



**BRAIN INJURY
ASSOCIATION
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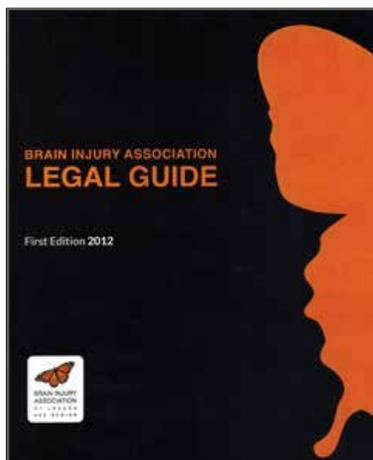
Winter Issue December 2015

THE MONARCH

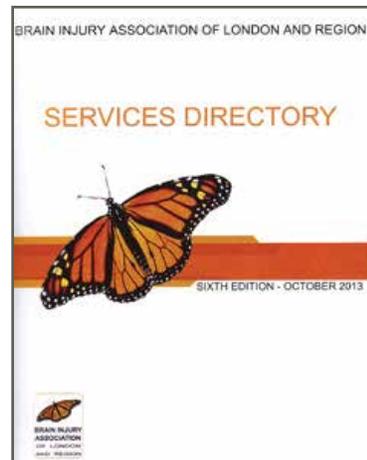
Brain Injury PTSD and the Military



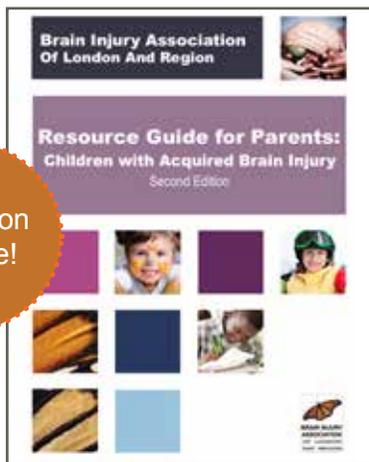
Check Out These Great Resources!



This legal guide is published by BIALR, in collaboration with Harrison Pensa, and is in its first edition. It is designed to provide straightforward accessible explanation of key legal issues and fundamental legal rights of those who have suffered brain injuries and their support teams. Print copies are available from the BIALR office and electronically on the website.

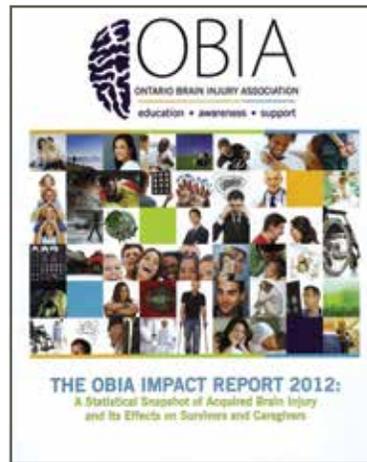


This directory is published by BIA London and Region and is in its 6th edition. It is designed to help individuals suffering from the effects of a brain injury identify and locate the services in London and Region. (Print copies are available from the BIALR office and electronically on the website.)



new edition available!

This resource is published by BIALR and is in its first edition. This compilation of articles is designed as an informational resource for parents of children who are suffering from the effects of an acquired brain injury. Print copies are available from the BIALR office.



The OBIA Impact Report 2012 is published by the Ontario Brain Injury Association (OBIA), with support and funding provided by the Ontario Neurotrauma Foundation. It is designed as an easy to read statistical snapshot of acquired brain injury and its effects on survivors and their caregivers. Electronic copies are available on the OBIA website.

Online Resources:

- Brain Injury Association of London and Region - braininjurylondon.on.ca
- Ontario Brain Injury Association - obia.ca
- Brainline.org, preventing, treating, and living with traumatic brain injury - brainline.org
- Brain Injury Association of Queensland - synapse.org.au
- National Resource Center for Traumatic Brain Injury (Virginia Commonwealth University) - www.tbinc.com

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We Need Your Help!

Volunteer Opportunities Available

If you or someone you know is interested in volunteering, we are looking for energetic people to join our team!

We are currently seeking volunteers to assist us with various support groups, charitable events and committees.

Support Group Leaders and Speakers:

-For all 5 counties: London/Middlesex, Perth, Elgin, Oxford and Huron

Committee Members:

- Community Awareness
- Fundraising
- Support Services
- Conference
- Editorial

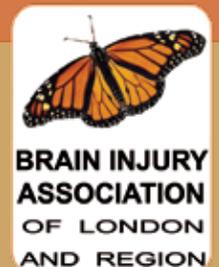
50/50 Ticket Sellers:

- Nationals Hockey Games



If you are interested in volunteering or have questions please email:

volunteer@braininjurylondon.on.ca



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Brain Injury Association of London & Region
341 Talbot Street
London, ON N6A 2R5
Phone: 519-642-4539
Fax: 519-642-4124
Email: info@braininjurylondon.on.ca
website: www.braininjurylondon.on.ca

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Letter from The Executive Director

Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) frequently coexist because brain injuries are often sustained in traumatic experiences. The theme of this issue of the Monarch highlights various aspects of PTSD and TBI.

This September marked the beginning of a new partnership with Joy Cameron and our Association in presenting the 2nd Annual Bikes n Brains event. Joy initially created this event in commemoration of her injury to raise awareness of bicycle safety.

Along with our co-host, H.A.B.I.T. Helping Acquired Brain Injury Treatment, we had a beautiful day on the links at our annual Brain Injury Golf Classic in September. Many thanks to Lisa Bradshaw for her tremendous organizational skills in planning the tournament.

The Conference Committee hosted the first in a two part series on the impending changes to the Statutory Accident Benefits. Keep an eye on our website and watch for the e-newsletter with the details of part two.

The Fundraising Committee has been exceptionally busy these past couple of months. Our newest fundraiser, the Boot & Brains Barn Dance & Country Market, held at the Plunkett Estate was a resounding success with 260 country music fans in attendance. In addition, our 8th Annual Casino Night was also well attended. We are now in the planning process for our annual Gala in March.

It is hard to believe that we are nearing the end of 2015. I would like to thank each of our sponsors for their contributions to the Association over the past year, without your support, we would not exist!

May all of our supporters experience a safe, healthy, happy holiday season!

Donna Thomson

Highlighting Our Volunteers



Just A Note To Say Thank You!

Tina Lojpur

Tell us a little about yourself?

I'm currently a second year Medical Science student at Western University. My future career goal and interest is to work in the medical field. In my spare time I am an active volunteer in London, and love being part of different clubs and committees. My favourite hobbies are going on hiking adventures and exploring new activities. Overall, I like to be a busy person!

How long have you been volunteering with the Brain Injury Association?

I have been volunteering with the Brain Injury Association for almost a year now, and what a fast year it has been!

Why did you choose to volunteer with the BIA?

Being surrounded by friends and family who are victims of ABI; I felt the need to be a part of an organization to help spread awareness. Before I joined the BIA, I wasn't quite aware of what it was all about, but as soon as I started getting involved with different fundraisers, I knew it was the perfect place to volunteer!

What makes you come back to BIA year after year?

I've decided to continue volunteering at BIA this year because of the people and the energy. Donna, Stephanie, and all the other volunteers are incredibly friendly and welcoming. Seeing all the hard work and effort that goes into planning events is very fulfilling and I'm thrilled that I get to be a part of it too!

Do you have a favorite moment from your time here that you would like to share?

My favourite moment would have to be the first event I attended when I started to volunteer at the BIA. This event was the Margaritaville Fun Raiser. After weeks of preparation and hard work, seeing the event come together is overwhelming. I was so surprised to see how much effort is put into these events, and how much fun they actually are. Seeing everyone come together, have fun, and raise money for a great cause is really rewarding!

What would you say to someone that is considering volunteering with BIA

Do it! Volunteering at the BIA has been very rewarding and has exceeded my expectations of what the organization is truly about. From coming in weekly to work on different tasks, and to help organize events; there is always something new to do. I would highly recommend volunteering at the BIA as I have become more aware and will continue to volunteer here!

Brain Injury Support Groups

If you or someone you know has experienced a brain injury, you may benefit from participating in one of our many support groups. Groups meet either monthly or weekly and offer you the chance to learn more about living with ABI. Discuss common issues and problems or have fun in a positive environment.

 <p>Huron County Support Group Meets the second Monday of the month OMAFRA Office 100 Don Street Clinton ON 6:00 - 8:00pm</p> 	 <p>Oxford County Support Group Meets the First Tuesday of each month Dundas United Church 285 Dundas Street Woodstock, On 6:30 - 8:30pm</p>
 <p>Perth County Support Group Meets the last Tuesday of each month Zehrs Markets 2nd Floor Community Room 865 Ontario Street Stratford, On 7:00 - 9:00pm</p>	 <p>Elgin County Support Group Meets the second Monday every month Community Room at the Elgin Mall 417 Wellington Street St. Thomas, On 6:30 - 8:30pm</p>
 <p>Perth County Social Leisure Group Meets every Wednesday of each month Central United Church 194 Avondale Avenue Stratford, On 1:00 - 4:00pm</p>	 <p>London/Middlesex Support Group Meets the last Thursday of each month First Baptist Church London 568 Richmond Street (parking in rear) London, On 7:00 - 9:00pm</p>



JOINT MEMBERSHIP PROGRAM

Brain Injury Association of London and Region & The Ontario Brain Injury Association

Invite you to belong to both organizations for one low fee!
Further information and the application form can be found at

www.braininjurylondon.on.ca
under "How to help"



We want to hear from you!!

Do you have a suggestion for the Monarch magazine? Let us know!

We would love to hear your feedback.

email your suggestions to
editorial@braininjurylondon.on.ca



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Making Numbers Make Sense

DISCLAIMER:

The Monarch is published by the Brain Injury Association of London and Region.

Opinions expressed in the articles are those of the authors and do not necessarily reflect the opinion of the Board of Directors.

All articles remain in their submitted un-edited form to preserve the original views and intent of the author.

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Phone: 519-642-4539
Fax: 519-642-4124
Email:

info@braininjurylondon.on.ca

Editors: Editorial Committee

Layout and Design:
Stephanie McGill

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Peer Support Coordinator's Report



Jamie Fairles
Peer Support Coordinator
519-642-4539
editorial@braininjurylondon.on.ca

Many brain injury survivors and those close to them have suffered from the effects of PTSD (Post Traumatic Stress Disorder) after acquiring their injury. PTSD “is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood. Whether the sufferer realizes that what they are feeling is not just from their brain injury, but it may very well be the signs of PTSD comingling with the injured brain is something to be questioned because many symptoms of PTSD like dizziness, anxiety, flashbacks, nightmares, and turning to substance abuse to self medicate are both quite common after a brain injury is sustained as well as in PTSD. This month’s theme is PTSD and brain injury and hopefully you can read how to distinguish brain injury from PTSD and alleviate some of their symptoms. The Association’s next peer mentor training session has been tentatively scheduled for November 20 from 9-2 in the office boardroom. This month also sees the highly successful provincial Brain Injury Conference held once again in Niagara Falls On November 11-13. The day before the conference, the 14 Peer Support Coordinators from across Ontario will meet to have our annual meeting to discuss how each association is doing in their area for peer support, get updates on policies and procedures to ensure that this program offers its services to all affected by brain injury. In fact, at this year’s conference there will be a breakout session specifically on peer support. There will be a cross province representation of a mentor, a partner, and a Peer Support Coordinator and since I’m the only one that’s been involved with the program since its inception 8 years ago, when I was first trained as a mentor, I have been asked to represent the Peer Support Coordinator!

Looking To Get Involved?

We are looking for individuals to become mentors in our Peer Mentor Program. Mentors provide support and share information and resources with partners who are coping with a similar ABI-related situation. We are in particular need of mentors who are family members and caregivers. Visit our website or contact our Peer Support Coordinator for more information.

www.braininjurylondon.on.ca



PARKWOOD INSTITUTE Medical Driving Assessment Program

The medical driving assessment program has two options:

Driver Assessment Rehabilitation Program

Driver assessment and rehabilitation services for those:

- whose health status has changed due to trauma, illness and natural aging
- with physical disabilities who may require equipment and/or modifications
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DriveABLE

- A driving assessment program for older drivers with a confirmed or suspected cognitive impairment such as dementia or Alzheimer's.
- Outcomes for a DriveABLE assessment include pass (an individual is safe to continue driving) or fail (it is no longer safe for that individual to drive)

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Parkwood Institute is an approved Ministry of Transportation Driving Assessment Centre
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For more information: **www.sjhc.london.on.ca/darp**

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- ◆ Our team of rehab specialists helps those injured in car or work-related accidents. Our expertise is in neurological trauma including spinal cord and brain injuries.
- ◆ Please call us if you, your family member or client needs help:
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 - Organizing their day
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 - Exploring strengths and learning new strategies

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ABI: Top Ten Tips

Submitted by: Jenica Groot-Nibbelink

Often, the general population does not know how to deal with Acquired Brain Injury and its survivors. Unkindness is not intended during interactions but yet some unhelpful interactions do occur. Rather, the case is, often, a lack of knowledge. The purpose of this article is to educate others on acquired brain injury:

Acquired Brain Injury is a surprisingly common injury. For example, concussions are mild brain injuries, injuries to the brain that an individual is not born with. The individual acquires the brain injury later in life. They vary in severity and source. NHL hockey players frequently experience what would qualify as acquired brain injuries. The famous Sydney Crosby and before him, Eric Lindros, have had acquired brain injuries. They each have raised awareness for acquired brain injury and its survivors.



I believe, the general population should be better educated on how to treat individuals with acquired brain injury. This article hopes to provide you with a list of suggestions to consider when dealing with individuals who have an acquired brain injury (ABI):

1. EVERY case is different. Find out about the person, the type of injury, the seriousness of the injury and, if possible, the recovery that has already taken place.
2. Be inquisitive. Ask questions in a manner that shows the individual you care about their life.
3. Rehabilitation can be a full-time job. Therapy may take most of a person's day and energy. These individuals work just as hard as you do (if not harder). However, this individual may not get paid in any monetary value.
4. Suggest quieter locations to gather. People with ABI are often very sensitive to noise. Perhaps changing the venue might be helpful for the person affected. Better yet, allow them to suggest locations and activities.
5. Be patient. It often takes people with an acquired brain injury some time to think and respond. Allow them to have that time.
6. Allow for rest periods. Fatigue is perhaps the most common trait in people who have an acquired brain injury.
7. Treat them as you did before the injury, unless otherwise told to act or talk differently by family members, friends, or therapists. Sometimes, all that is required is for you to slow down the rate of your speech.
8. Be gracious: People who have an acquired brain injury may get easily agitated or upset. Depending on the case, people with ABI may not respond in socially acceptable ways.
9. Treat the individual as their age dictates. Allow them to ASK for help when needed.
10. Above all, treat individuals with acquired brain injury with respect.



Brain Injury? Think Brainworks

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Cornerstone Clubhouse



A Dale Brain Injury Services day and evening program for adults living with the effects of an acquired brain injury.

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“What was taking place inside my head my family could not see or understand.”



Post-Traumatic Stress Disorder - What You Don't See

Submitted by Kevin Acs

My name is Kevin Acs, I am in my last year of the Social Service worker Program at Fanshawe College. Presently I am doing my internship at the Brain Injury Association of London & Region. To those that don't know, I seem normal, but to those that do it is a different story. I have an operational stress injury that I incurred in the military. As with many other members of Canada's military, I lived with the stigma surrounding mental health. It was viewed as a sign of weakness to reach out for help- that is until the last few years. With all the publicity of suicide from Post-Traumatic Stress Disorder (PTSD) this stigma is now being broken down. An operational stress injury means the cause does not matter whether it be domestic or in a theater of operation. We experience the same horrors.

Personally I tried to bury a number of things I saw during the fifteen years I served in Search and Rescue. In 2009 a situation occurred that caused my injury to resurface and lasted four

years. Over those many years I knew something was not right with me but did not know what it was. This caused great hardship to my family as they lived with my mood swings, depression, irritability and anger. This would eventually lead to the breakup of my marriage.

What was taking place inside my head my family could not see or understand. I was experiencing sleepless nights, nightmares, night sweats, wild emotion, suicidal ideology, isolation, stomach issues, hypervigilance and the constant wars in my brain. Three very bizarre issues had developed: 1) fear of travelling 2) fear of flying (which is mind boggling as I am in the Airforce) and 3) crowds such as at Costco, shopping malls and classrooms. Even sitting in a booth at Tim Hortons when I am between someone and the wall aggravates my symptoms. I begin to sweat, my breathing accelerates and I begin to fidget almost as if I were having a panic attack.

For those of us who are living with PTSD it is like a roller coaster ride. We go from good days to bad days hoping there are more good than bad. It is often day to day or hour by hour as we deal with our issues. Our greatest comfort is that we are not alone, the peer support network is there for us. Peers truly understand, they are supportive, not judgemental and can help through the toughest times.

In London, the Operational Stress Injury Clinic at Parkwood Institute is one of our biggest supports. The psychiatrists, psychologists, social workers, clinicians and staff help us deal with our issues, get us through the tough times and on the road to healing.

I cannot thank my military family, the staff at both the Integrated Personnel Support Unit and the Operational Stress Injury Clinic for all their help and support as I deal with my issues. I would give anything to say "I do not have PTSD."

The Science Behind PTSD Symptoms: How Trauma Changes the Brain

By: Michele Rosenthal



After any type of trauma (from combat to car accidents, natural disasters to domestic violence, sexual assault to child abuse), the brain and body change. Every cell records memories and every embedded, trauma-related neuropathway has the opportunity to repeatedly reactivate.

Sometimes the alterations these imprints create are transitory, the small glitch of disruptive dreams and moods that subside in a few weeks. In other situations the changes evolve into readily apparent symptoms that impair function and present in ways that interfere with jobs, friendships and relationships.

One of the most difficult aspects for survivors in the aftermath of trauma is understanding the changes that occur, plus integrating what they mean, how they affect a life and what can be done to ameliorate them. Launching the recovery process begins with normalizing post-trauma symptoms by investigating how trauma affects the brain and what symptoms these effects create.

The 3 Part Brain

The Triune Brain Model, introduced by physician and neuroscientist Paul D. MacLean, explains the brain in three parts:

- **Reptilian (brain stem):** This innermost part of the brain is responsible for survival instincts and autonomic body processes.
- **Mammalian (limbic, midbrain):** the midlevel of the brain, this part processes emotions and conveys sensory relays.
- **Neomammalian (cortex, forebrain):** the most highly evolved part of the brain, this area outer controls cognitive processing, decision making, learning, memory and inhibitory functions.

During a traumatic experience, the reptilian brain takes control, shifting the body into a reactive mode. Shutting down all non-essential body and mind processes, the brain stem orchestrates survival mode. During this time the sympathetic nervous system increases stress hormones and prepares the body to fight, flee or freeze.

In a normal situation, when immediate threat ceases, the parasympathetic nervous system shifts the body into restorative mode. This process reduces stress hormones and allows the brain to shift back to the normal top-down structure of control.

However, for those 20% of trauma survivors who go on to develop symptoms of post-traumatic stress disorder (PTSD)- an unmitigated experience of anxiety related to the past trauma- the shift from reactive to responsive mode never occurs. Instead, the reptilian brain, primed to threat and supported by dysregulated activity in significant brain structures, holds the survivor in a constant reactive state.

The Dysregulated Post-Trauma Brain

The four categories of PTSD symptoms include: intrusive thoughts (unwanted memories); mood alterations (shame, blame, persistent negativity); hypervigilance (exaggerated startle response); and avoidance (of all sensory and emotional trauma-related material). These cause confusing symptoms for survivors who don't understand how they've suddenly become so out of control in their own minds and bodies.

Unexpected rage of tears, shortness of breath, increased heart rate, shaking, memory loss, concentration challenges, insomnia, nightmares and emotional numbing can hijack both an identity and a life. The problem isn't that the survivor won't "just get over it" but that she needs time, help and the opportunity to discover her own path to healing in order to do so.

Throughout the brain several chemical and biological imbalances can present after trauma. Their effects are especially exacerbated by three major brain function dysregulations:

- **Overstimulated amygdala:** an almond-shaped mass located deep in the brain, the amygdala is responsible for survival-related threat identification, plus tagging memories with emotion. After trauma the amygdala can get caught up in a highly alert and activated loop during which it looks for and perceives threat everywhere.
- **Underactive hippocampus:** an increase in the stress hormone glucocorticoid kills cells in the hippocampus, which renders it less effective in making synaptic connections necessary for memory consolidation. This interruption keeps both the body and mind stimulated in reactive mode as neither element receives the message that the treat has transformed into the past tense.
- **Ineffective variability:** the constant elevation of stress hormones interferes with the body's ability to regulate itself. The sympathetic nervous system remains highly activated leading to fatigue of the body and many of its systems, most notably the adrenal.

How Healing Happens

While changes to the brain can seem, on the surface, disastrous and representative of permanent damage, the truth is that all of these alterations can be reversed. The amygdala can learn to relax; the hippocampus can resume proper memory consolidation; the nervous system can recommence its easy flow between reactive and restorative modes. The key to achieving a state of neutrality and then healing lies in helping to reprogram the body and mind.

While the two collaborate in a natural feedback loop, processes designed for each individually are vast. Hypnosis, neuro-linguistic programming and other brain-related modalities can teach the mind to reframe and release the grip of trauma. Likewise, approaches including somatic experiencing, tension and trauma releasing exercises and other body-centric techniques can help the body recalibrate to normalcy.

Survivors are unique; their healing will be individual. There is no one-size-fits-all or personal guarantee for what will work (and the same program will not work for everyone). However, the majority of evidence suggests that when survivors commit to a process of exploring and testing treatment options they can, over a period of time, reduce the effects of trauma and even eliminate symptoms of PTSD.





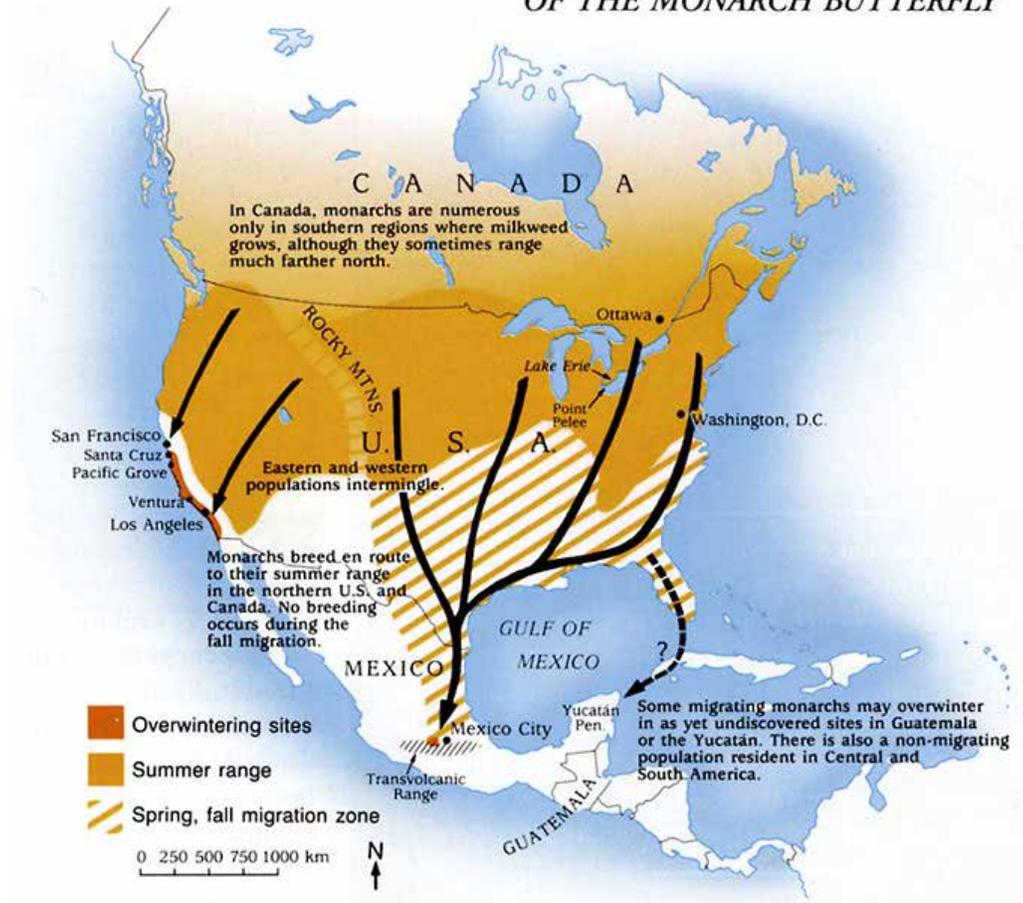
Is There Hope for the Monarch Butterfly?

Submitted by: Janko Stukic

The Monarch butterfly or simply the monarch is a milkweed butterfly in the family Nymphalidae. They are the most beautiful of all butterflies and are considered the “king” of the butterflies, thus the name monarch. They are one of the most recognizable butterflies in all of North America thanks to the easily recognizable black, orange and white pattern. Clouds of these iconic butterflies once migrated from Canada and the United States to Mexico each year. But new research has revealed that the monarch population has decreased by 90% over the past 2 decades, from nearly 1 billion butterflies in 1990 to just 35 million last year!!!!

The “Monarch” is the magazine of the Brain Injury Association of London & Region. It is published quarterly and it is the prime means of communication of the Association and it keeps readers informed and up-to-date about new and interesting related topics to brain injury. The Association decided to use the monarch butterfly as their logo for their newsletter because the monarch represents the life change that a person goes through after a brain injury (from a cocoon to a butterfly).

AUTUMN MIGRATION OF THE MONARCH BUTTERFLY



Each winter, monarchs head south, as they travel from Canada and the United States to nesting grounds in western Mexico, often covering a total distance of nearly 5,000 kilometres. But the journey is not even the hardest part, as the species has many factors threatening its survival. These include deforestation, logging, increased development, agricultural expansion and forest fires.

The balmy climate of the mountains west of Mexico City creates the ideal conditions for the delicate creatures, so experts were hopeful when vast numbers of monarchs arrived there this past November. Unfortunately, the winter forecast looks to dash any hope of regenerating their declining numbers. The danger of an unusually cold winter could lead to another major decline in the monarch’s numbers. Furthermore, pesticides have also had a significant effect on their population

decline, as herbicides kill the monarch caterpillar’s main food source, milkweed. Plant numbers have dwindled drastically in the Midwestern United States, wiping out monarch habitats collectively equal to the size of Texas.

According to the U.S. Fish and Wildlife Service, the iconic black-and-orange butterflies will be listed as an endangered or threatened species within the next year.

Here is How You Can Help:

Researchers are looking for help, as the monarch butterfly population is on a drastic decline.

Traveling up to 160km per day as migrate to Mexico, they work to help pollinate approximately one-third of the fruits and vegetables humans consume. Additionally, they assist researchers track changes in weather, climate and

ecosystem. Jenna Quinn, a program scientist with the Rare Charitable Nature Reserve in Cambridge, ON tells BBC that this species is at risk. “These monarchs used to cover nearly 30 acres of forest in Mexico and now they’re covering maybe 2 acres, so it’s a really drastic decline.”

Their migration is the longest butterfly migration on Earth, as it can take up to 2 months in length. It starts in the United States, continues through Canada and ends in the Sierra Nevada Mountains of Mexico. In the past, as many as 300 million monarchs would be seen wintering in Mexico. However, the according to a report released by the World Wildlife Fund in 2014, that number dropped below 60 million.

Climate change, severe weather events, such as drought and widespread pesticide use have contributed to the decline. Take drought, for example, it kills milkweed, a vital plant in the monarch life cycle and other pollinator plants. Caterpillars can be kept in the chrysalis stage longer due to cold snaps and this leaves them more vulnerable to predators.

Monarch Watch was founded in 1992 and they use the data collected from tagged butterflies, so if you happen to spot a monarch that is tagged, you should let the organization know. Data collected helps researchers determine how far a monarch travels in a day, their migration pathways and whether they are off track. The tags are actu-

ally quite simple, as they are just a sticker that attaches to the wings.

Creating Monarch Waystation

More than 90% of milkweed has vanished due to agricultural practices. Jode Roberts, a communications specialist with David Suzuki Foundation told The Weather Network, “Milkweed is an essential plant for the monarch butterfly because it’s the only plant that female will lay eggs on and it’s the only food that monarch caterpillars will eat. So they’re wholly dependent on this one specific plant.”



You can help out the butterflies by planting one of many species of native milkweed in your garden. In addition, you can set up a monarch waystation and register it online with monarchwatch.com. The types of plants used in a waystation vary based on geography. Monarch Watch recommends the following:

For gardens east of the Rocky Mountains:

Milkweed

- Butterfly Weed (*Asclepias tuberosa*)
- Common Milkweed (*Asclepias syriaca*)
- Swamp Milkweed (*Asclepias incarnata*)

General Nectar Plants:

- Indian Blanket (*Gaillardia pulchella*)
- Purple Coneflower (*Echinacea purpurea*)
- Joe Pye Weed (*Eupatorium purpureum*)
 - Scarlet Sage (*Salvia coccinea*)
- Tithonia Torch, Mexican Sunflower (*Tithonia*)
 - Zinnia, Dahlia Mix (*Zinnia elegans*)

For gardens west of the Rocky Mountains:

Milkweed

- Butterfly Weed (*Asclepias tuberosa*)
- Narrowleaf Milkweed (*Asclepias fascicularis*)
- Showy Milkweed (*Asclepias speciosa*)
- Swamp Milkweed (*Asclepias incarnata*)

General Nectar Plants:

- Blue Sage (*Salvia farinacea*)
- Chia (*Salvia columbariae*)
- Scarlet Sage (*Salvia coccinea*)
- Tithonia Torch, Mexican Sunflower (*Tithonia*)
- Zinnia, Dahlia Mix (*Zinnia elegans*)



“our MEG results offer hope that MEG functional imaging might hold the key to making the invisible visible”

A Novel Brain Imaging Technique Can See the Cognitive Complaints in Concussion and PTSD

Submitted by: Elizabeth W. Pang, Ph.D., Neurophysiologist & Scientist, Hospital for Sick Children, Toronto

‘If only I could wear a sign so people would know that I am trying, maybe they would be more understanding.’ I heard this statement from a young man who recently suffered a sports-related concussion. Months later, he continues to struggle with fatigue, depression, and cognitive complaints. This same lament could be spoken by someone suffering from post-traumatic stress disorder.

Although a mild traumatic brain injury (mTBI or concussion) and post-traumatic stress disorder (PTSD) are triggered by different events, their outcomes can look similar. Often referred to as an ‘invisible injury’ because MRI imaging shows no obvious damage to brain structures, some individuals with a concussion or PTSD report long-term struggles with cognitive functions.

We hypothesized that since the complaints in mTBI and PTSD involved cognitive brain functions, brain functional imaging studies might be more helpful than structural imaging. For this, we proposed to use a new modality called magnetoencephalography (MEG).

MEG is a functional neuroimaging modality that measures the synchronized firing of groups of neurons, and can capture brain function with millisecond timing resolution. MEG can also locate active areas in the brain with spatial resolution to several millimetres. Thus, MEG can identify where and when specific parts of the brain become activated to participate in a task.

Our research team at the Hospital for Sick Children (co-led with Dr. Margot Taylor) has focused on using MEG to understand how typical children’s brains change as they grow, develop and learn new cognitive functions. As well, we explore how these cognitive functions fail in children with various developmental disorders. As such, we have developed a battery of cognitive tests for the MEG where we can track brain activations associated with a specific cognitive function.

With funding through a Defence Research and Development Canada contract, we applied our MEG cognitive testing paradigms to individuals suffering from a mild traumatic brain injury and soldiers with PTSD. The cognitive domains that we examined were mental flexibility, inhibition, emotional processing, attention and memory. I focus below on our findings with the mental flexibility dataset.

Mental flexibility refers to the ability to adapt when presented with new information. Having mental flexibility is important for learning. Being mentally inflexible results in being unable to ‘shift gears’ when needed, and thus becoming ‘stuck’ on a task. We have used this mental flexibility task in the MEG to look at control individuals from childhood to adulthood, so we had a good grasp of what we should expect to see.

Not surprisingly, the results from the concussion group and the PTSD group were abnormal; however, what surprised us was that the abnormalities looked strikingly different between the two groups.

The concussion group maintained their level of accuracy throughout, but compensated by slowing their reaction times as the mental flexibility task got harder. These behavioural changes were accompanied by a pattern of brain changes that can best be described as disorganized. The brain regions typically activated for mental flexibility did not activate in the expected order and they did not activate in synchrony. When we examined the connectivity of the neural network, we found that the mTBI group showed extreme underconnectivity suggesting that key brain regions, ones which should have been talking to each other, were not.

On the other hand, the PTSD group showed a different pattern compared to the mTBI group. The abnormality seen in PTSD was an excessively large activation generated by limbic structures that occurred immediately after presentation of each stimulus. The limbic system is in charge of emotional control and regulation, and one theory of PTSD is that parts of the limbic system are not adequately regulated and this is what generates PTSD symptomology. Our findings fit with this hypothesis. We saw high amplitude activations in limbic structures that acted like a dam to block the initiation of the flow of typical processing. Once processing passed this ‘dam’, it proceeded as normal. When we investigated the connectivity of the neural network, we found that one key hub, in right parietal cortex, was hyperconnected and the strength of this hyperconnectivity correlated with symptom severity.

If the analogy for mTBI is that key brain regions are not talking to each other and thus unable to do their jobs, then the analogy for PTSD is that key brain regions are talking too much to each other and too busy to do their jobs. These findings were unexpected in the clarity with which they distinguished the two clinical conditions.

Returning to the idea that mTBI and PTSD are usually considered invisible injuries, our MEG results are the first to suggest that brain functional impairments can be seen and linked to these clinical symptoms. This is the first demonstration that the cognitive injuries in mTBI and PTSD are visible through MEG imaging. This opens the door to new possibilities for diagnosis and monitoring. It may also offer relief for those who suffer from the invisible burden of mTBI or PTSD-related cognitive complaints – if the burden becomes visible, then perhaps it will be easier to get the help and support that is so keenly needed.

While it is still early days for this research, our MEG results offer hope that MEG functional imaging might hold the key to making the invisible visible.



A SERVICE DOG AND HER VETERAN

Submitted by Stephen Evans

My name is Jim and am a Veteran of the CAF, (Canadian Armed Forces). It is from my Service to Canada that I acquired PTSD, (Post Traumatic Stress Disorder). Veterans Affairs Canada and the Canadian Armed Forces refer to this disorder as an OSI, (Operational Stress Injury). In general terms, PTSD is a diagnoses which is derived from the onset of a number of symptoms as described in the DSM IV , (Diagnostic and Statistical Manual of Mental Disorders); some of these symptoms are Major Depression, Social Phobia, and Anxiety, all of which I still experience to this day.



To add a little perspective to my story; today, in 2015, I am 62 years old, so, even though I am a young man still, time passed has made changing a most difficult task. I have been single since 2003 and have since lived alone. I have one child, (18yrs), who lives with her mother, but I see her as often as she likes. I do not have any friends, nor do I socialize or care to. My injuries are not visible making it difficult for others to recognize, help or compensate for my disabilities or abilities.

The first of several exposures to traumatic events occurred in 1981; I released from the CAF in 1996 after twenty years of service and was not diagnosed until March 2009. Since

March 2009, I have received excellent treatment for the OSI/ PTSD through Veterans Affairs Canada. After a few years I finally reached a point in my recovery where I felt that I might be able to do something for myself, outside of the rigorous and painful, but, very effective psychiatric/ psychological regime that I was following.

It was about this time that the suggestion of a Service Dog was posed to me, so I investigated the possible benefits and then sources of a Service Dog. I struggled with the realization of the responsibility for another being, as I was struggling to care for myself. My on-line search was exhaustive and therefore very time consuming but came to an abrupt halt when I came upon the

site for National Service Dogs. I lived in London at that time and traveling an hour or so to Cambridge every so often was not a consideration. Everything seemed to fall into place as I explored their site; everything has fell into place from the time I contacted NSD to the present.

I could likely fill a few pages explaining all the important details of occurrences and experiences since the first day of contact with NSD, but due to obvious restraints I will try to give a précis of what could be rather elaborate.

I will start off by saying that this almost-human creature constantly amazes me with her intelligence. She learns and adapts immediately to each-and-every

demand or new situation. As may become apparent, she is much more than a Service Dog, she is a true friend and companion. She is a hybrid of Golden Retriever and Yellow Lab, making her a Golden Lab. Her name is Sookie.

At the times that I slip deeper into depression, she senses it and comes to me, placing her head on my lap. She will not leave until she knows that my spirit has been lifted by her mere presence. She will wake me when I am experiencing "a bad dream".

She stands between myself and anyone nearing me and keeps them at bay, such as in a grocery check-out line. She will lead when we are in a crowded place and by doing so, she divides the crowd, diverting them farther away from me. She has several other talents that she has been trained to perform; however, too many to describe here.

By her presence in public, she 'grounds' me in that while we are in public places I must attend to her. My attention, to some degree must always be directed to her and therefore distracting me from those things that trigger the onset or the heightening of my PTSD symptoms.

Sookie knows when she is working or not, her entire demeanour changes as her roles change. Admittedly, I know my attitude changes as well and this may contribute to her changing behaviour, however, Sookie learned to do this, she was not taught. When she is not working, she is very affectionate and demands attention and this promotes physical contact, which, as we know has a healing effect of its own.

This encourages me to allow emotion to seep to the surface and it builds a trust; with my knowing that what I share will be returned many fold, without conditions or expectations. I know that it will never be withdrawn or used as a tool or a weapon against me. This, I guess, is what creates a bond, or perhaps, this is what becomes the bond.

Since starting therapy in March 2009, with the exception of a few weeks, I have been seeing two separate, 'specialists' every single week, and progress has been made and will continue to be made, however, this progress is the result of my hard and often painful work. My relationship with Sookie has also created progress, but it has nothing to do with my efforts and her actions require no effort at all.



This kind of progress can not be garnered from another person, regardless of their profession or expertise. It is very distinct from what I gain from the professionals. It is something that is acquired on a very special and personal level. I can not describe it any more than I have other than to say that I feel that is a very important component for the healing process, perhaps essential for this kind of disorder.

I am forever grateful to Mr. Jerry Van Dyke, (Journeys by Jerry Van Dyke Travel Service), whose generosity makes it possible for individuals such as myself to have the wonderful and necessary experience of having a Service

Dog. There are far too few people who give more than they are asked, time and time again. I know of Mr. Van Dyke's motifs, and they are far more than honourable. I thank you, Sir.

National Service Dogs is nothing without its staff and volunteers. These are very special people who do a very special job. I have never felt so comfortable around a group of people as I have when I have visited there. Everyone seems to be so natural, sincere and dedicated, not just to the dogs, but to their clients as well. I have benefited from their service in so many ways and to such great degrees; I owe a debt that I could never repay. The dog that I received, the training that she received and the training that I received were exceptional and outstanding, (that's a 10 out of 10 by the way).

I thank everyone involved with NATIONAL SERVICE DOGS and I am more grateful than I could ever express.

My personal experience leads me to believe that a Service Dog who is not Public Access Qualified, (PAQ), is of little use to a PTSD inflicted Veteran, it will serve to be a companion dog at best. The value of a PAQ Service Dog will never be calculable.

It is my sincerest wish that Veterans Affairs Canada will soon conclude that the benefits of a Service Dog for a PTSD inflicted Veteran may provide many important and necessary benefits that conventional treatments can not. Veterans with PTSD should also know that a Service Dog can and will be provided at no cost without the authorization of Veterans Affairs Canada. However, regardless of how a Service Dog is acquired, it must be noted that all expenses for the care and wellbeing of the dog will be borne by the Veteran. The Canada Revenue Agency provides tax exemptions for qualified expenses for those owning a Service Dog.

If not for my PAQ Service Dog Sookie, I may not be here.



A Circle of Hope....

Where Nature Nurtures People...and Horses Help Heal Trauma

Submitted By: Diane Kelly

Winston Churchill once said “There is something about the outside of a Horse that is good for the inside of a man”. How true this statement has proven over the centuries.

Nestled on serene country property, located just minutes north of London, Ontario lies a sanctuary of.... Peace. It is here one can enjoy forests, fields, ponds and gardens. It is here that Nature speaks through the call of ducks, chickens, goats, pot bellied pigs, dog and cats. In the natural calming and peaceful setting, people can relax and more importantly, feel safe, to open to discovery and actualizing their full potential. Research has shown that Nature can induce a sense of well being and calm despite challenges. At A Circle of Hope lives are changed through the integrative health and healing modalities offered in a range of unique settings. However, what seems to touch the hearts of humans most is the gentle nicker of horses that now call this sanctuary, home. All of these horses have known the effects of trauma and have been rescued by A Circle of Hope, their forever home.

This not-for-profit healing center, was founded in 2009 by Diane Kelly, a Registered Nurse who specialized in the field of mental health. The programs here take a holistic approach to challenges like post-traumatic-stress, traumatic brain injury, anger, depression, addictions, grief, identity problems, poor self esteem, anxiety disorders, sleep disorders, relationship difficulties, and spiritual challenges to name only a few. It is here that successful treatment has been provided for at-risk youth, individuals, families and groups. No challenge is too great for the healing ability of Nature.

In 2016, an exciting new program for veterans and their families is now being included that emphasizes healing relationships and recognizes each Veteran as a whole person. “Horse Therapy”, Equine Assisted Psychotherapy, is gradually becoming more accepted as a means of treatment for PTSD, and Operational Stress Injury, as it improves the emotional, psychological, spiritual and social well-being of its post-deployed service members who suffer from post combat related stress. The unique approach to helping heal the ravages of war can be now found internationally over the last 15 years. Showcased on Dr. Phil, Dr. Oz, Oprah, and various talk shows throughout the nation, equine assisted treatment illustrates the healing power of horses in a peaceful setting. This form of animal-assisted therapy continues to gain support among mental health professionals as an effective therapeutic approach, addressing a number of mental health concerns.

Diane became a professional member of E.A.G.A.L.A in 2006 (Equine Assisted Growth and Learning Association) and she has chosen to utilize the E.A.G.A.L.A Model for some of the services offered at A Circle of Hope. E.A.G.A.L.A was founded in 1999 as a non-profit 501(c)3 organization developed to address the need for resources, education and professionalism in the fields of Equine Assisted Psychotherapy and Equine Assisted Learning. E.A.G.A.L.A has now grown to over 4,000 members in 49 countries, with regional coordinators helping support members and networking groups in EAGALA Europe/Middle East, EAGALA Africa, EAGALA LatinoAmerica, EAGALA Pacific, and EAGALA U.S./Canada. This research based Model incorporates mental health professionals and equine specialists for customized programs for each client and group, face to face with horses in an interactive experiential approach under the direction of the treatment team. The horses serve as powerful living metaphors and stand-ins for the people, issues, and challenges in clients lives, or in the lives of the couple, family or military unit.

Why Horses?

The horses, being prey animals, have a special capacity to read and respond to the energy of people, to read and respond to peoples' non-verbal signals and cues. Their very existence and survival depends on their ability to "read" their environment. They are non-judgmental and offer an unfiltered, non-threatening reflection of the client's inner emotional state and behavioral patterns. They offer this without stigma or shame. The horses act as powerful metaphors for situations and people. This is specifically why the hands-on, experiential, fully engaging work through equine assisted activities and the EAGALA Model leads to powerful breakthroughs and life-changing insights. EAGALA is the only association of equine-assisted psychotherapists and trainers that requires a licensed, credentialed mental health practitioners and certified equine specialists to collaboratively lead the treatment at all times. It is also the only association of its kind with its own special Military Services Designation, which adds additional military-grounded experience and training requirements, beyond the standard EAGALA credentialing, for professional members for want to work with military clients. In addition, A Circle of Hope is dedicated to research to show if these unique approaches reduce the effects of trauma and help to assist people on finding the path to peace and long term healing. Pre and Post data collection can allow for measuring the impact of particular treatments and interventions over time in order to learn if post-traumatic stress levels changed and how that change translates into behavior and a newly established sense of well-being.

A Circle of Hope's goal is to combine equine-assisted therapy with other traditional and non-traditional therapies as the basis for treatment programs and 7 day retreats that will be made available to service members and their families experiencing specific challenges. The ultimate goal for the programs is to rebuild interpersonal skills, to reconnect with loved ones, to develop peace of mind, and to establish hope for tomorrow. Along with the successful equine-assisted therapy programs, A Circle of Hope will continue to provide other treatment approaches involving creative arts, body works, physical and recreational activities, cognitive retraining, desensitizing activities, and group processing in a range of unique settings. In addition, the professionals here partner with indigenous Elders for addressing spiritual concerns through an approach focused on Ceremony.

The healing experience for military personnel, veterans and their families in a sweat lodge, meadow, forest, pasture or stable is deliberately very different from anything they would experience in a traditional treatment setting. This is one major element that makes these programs so uniquely effective.

Operating as a not for profit, means community support is greatly needed. Please consider donating to help us help our returning Heroes. Visit www.acircleofhope.ca to donate any amount. All form of "giving" goes back to those who have already given so much of themselves to keep our country safe. To contact Diane directly please email d.kelly.acircleofhope@gmail.com.



Dan Macdonald
Legate And Associates

Ask A Lawyer

PSYCHOLOGICAL INJURIES – PROVING AN INVISIBLE HARM

When an injury is psychological in nature and can't be seen, how do we prove that injury and its impact in a lawsuit?

As personal injury lawyers almost all of our clients have been injured in a traumatic event. The injuries suffered can be physical or psychological in nature. A car crash, fall, or other traumatic event can leave lasting and permanent injuries. No one doubts this when there are broken bones or a person ends up in a wheel chair. But other injuries are not as easily recognized. Depression, anxiety, and PTSD are all examples of invisible psychological injuries. Not having outward physical signs of trauma, individuals suffering psychological injuries may be doubted, told they “don't look hurt”, and that they just need to get over it. But a psychological injury can impact an individual's capacity to function just as much as a physical injury.

To prove an unseen psychological injury and its impact we rely on a combination of expert witnesses, fact witnesses and demonstrative evidence.

Expert evidence is required as psychological injuries are beyond what a jury or judge can assess on their own. The expert provides opinion evidence that assists the jury or judge in making a conclusion on what psychological injury a person has, whether it was caused by the incident, the expected prognosis for the person, and what treatment they will require. Typically expert opinions on psychological injuries are given by psychiatrists or psychologists. In order to give an opinion, we will have the expert meet with and assess our client in well in advance of trial.

Fact witnesses include family doctors, treating psychologists or psychiatrists. These health practitioners give evidence about a person's health before the traumatic event, and how it has changed since. They can also give evidence about any treatment or therapy the person has participated in. This evidence assists in laying the ground work to show that the traumatic event caused the psychological injury and not some other event.

Family, friends, and co-workers are also fact witnesses. Their first hand account is a powerful tool to show the impact of a psychological injury. These witnesses are in a unique position and can talk about how someone who was full of vigor, was outgoing and hard working now avoids people and stressful events, and no longer participates in employment or other activities they once enjoyed. Some of the best evidence about the impact of an injury comes from family and friends.

Demonstrative evidence relied on often includes pictures and videos. It is true that these are worth a thousand words. Pictures and videos from before the traumatic event, showing fun, adventure, and smiles can be contrasted to the absence of this after the event.

All of these sources of evidence are used to show that a traumatic event caused a psychological injury, and that injury has caused impairment in function. Through these sources of evidence we are able to expose an invisible psychological injury.

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Community Resources for London and Region

The Canadian Armed Forces has resources available to its members and families. The following resources are to help members and families who are having trouble dealing with the effects of an operational stress injury.

Canadian Armed Forces Member Assistance Program	1 – 800 – 268 – 7708 (24 Hrs)
Medical Inspection Room 32 Canadian Forces Health Services Centre Detachment London (reception)	519-660-5275 x5199
Integrated Personnel Support Centre	519-660-5275 x5091
Family Liaison Officer (Integrated Personnel Support Unit – Military Family Resource Centre)	519 660-5275 x5169
Military Family Resource Centre (Military Family Resource Centre)	519-660-5366
Operational Stress Injury Social Support Peer Support Coordinator	519-685-4292 x42277
Mental Health Helpline	1-866-531-2600
Drug & Alcohol Helpline	1-800-565-8603
Problem Gambling Helpline	1-888-230-3505



Operational Stress Injuries: What are they and how are they treated?

Submitted By: Amanda R. Levine, Ph.D., C.Psych (Supervised Practice)
Parkwood Operational Stress Injury Clinic, St. Joseph's Health Care London

Serving in the military can be a rewarding and noble experience, but it is not without its possible consequences to physical and mental health. This article focuses on the mental health problems that are most prevalent among members of the Armed Forces, treatments for these disorders, and some physical health factors that can impact on mental health.

Operational Stress Injuries

Operational Stress Injury (OSI) is a term used by the Canadian Armed Forces and the Royal Canadian Mounted Police to describe any psychological problem that develops as a result of service. It is a broad term, encompassing an array of mental health issues. These injuries often arise in response to exposure to traumatic events and/or to chronic stressors associated with military/law enforcement life. These injuries can be debilitating, causing distress and a decline in social and occupational functioning.

OSIs are prevalent among individuals who have served in the military. A study published in the Canadian Journal of Psychiatry which examined OSI prevalence in a random sample of 16,193 members of the Canadian Forces who were deployed to Afghanistan, found that 10.2% had one or more mental health problems after their return.

Depressive Disorders were the most common diagnosis in Zamorski and Garber's study, occurring in 6.5% of the sample. The hallmark of Major Depressive Disorder (MDD) is depressed mood and lack of interest in or pleasure derived from previously enjoyed activities, as well as a number of other symptoms such as fatigue, appetite change, impaired concentration, and feelings of worthlessness. The second most common diagnosis reported was Post-traumatic Stress Disorder (PTSD) which was diagnosed in 2.8% of the sample. A diagnosis of PTSD requires exposure to actual or threatened death, serious injury, or sexual violence, as well as a number of re-experiencing symptoms (e.g., nightmares), avoidance of reminders of trauma (e.g., avoiding crowded places), negative changes in mood or ways of viewing oneself or the world (e.g., viewing oneself as incompetent or the world as dangerous), and changes in arousal (e.g., being easily startled). Furthermore, OSIs often overlap, with 38.6% of those experiencing a depressive episode also meeting criteria for PTSD.

Treatment of OSIs

Fortunately, OSIs are highly treatable through psychological and/or psychiatric means, and there exists a network of clinics (OSI Clinic Network) across Canada specifically created to support Canadian Armed Forces personnel and veterans and RCMP personnel and veterans through their

recovery. The OSI Clinic that covers the geographical area of the readership of this magazine is located at St. Joseph's Health Care London's Parkwood Institute. This clinic, staffed by a multidisciplinary team, targets OSIs through a combination of individual therapy, group therapy, and psychiatric medication. Treatment is tailored to each client, depending on the diagnosis and symptoms that each client reports, their treatment history, and personal preferences.

For the treatment of PTSD, the most common OSI experienced by clients at the Parkwood OSIC, there are a number of psychological treatments that have been found to be effective. One such modality of treatment is Prolonged Exposure (PE), which is a manualized treatment that encourages exposure to trauma memories and approaching situations that are avoided due to their association with the trauma (e.g., avoiding crowded places if the event took place in a market). By diminishing avoidance of memories and reminders of the event, corrective information about the true dangerousness of situations reminiscent of the traumatic event can be attained, and fear surrounding the memory diminishes. Memories and feared situations then lose their power over the individual and they can return to a life that isn't dominated by the traumatic event. Eye Movement Desensitization and Reprocessing (EMDR) is another approach that belongs to the family of exposure therapies. It combines the use of eye movements with talking about the traumatic experiences to help process the trauma, until the memory no longer produces high levels of emotional distress. Cognitive Processing Therapy (CPT), a structured intervention which focuses on techniques to identify, challenge, and modify how a person's thoughts, beliefs, and emotions may have changed following the traumatic experience, has also been found to be effective for the treatment of PTSD. For OSIs other than PTSD (e.g., MDD and Anxiety Disorders), Cognitive Behavioural Therapy (CBT) is often used. This approach focuses on exploring and modifying the relationship between emotions, thoughts, and behaviours, in order to encourage adaptive functioning. These psychological treatments are often combined with psychiatric medications that are effective in the treatment of these disorders. The specific medication prescribed is determined by a psychiatrist after careful assessment of psychiatric symptoms, other prescribed medications, and previous response to prescribed psychiatric medication, amongst other considerations.

Physical Factors that Complicate OSIs

Comorbid physical conditions can complicate the assessment and treatment of OSIs. These factors may have been acquired as a result of military service, or may represent preexisting conditions. Chronic pain is one such factor that may be the aftereffect of a physical injury (often musculo-

skeletal) obtained while serving. Chronic pain is not always completely managed with medication, and living with constant or intermittent pain can negatively impact on mood and psychological well-being. Although chronic pain can be physical in nature, it can be approached from a CBT perspective, wherein behavioural activation is encouraged and beliefs about pain are identified and modified. Thus, treatment of chronic pain from a psychological perspective can easily be incorporated into interventions targeting OSIs, such as MDD. As well, when PTSD and chronic pain emanate from the same traumatic event, they can reinforce each other. This is important to consider in treatment, but can be addressed using evidence-based treatment.

Mild Traumatic Brain Injury (mTBI) frequently co-occurs with PTSD because an event that results in a brain injury (e.g., the detonation of an improvised explosive device) is often traumatic in nature. Symptoms of mTBI include headaches, irritability, sleep problems, and memory complaints. These symptoms are often short-term (resolving in three months or less), but in some cases they may be more enduring and can mimic the symptoms of Major Depressive Disorder or PTSD, making it difficult to disentangle the clinical presentation. Furthermore, some studies have found that the presence of mTBI increases the likelihood of the development of PTSD even when factors related to the severity of the traumatic event are controlled for (Vasterling, Bryant, & Keane, 2012). Although further research is warranted, there is some indication that treatment for those at risk of developing PTSD can still be effective in the presence of mTBI (Bryant et al., 2003), but modifications may be needed. Techniques for brain injury rehabilitation, such as cognitive rehabilitation, may be incorporated into treatment or may be conducted simultaneously.

Psychological conditions stemming from military service are not rare, but they are treatable if proper care in the form of evidence-based psychological and/or psychiatric treatment is sought. Many individuals are able to return to a higher level of functioning and can go on to attain personal and professional goals that may have seemed impossible when symptoms were at their most severe.

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Cognitive Processing Therapy for Post-Traumatic Stress Disorder

Submitted by: Kevin Acs

Cognitive Processing Therapy (CPT) is a Cognitive Therapy for Post-Traumatic Stress Disorder (PTSD). All humans organize incoming information into schemas through these beliefs individuals make sense of their world interpret new information to formulate expectation about future expectations. Individuals with PTSD have disruptions in areas of safety, power, esteem, and intimacy focusing on faulty cognitions related to the traumatic event. These are manifested by inaccurate statements that interrupt normal recovery process or stuck points which keeps the individual stuck in PTSD prohibiting recovery to normal functioning. The goal of CPT is to help the individual identify stuck points and promoting balanced thinking takes into account the reality of the traumatic event without overreacting. CPT is designed to improve symptoms and associated symptoms such as anxiety, depression, guilt, and shame which will improve the day to day living of the individual.

CPT consists of twelve one on one sessions lasting 50 – 60 minutes which a number of topics will be covered such as education on symptoms, thoughts, feelings, stick points, problematic thinking to name a few. The individual is also required to do a number of take home assignments, this includes a hand written account of the traumatic event to be done in great detail. This detailed description is to include thoughts, feelings, sights, sounds and smells surrounding the event. The individual is encouraged to write the account in one attempt if not the individual draws a line where they have stopped. This would then be investigated by the therapist and individual as a possible trigger. The individual is also required to read over the written account daily between sessions. Over the course of the treatment period the individual is required to re-write the account so that new memories of the account can be addressed.

CPT changes the way a patient emotionally processes the traumatic event and their responses such as avoidance, isolation, trust, self-esteem and abusing substances such as drugs, food, compulsive spending, gambling and over dependence of a person. This is accomplished by continual evaluation, to see how the person's perceptions of the incident have changed.

At the completion of the twelfth session the individual is encouraged to continue using the skills that they have learnt. The individual now takes over as their own therapist. The individual will be required to attend a follow-up session within one month of the last session. Some of the individuals may then go onto peer support with the Operational Stress Injury Support Services as a support.

Reference

Resick P.A., Monson C.M. Cognitive Processing Therapy Veteran/Military Version, VA Boston Health Care System and Boston University October 2006

Coping Strategies to help with Triggers

- 30 seconds of relax
- Tactical breathing exercises
- Positive imagery
- Progressive relaxation
- Pleasant events
- Reduce isolation
- Grounding
- Go for a walk
- Exercise
- Call a friend

Free Apps Available



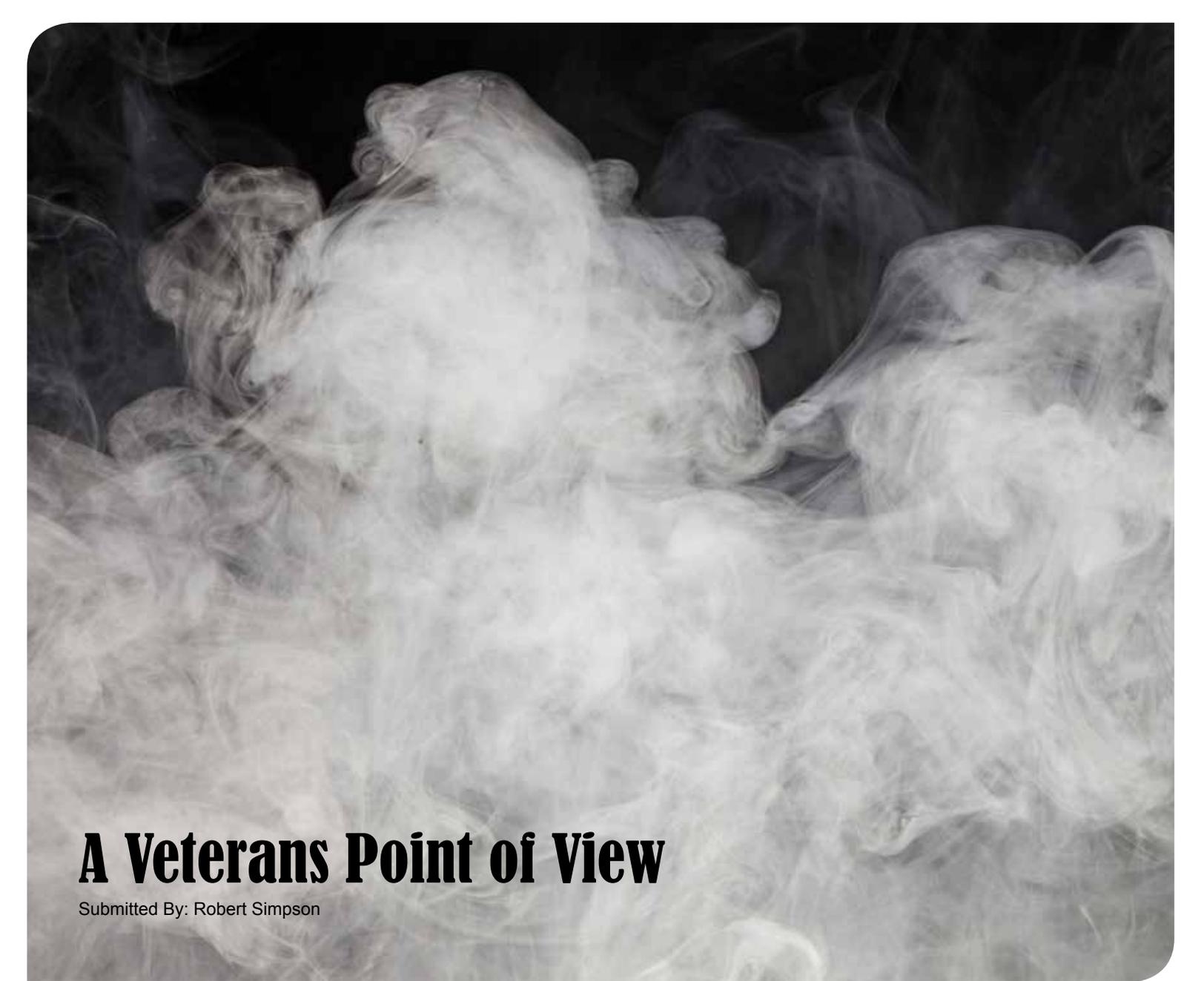
OSI Connect

OSI Connect is a mobile learning and self-management app developed to assist the Canadian Armed Forces, veterans and RCMP community with operational stress injuries (OSI). OSI Connect is portable and provides information and assistance at the touch of a button.



PTSD Coach Canada

Together with professional treatment, PTSD Coach Canada provides you dependable resources you can trust. If you have, or think you might have PTSD, this app is for you. Family and friends can also learn from this app. PTSD Coach Canada provides you with information and self-help tools based on research.



A Veterans Point of View

Submitted By: Robert Simpson

This is a day in my life with my struggles of PTSD. The demons got through tonight and they attacked without mercy. Over and over they came out of the darkness to attack in my dreams. It never seems to end, they rob you of that most precious need called “sleep”. There is no way to stop them other than to get up. But what then? Your mind races searching for an answer to it all. How do I stop the demons from attacking? How do I fight them off? Your mind rehashes the dreams, the nightmares, the hell of it all. You are looking for the answers, but you cannot find the answers so badly needed. You know you can endure for a while, but then you will need that precious “sleep”. That’s when the demons become over powering, driving many to despair and madness. Driving the tormented deeper and deeper into the darkness of PTSD. The strong can endure, but only so long. The weak ones are driven to end it all. Just wanting to be rid of the demons.

Post-Traumatic Stress Disorder (PTSD) is caused by the mind not being able to stamp a date on your events. This is a theory of Dr. David Halsam of the London OSI Clinic. A Soldier for example: when the flashbacks or nightmares happen they happen as if it just happened. It may have been 10, 20, 50 years ago. But it happens like it was today, right now. Having PTSD on a good day you feel like you are missing a limb. But on a bad day it’s like you are missing many limbs, I use this as an example so you can try to understand how crippling it can be. It is a cold and calculating beast waiting until you are not 100%. Then it unleashes the demons attacking you in your sleep and while you are awake. It tries to consume you, to sum it up, you are in a hell and at their mercy.

Most of us try to slap a smile on our face and try to act like everything is alright. But it is really, just that, an act. All the while the battle rages in our minds. Some show signs such as edginess, twitching. We try to self-medicate with Booze or Street Drugs. That will give you but a short spell of relief while you are passed out. But once you wake up, the demons will attack you, 10 fold. It becomes overwhelming to you. Some will withdraw from the public, I call it bunkering, holed up inside their home and rarely going out. Sadly too many try to or succeed at ending it all with suicide. Their deaths could have been prevented!

However there are ways to fight the demons, first is admitting you have a problem to yourself. Then comes the hard part, asking for help. Yes you don't want to appear to be weak in front of the others such as a serving Soldier, but you need to be honest with yourself because you are wounded! If shot you'd call for a Medic, this is no different. Worst is when you are no longer serving and you have too much happening in your life. Then where do you go for help and what can be done to bring relief? Well there is help via Veterans Affairs Canada who can give you access to Operational Stress Injury Clinics across Canada which are there to help Soldiers, Veterans and RCMP.

They check you over then, decide your best course of treatment. It can be in a group setting or in one on one treatment or a combination of both. There is also OSISS a peer support group. The most important tool you have is under your nose, its your mouth. You need to talk about things to get it out. In time you begin to speak more freely about the things you experienced as a Soldier. It is a long trip, the road to healing and learning to cope with your PTSD. But you will not be alone. Many have suffered for years with their PTSD. Now is the time to reach out for treatment of this wound. Then you prove you're not weak, but you are strong, because you asked for help. The strongest ask for help.

That's also when knowing someone else who suffers from PTSD is helpful. Together you both can be learning how to recognize your triggers and what helps you to cope. It is as important as any medications prescribed to you, which will help you. Coping is complex but the good news is the treatments are evolving every day to help you to cope with PTSD. Knowing your triggers is important, some are straight forward such as fireworks, but it can be a sound, a smell, a date or something you see. Then you can work to control the effects. During a flashback try to say the following, "NO this happened in October 1978 and this is 2015!" You would be surprised how often it will

help to shut down a flashback. The same can happen on waking from a nightmare, try stating when it happened and what date it is now. I have found it to help about 75% of the time. Then there's that 25% of the time when it does not seem to help. You need someone who will listen and talk to you when you're having trouble, in fact they can be a Life Line. Knowing that you're not alone with this wound helps so much.

Hyper alertness is also hard to control you have to fight to keep from striking out if someone brushes up against you. Many of us try to avoid crowds because it is so overwhelming to us. The last thing we want to do is hurt someone who is trying to help us.

I find trying to keep myself in control and when it's stressful because of triggers the best thing I can do is just to breathe. Before I react to someone or something I try to stop, breathe, and think before reacting. It doesn't always happen, but it's a work in progress which will continue for the rest of my life. I have come a long way in the last 10+ years. I am helping others learn to speak out and I will keep helping others on this long road home.

Do yourself a huge favor and say something to someone. Ask for help, see your Doctor, Pastor, go to the ER at your hospital, and go to Mental Health Canada. If you are thinking of harming yourself please call 911 and ask for help. You are not alone and there is help out there. Closer than you may think. Lest we forget.



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