

"The Trauma Resiliency Model Training (TRM-V,W) is the best form of showing that you care for the Nation's veterans. . ." Dale Adams of the Veterans' Administration, Los Angeles, California, July 2008

"My BIG, BIG, BIG dream is that every soldier, every marine, every sailor, and every air force person will have learned these VRM skills before they go into a combat zone, so they can help themselves stay regulated!! Several veterans have told me what a difference this would have made if they would have learned these skills prior to deployment." Jan Click, LCSW, Greater Los Angeles VA Healthcare System

INTRODUCTION TO BIOLOGICAL INTERVENTION WITH VETERANS AND WARRIORS USING THE TRAUMA RESILIENCY MODEL (TRM-V,W)
M. Laurie Leitch, PhD

TRM-V,W is a skills-based, biological approach to working with trauma that focuses on the biology of fear and threat and the automatic ways that all humans are neurologically programmed to respond when they are frightened or perceive themselves to be in danger. When the focus is on biology rather than psychopathology, the shame and secrecy veterans often feel because of their traumatic stress symptoms are normalized. Symptoms are viewed as the body's attempt to re-establish balance in the nervous system. The orientation of TRM-V,W is to the somatosensory aspects of traumatic distress. Although like traditional psychotherapy it incorporates narrative, in TRM-V,W verbal expression of thoughts and feelings is treated as secondary and is only one of a number of pathways available to help unlock patterns of traumatic symptoms. TRM-V,W has been adapted from the Trauma Resiliency Model (TRM-V,W). VRM training and treatment protocols have been piloted tested in VA centers as well as by therapists outside of the VA system.

TRM-V,W has been designed as both a treatment model as well as a self-care model. It is a skills-based approach which can be immediately used by veterans for their own self-regulation outside of the counseling setting. This reduces dependency on external "helpers" as well as promotes a sense of mastery and hope. Military parents can use TRM-V,W skills with their children who may be reacting to the stresses of the veteran's deployment or return to civilian life, veterans can use TRM-V,W with each other as a peer model. Counselors exposed to secondary trauma in their work with combat-zone trauma can use TRM-V,W skills to manage their own activation levels and to prevent burn-out. A TRM-V,W group-format intervention is also available, as are client workbooks and a group facilitator's guide. These can be purchased on the website's store.

TRM-V,W is taught to counselors and others working with combat-zone trauma as a 3-day workshop for Level-1. There is also a 3-day Level-2 TRM-V,W training available, that deepens understanding of the didactic material and provides additional skills practice. Case-consultation is encouraged and offered by TRI following Level 1 and 2 training in order to anchor the skills and expand participants' competency when utilizing TRM-V,W.

Table 1 below summarizes ways in which the TRM-V,W approach differs from traditional psychotherapeutic approaches to traumatic distress.

Traditional Psychotherapy
Biological Model
Trauma Resiliency Model Veterans and Warriors (TRM-V-W)

Traditional Psychotherapy	Biological Model Trauma Resiliency Model Veterans and Warriors (TRM-V-W)
Therapeutic focus is insight and problem-solving	Therapeutic focus is on the biological basis of trauma. Is well-suited to populations that are not psychologically oriented.
Is "Top-Down" by utilizing functions of the neo-cortex.	Is "Bottom-Up" by focusing on brainstem functions that are biologically programmed in all humans.
In cognitive therapy, the patient narrates the trauma experience fully, telling, feeling and listening to the details of the story of the trauma (sometimes many times as in the case of Exposure Therapy). There is a risk of "flooding," hyper- or hypo- arousal, and re-traumatization.	In TRM-V,W, work is with small gradations of traumatic material alternated with Resource material. If the story is told, it is told in a particular way that is oriented to monitoring arousal and emphasizing management of highly activating material. Alternating attention between traumatic material and resource material helps restore the natural rhythm and equilibrium of the nervous system, as well as restore hope and resiliency.
Formal "relaxation training" techniques using breathing exercises and mindfulness based exercises may be used	The focus is on re-calibrating the autonomic nervous system to restore natural resiliency rather than on

<p>for symptom management.</p>	<p>symptom management. When the nervous system is in balance symptoms diminish or resolve.</p>
<p>The focus on insight and problem-solving requires the vet's access to higher order cortical functions which, as current brain imaging studies have shown, often have been de-activated (and, therefore, may be inaccessible) following trauma.</p>	<p>By utilizing increasing levels of sensory awareness the vet is helped to learn how to report on and then manage the survival activation from the brainstem and limbic system. Cortical functions are utilized only secondarily.</p>
<p>Use of cognitions and restructured belief systems focus on mediating the limbic system's on-going risk assessment, where even "normal" events may be associated with fear and threat.</p>	<p>Use of Sensory-motor patterns remaining in the body (from visual, auditory, olfactory, pain and other sensory trauma) focus on releasing encapsulated traumatic energy. As the traumatic energy is released the vet's arousal level comes back into the "normal window" and cognitive functioning improves.</p>
<p>Useful once activation levels are restored within the "normal window of arousal" and cortical functions are restored.</p>	<p>Useful in the earliest stages of treatment to prepare the vet for more cognitively-based problem-solving. Can be used as a complement to cognitive models in interventions conducted in phases.</p>