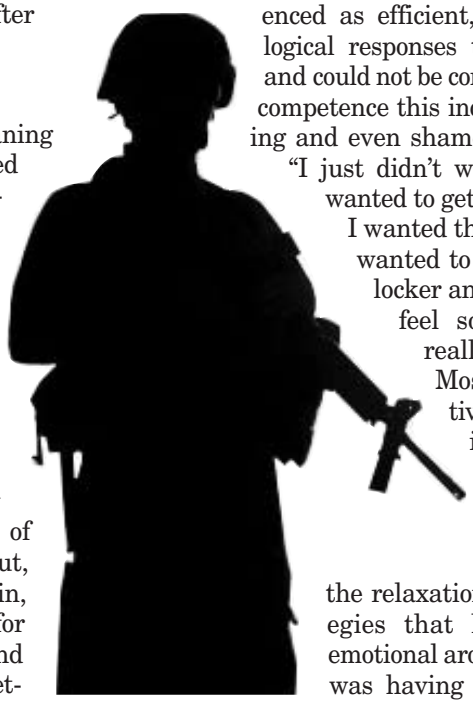
In contrast to the connection, meaning and purpose generally experienced in the forces, when veterans returned from active service they often experienced disconnection from the wider population. A recurrent theme was the lack of understanding from civilians, even when those civilians were trying to understand, as in the case of close family members. There was a sense that certainty and meaning were ebbing away in the face of wider public lack of interest in, or even hostility about, the conflict they had taken part in, and a perceived lack of respect for the serviceman, his experiences and his role. One mentioned the upsetting experience of being booed. Veterans experienced not only a loss of status on their return to the UK but a sense of negative status and of being adrift in their own country.

There was a growing sense of disconnection in personal relationships too. This, again, was in stark contrast to the close, mutually supportive military relationships that had been experienced. Most had no regrets about serving and many expressed the wish to go back, for the comradeship, the meaning/sense of purpose, or for the adrenalin, without which life seemed flat. Some mentioned a sense of guilt about surviving when others did not, or being safe in the UK when others were not. Guilt during or immediately after trauma is a strong predictor of PTSD.[22]

Some experienced or perceived a lack of support from official sources and thus a sense of growing isolation both from the 'forces family' and the general population – a doubly difficult burden to bear.

Lack, and return, of control

Participants experienced a frightening lack of control as the PTS symptoms began to manifest and their minds and bodies, previously experienced as efficient, were hijacked by physiological responses that were not understood and could not be controlled. The sense of lack of competence this induced was often overwhelming and even shameful for some. As one said, "I just didn't want to be near anybody. I wanted to get away from it all and just – I wanted them to leave me alone and I wanted to go into my own little hurt locker and just get away from it and feel sorry for myself. And not really do anything about it." Most resorted to the destructive types of coping mechanisms mentioned earlier.



Veterans derived a sense of returning control and competence and a growing sense of security from the relaxation training and other strategies that helped them to manage emotional arousal. Also important in this was having the choice about whether

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or not to discuss the traumatising events, and the facility to reprocess them privately during the therapy.

PTSD – so, is there much of it about?

As mentioned at the startof this article, obtaining a diagnosis of PTSD has legal and political connotations,[7] and many veterans may be suffering many of the symptoms of PTSD without actually being diagnosed. Some of the veterans in this study believed that the government might be manipulating the statistics to avoid having to recognise the true extent of the problem. One commented, "I recognised the signs that I was about to be given an administrative discharge which meant you'd get nothing and I'd just be, quite frankly, on the scrapheap, which I could see them doing to other people … I know that their attitude to [PTSD] was to get them out under an administrative discharge. They don't want the stats, you know. And I know it to be that way because I actually worked in a job where I was going to get people to sign the papers, and I thought this isn't right because the guy can't even cope with his life, let alone fighting the system."

Another stridently disagreed with what he had read recently in a King's Centre for Military Health newsletter,[2] indicating that PTSD is not a major problem for UK forces: "That's total rubbish. I strongly disagree with that… They're just saying, 'Oh it's not the case! Oh it's not the case! Get out of it! What, the more deployments, the more people, the more bullets you face, the more you get shot at, people blown up, your mate gets killed, your two mates get killed, that doesn't take anything? Who else will get killed that you like? And that doesn't take anything out – piss off!"

Several participants thought early recognition and treatment of PTS was essential, and that serving personnel as well as veterans should be targeted to check whether treatment is needed. This would require some official recognition of a potential link between typical coping strategies, such as alcohol misuse, anger and violence, and conditions such as depression, anxiety and PTSD, as well as further changes to the military culture to make it more generally acceptable to disclose these conditions. Interestingly, a recent House of Commons Defence Committee report has called for a study into whether alcohol misuse in the forces is stress related, stating that "The MOD has yet to recognise the seriousness of the alcohol problem and must review its policy in this area." [23]

Until such time as the military culture does change, however, PTSD Resolution seems to be providing an invaluable service in offering human givens trauma treatment. The promptly available treatment meant help was available at the time when the veteran was ready to deal with it, thus taking advantage of the 'action' stage of the well known cycle of change (pre-contemplation, contemplation, commitment, action and maintenance).[24] Human givens therapists also appeared to develop good rapport and inspire confidence, which allowed veterans to relax and begin to feel optimistic.

It is interesting that the overarching themes which emerged through review of the interview material correspond to many of the organising ideas of the human givens approach, reflecting that emotional good health comes with the meeting of emotional needs (healthy connection with others, balanced giving and receiving of attention, meaning, valued status, a sense of control, competence, and security) and the use of innate personal resources to achieve that. It was the elements of the therapy not generally available elsewhere that were particularly valued. Most participants experienced a marked sense of resolution in relation to their traumatic experiences and a welcome awareness of returning control, competence and security. ■

The rewind technique

This technique should be carried out by an experienced practitioner and is only performed when people are in a state of deep relaxation. When fully relaxed, they are encouraged to bring their anxiety to the surface and then are calmed down again by being guided to recall or imagine a place where they feel totally safe and at ease. Their relaxed state is then deepened and they are asked to imagine that, in their special safe place, they have a TV set and a video or DVD player with a remote control facility. They are asked to imagine floating to one side, out of body, and watching themselves watching the screen, without actually seeing the picture (double dissociation). They watch themselves watching a 'film' of the traumatic event that is still affecting them. The film begins at a self-selected point before the trauma occurred and ends at a point at which the trauma is over and they feel safe again.

They are then asked, in their imagination, to float back into their body and experience themselves going swiftly backwards through the trauma, from safe point to safe point, as if they were a character in a video that is being rewound. Then they watch the same images but as if on the TV screen while pressing the fast forward button (dissociation).

All this is repeated back and forth, at whatever speed feels comfortable, and as many times as needed, till the scenes evoke no emotion from the client. If the feared circumstance is one that will be confronted again in the future, the person is guided, while still relaxed, to visualise themselves doing so confidently.

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