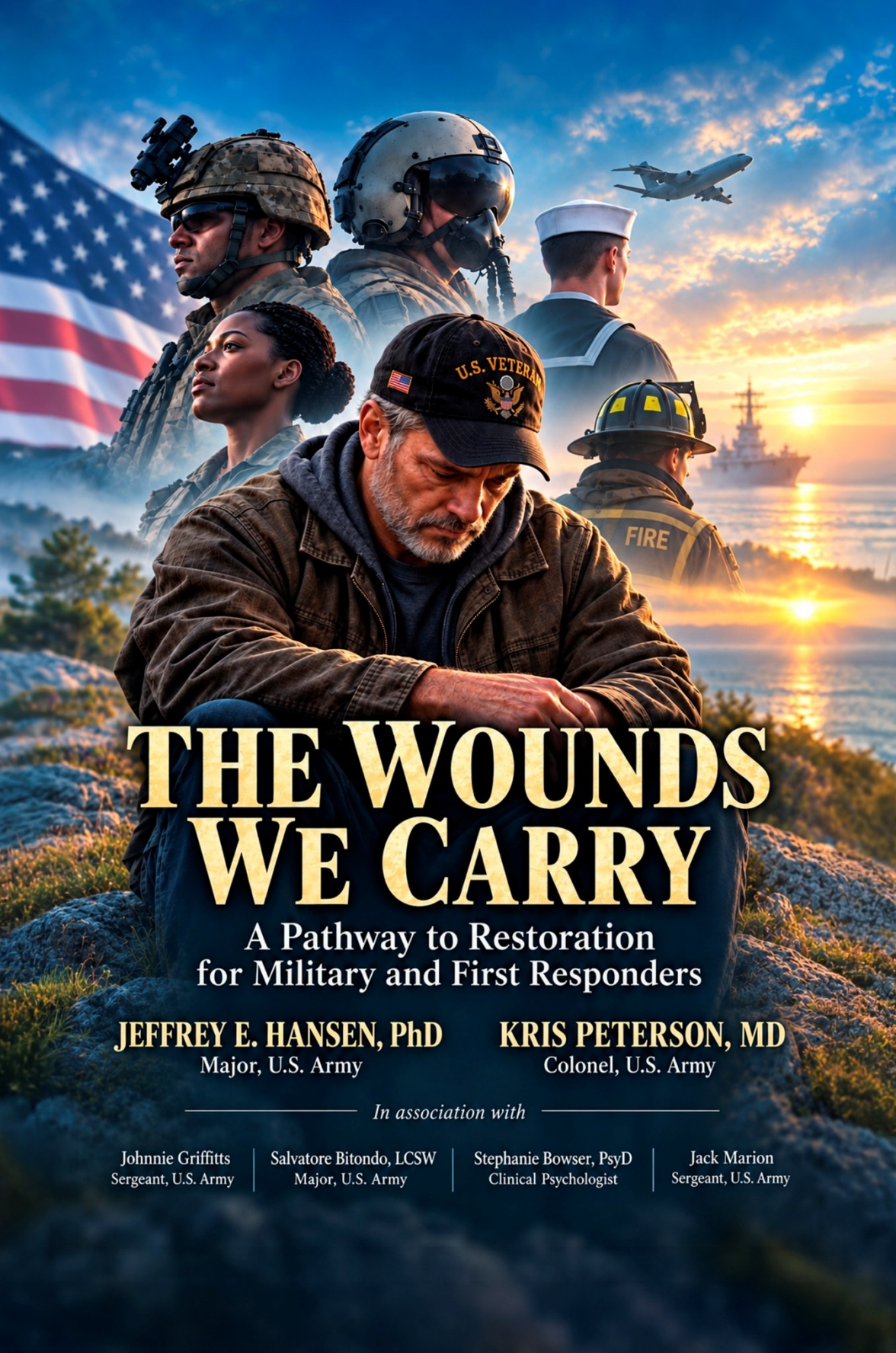

THE WOUNDS WE CARRY

A Pathway to Restoration for Military and First Responders

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Author's Note on AI Collaboration

This book reflects decades of clinical work, research, and the development of the NeuroFaith® model, integrating neuroscience, trauma-informed therapy, and Christian spirituality. In the writing process, I utilized AI tools, including ChatGPT, to assist with drafting, organization, and refinement of ideas. These tools served strictly as support for clarity and efficiency. All clinical insights, theoretical frameworks, and conclusions presented in this work are my own, and I (Jeffrey E. Hansen, Ph.D.) stand fully behind them.

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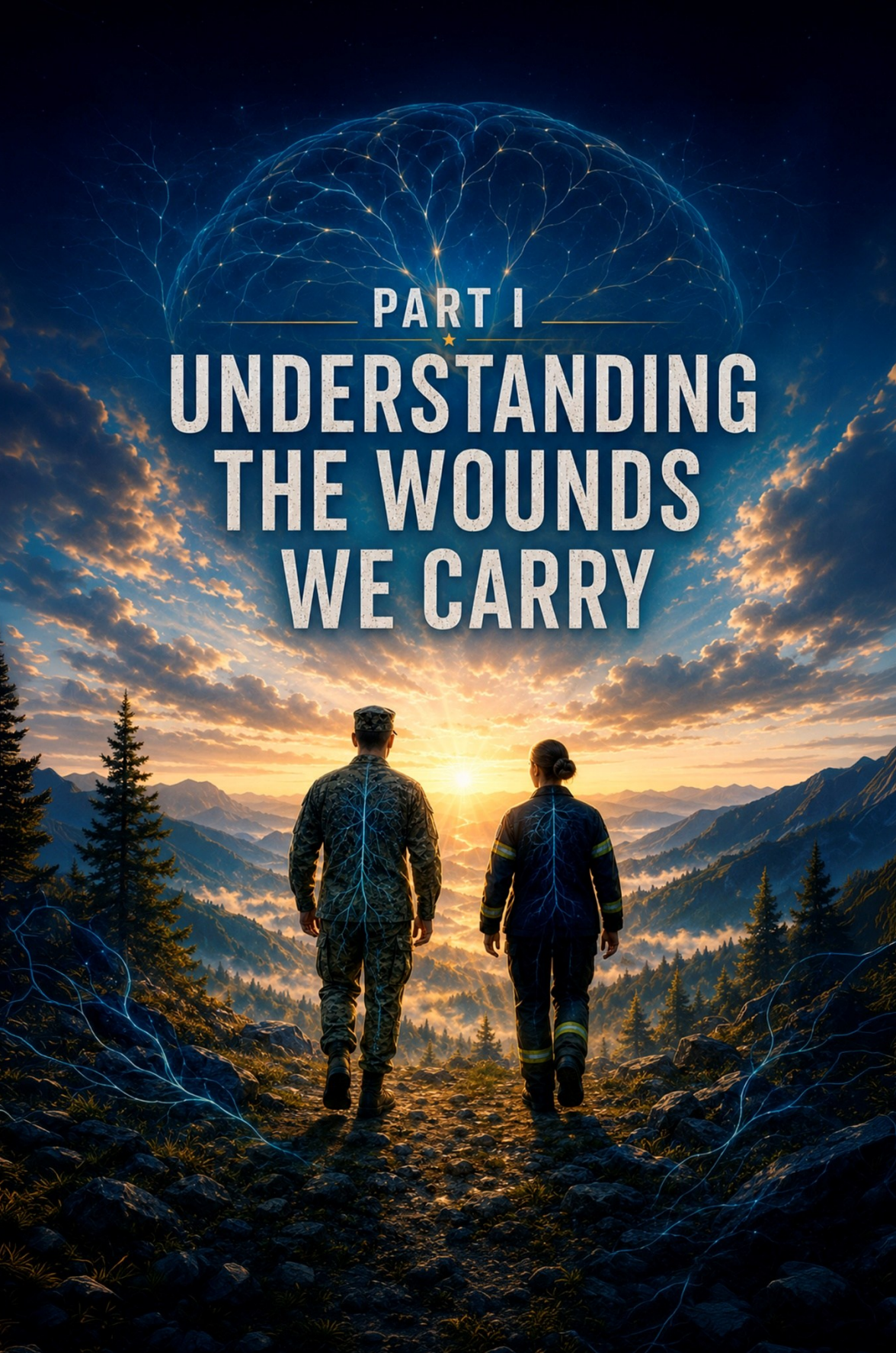
DEDICATION

To those who answered the call,
carried the wounds home,
and kept fighting long after the battle was over.

And to the families who carried those
wounds beside them,
often without recognition and never without cost.

May you discover that your wounds
do not define you,
that you have not been abandoned,
and that hope, grace, and restoration
are still possible.



PART I

UNDERSTANDING THE WOUNDS WE CARRY

CHAPTER ONE
WALKING INTO THE FIRE

Perhaps only those who have walked into the fire can fully understand what it means to walk into the fire.

For most of us, mortality remains comfortably abstract. We know we are going to die someday, but we do not expect death to come looking for us this afternoon. We drive to work, make dinner reservations, complain about traffic, argue about things that will seem utterly insignificant a year from now, and make plans for next weekend. Somewhere beneath all of it is an assumption so fundamental that we rarely notice it: I will probably still be here tomorrow.

Combat strips away that assumption.

A twenty-two-year-old soldier is thousands of miles from home, moving through a place where someone he has never met may be watching through a window, waiting for an opportunity to kill him. His body carries armor, ammunition, water, communications equipment, and a weapon he has learned to operate almost as naturally as his own hands. Sweat runs beneath the body armor. Dust works its way into

everything. He is exhausted, but exhaustion does not give him permission to stop paying attention.

His eyes keep moving: rooftop, window, doorway, vehicle, roadside, hands, faces. A pile of trash that was not there yesterday. A car moving too slowly. Another moving too quickly. A man standing where nobody was standing the last time the patrol came through. For hours, nothing happens, but nothing happening does not mean nothing is about to happen.

The soldiers beside him are doing the same thing. These are no longer simply people assigned to the same unit. They have eaten together, slept beside one another, sweated together, complained together, and laughed together in circumstances where laughter sometimes seemed impossible. They know who snores and who tells the worst jokes. They know whose wife is pregnant, whose daughter just learned to walk, and who plans to propose when he gets home. They know one another's dreams, and they live with the knowledge that one of them may not be alive by nightfall.

Then the world explodes.

The concussion comes first. Dust and debris fill the air. Gunfire follows. Rounds strike dirt, walls, and vehicles. Someone screams for a medic. The radio erupts with overlapping voices. The soldier's heart hammers beneath his armor. His mouth goes dry. Vision narrows. Fine motor control changes. Time becomes strange. Events unfolding over seconds will later be remembered as though they lasted minutes.

There is no time to contemplate fear or mortality. Training takes over because training has to take over. He moves toward cover, returns fire, searches for the threat, and looks for his people.

Then someone calls his name. His friend is on the ground.

The man who was giving him hell at breakfast is bleeding badly. The soldier drops beside him and applies a tourniquet. His hands are slick as he tries to control the bleeding. His friend is conscious and looking directly at him. "Am I going to be okay?" He tells him yes. Of course he tells him yes. He tells him the medic is coming. He tells him to stay awake. He tells him he is going home. He says whatever he can say to keep his friend connected to this world for another thirty seconds.

Sometimes the wounded soldier lives. Sometimes he dies. There is no cinematic ending and no perfectly composed final sentence. One moment a friend is speaking. The next moment he is not.

The evacuation helicopter arrives. The wounded are removed. The dead are carried away. Equipment is gathered. Ammunition is counted. Reports are made. The same road still has to be traveled, the same village still has to be entered, and another patrol will leave. The world does not stop because yours just did.

So the soldier does what warriors have done throughout history. He compartmentalizes because there is work to do. Dark humor creates a few moments of distance from something otherwise unbearable. Anger comes. Silence comes. Sometimes nothing comes at all, and the absence of feeling becomes frightening in its own way.

Then morning comes. The armor goes back on, and the soldier goes out again.

When Survival Becomes a Way of Life

Combat trauma is not simply one terrible event with a beginning and an end. For many who serve, the psychological burden accumulates through months of living inside the possibility of catastrophe. The

nervous system learns that safety is temporary, vigilance is mandatory, and complacency can kill.

Roadside debris is no longer simply trash. It can conceal the device that takes someone's legs. A vehicle approaching too quickly is not merely an impatient driver. A rooftop is not merely part of a building. A hand disappearing beneath clothing matters. A sound in the night matters. Everything matters because the soldier has learned how quickly the ordinary can become lethal.

In that environment, hypervigilance is not evidence of weakness or dysfunction. It is adaptation. So is the ability to suppress fear, compartmentalize grief, scan constantly for danger, and continue functioning after witnessing things that would overwhelm most people. These responses allow a human being to survive extraordinary circumstances.

The difficulty begins when the circumstances change but the survival system does not.

The soldier returns home. The rifle is secured. The armor comes off. The deployment ends. Everyone who loves the soldier is relieved because the danger is over, and the veteran desperately wants to believe the same thing.

Then a pan crashes onto the kitchen floor and the body reacts before the mind understands what happened. Roadside debris catches the eye while everyone else drives past without noticing it. A restaurant is automatically evaluated for exits and lines of sight. Sitting with one's back toward the entrance feels wrong. Someone approaches unexpectedly from behind and the body turns before conscious thought catches up. Fireworks explode overhead, and what everyone else

experiences as celebration lands very differently in a nervous system trained by war.

The veteran knows he is home. He knows nobody in the restaurant is trying to kill him. He knows the object beside the highway is almost certainly garbage. He knows the fireworks are fireworks.

The veteran knows the war is over. The body may still be fighting it.

Different Uniform, Same Movement Toward Danger

Combat is unique, and we should never pretend otherwise. But the battlefield is not the only place where men and women repeatedly move toward circumstances the human nervous system instinctively tells us to escape.

A firefighter arrives at a house engulfed in flames. Heat pours from the structure. Smoke has erased visibility. A mother is outside screaming that her child is still upstairs. Every primitive survival system in the human body sends the same message: get away from the fire.

The firefighter goes in.

Inside, the world becomes heat, darkness, noise, equipment, limited air, and touch. Somewhere in that building is a child whose life depends upon what happens in the next few minutes. Sometimes the firefighter comes out carrying a living child. Sometimes the firefighter carries out a child who has died. The equipment is cleaned, the report is written, and another alarm sounds.

A police officer pulls behind a vehicle for what appears to be a routine traffic stop. He approaches the driver's window watching the hands, the passengers, and movement inside the vehicle. A hand disappears. A weapon appears. In a fraction of a second, an ordinary traffic stop

becomes a fight to stay alive. The officer survives, but years later he still watches hands.

A paramedic is dispatched to a home for an unresponsive person. The front door opens onto a family in chaos. Someone has taken his own life. On another shift, the call is a collision involving teenagers returning home from a football game. The paramedic arrives carrying equipment intended to preserve life and discovers there is no life left to preserve. There are still parents who have to be told.

There are scenes that do not leave simply because the ambulance does.

Military personnel, first responders, and veterans do not share identical experiences, and we dishonor them if we pretend they do. Combat is combat. Firefighting is firefighting. Law enforcement is law enforcement. Emergency medicine is emergency medicine. Yet they share something profound: again and again, these men and women are asked to move toward what the rest of us instinctively move away from. They encounter mortality as an occupational reality. They see human beings at their most frightened, injured, violent, helpless, and broken. They save lives, and they also encounter moments when everything they know, everything they have been trained to do, and everything they desperately attempt is not enough.

Then they go home, eat dinner, help with homework, kiss their spouse, try to sleep, and return to duty.

The remarkable question is not why some develop psychological wounds. The remarkable question is how anyone could repeatedly absorb these experiences and remain completely unchanged.

The Wounds No One Can See

We understand the wounds we can see. A soldier returns without a leg, and nobody questions whether something terrible happened. Burns tell their own story. Surgical scars require little explanation. A wheelchair immediately communicates that life has changed.

Invisible wounds receive a different reception.

The nightmare cannot be seen. Neither can survivor guilt, the memory that intrudes without invitation, the grief that has never found a place to go, or the nervous system that remains prepared for a danger that ended years ago. The person may look entirely intact while carrying experiences that continue to shape sleep, relationships, anger, intimacy, substance use, and the ability to feel safe.

Because we cannot see these wounds, we sometimes judge them. We wonder why someone is so angry, why sleep has become impossible, why alcohol has become necessary to quiet the night, why crowds are intolerable, or why the person who returned from deployment seems so different from the person who left. Eventually the wounded person may begin asking the same questions.

Why can I not just let this go?

That is the wrong question. The better question is: What did you have to become to survive what happened to you?

And the question that will guide this book follows naturally: What will it take to help you come home?

What Is Trauma?

The word trauma has entered our everyday vocabulary so thoroughly that it sometimes risks losing its meaning. Not every painful experience

is traumatic, and not every person exposed to an extraordinary event develops lasting psychological injury. Human beings are remarkably resilient.

At the same time, trauma is more than the external event itself. An event happens in the world; trauma describes what can happen within the person when an experience overwhelms the capacity to process, integrate, or adapt to it. Physician and author Gabor Maté has emphasized this distinction by directing attention not simply toward what happened to a person, but toward the wound that remains within the person afterward.

That distinction matters because two people can experience similar events and emerge differently. Biology matters. Developmental history matters. Previous trauma matters. Training, relationships, meaning, faith, community, and what happens after the event all matter. Repeated exposure matters. So does having to return to the same dangerous environment before the mind and body have had any meaningful opportunity to process what has already occurred.

Trauma therefore cannot be understood simply by cataloguing terrible events. We have to understand what those events do inside the person. For military personnel, veterans, and first responders, that means recognizing that many behaviors that later create suffering began as intelligent adaptations to environments in which survival demanded them. The clinical challenge begins when those adaptations remain active long after the environment has changed.

When Adaptation Becomes a Disorder

Modern psychiatry gives names to patterns of psychological suffering: Posttraumatic Stress Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Panic Disorder, Substance Use Disorder, and others.

These diagnostic categories have legitimate purposes. They create a common professional language, facilitate research, help clinicians communicate, and allow healthcare systems to authorize and reimburse treatment.

We need them. But we should remain humble about what they tell us.

A diagnosis describes a pattern. It does not tell us the whole story of the person carrying it. When we move too quickly from human experience to diagnostic category, we risk transforming understandable responses to extraordinary circumstances into evidence that something is fundamentally wrong with the person.

There is a profound difference between saying, "You are disordered," and saying, "Your mind and body adapted to circumstances no human being should have had to endure, and some of those adaptations are now causing tremendous suffering."

Both statements may lead to treatment. Only one begins with compassion.

Throughout this book we will use conventional diagnostic terminology because it remains important clinically and scientifically. But we will never confuse the diagnosis with the human being.

The diagnosis is a map. It is not the territory. And it is certainly not the person.

This Book Is for You

If you have worn the uniform and some part of you never completely came home, this book is for you. If you carry memories you cannot explain to the people you love, if your body still reacts to dangers your mind knows are no longer present, or if the skills that once helped you

survive now interfere with the life you fought so hard to return to, this book is for you.

If you are a firefighter, police officer, paramedic, or other first responder who has spent years moving toward danger and absorbing the worst moments of other people's lives, this book is for you as well.

It is also for the people who love you. Spouses, partners, children, parents, friends, pastors, chaplains, and colleagues often know something has changed without fully understanding what happened. One purpose of this book is to help them see more clearly, not so that destructive behavior is excused, but so that suffering can be understood in its proper context.

And this book is for those of us privileged to sit in the therapist's chair. We can know diagnostic criteria, understand trauma science, and spend decades studying human behavior without ever knowing what it was like to live the experiences described in these pages. Knowing the diagnostic criteria for Posttraumatic Stress Disorder does not mean we know what it was like to be in that firefight or to live for months wondering when the next attack would come.

Clinical expertise should deepen our humility, not diminish it.

This book begins with a simple conviction: before we ask what is wrong with someone, we should understand what happened to them and what they had to become in order to survive it.

Our task in the chapters ahead is larger than identifying symptoms. We will examine what prolonged exposure to danger, death, helplessness, loss, moral conflict, and human suffering can do to the brain, nervous system, body, relationships, identity, and human spirit. We will look closely at Posttraumatic Stress Disorder, depression, anxiety, and

addiction, but always within the larger story of the person who carries them.

Then we will turn toward healing.

We will examine treatments that help manage symptoms and approaches that may offer the possibility of deeper transformation. Both matter. A coping skill that gets someone through tonight matters. A medication that reduces overwhelming symptoms can matter. A therapy that helps someone sleep, function, reconnect with family, or remain alive matters enormously. But we will also ask whether healing can reach deeper. Can the nervous system learn safety again? Can traumatic memories become integrated rather than continually relived? Can shame give way to understanding? Can damaged relationships be rebuilt? Can a person rediscover meaning, purpose, faith, connection, and an identity larger than what happened to them?

We will explore established treatments and emerging ones, including trauma-focused psychotherapies, Internal Family Systems, polyvagal-informed treatment, HeartMath® and neurocardiology, spiritually integrated care, and the four pillars of the NeuroFaith® model. We will examine psychiatric medication with respect for its legitimate and sometimes lifesaving role while insisting upon informed consent and shared decision-making. We will also explore developing treatments including transcranial magnetic stimulation, ketamine-based approaches, neuromodulation, and psychedelic-assisted therapies, carefully distinguishing scientific evidence from enthusiasm and hype.

We will talk about finding the right therapist, not simply finding a therapist, because the relationship between healer and wounded person matters. We will also look honestly at the Department of Veterans Affairs, recognizing the extraordinary work accomplished within that

system while asking where large systems can become too dependent upon protocols and insufficiently attentive to the individual veteran sitting in front of them.

Most importantly, we are going to talk about restoration.

Healing does not mean forgetting what happened. It does not mean pretending that war was not war, that the friend did not die, that the fire never happened, or that the terrible call was never answered. It does not require returning to the exact person you were before these experiences, because that person may no longer exist.

Healing means that what happened no longer has to own the rest of your life. The memories may remain, but they do not have to remain in command. The losses remain part of your story, but they do not have to become the entire story. There can be connection beyond isolation, meaning beyond trauma, purpose beyond the mission, and a life beyond survival.

You carried the mission. You carried your people. You carried the wounded. You carried the dead.

You have carried some of it long enough.

This book is about learning how to carry it differently, and ultimately, how to come home.

Before we examine post-traumatic stress disorder, major depression, anxiety, substance use disorders, and the other diagnoses frequently assigned to military personnel, veterans, and first responders, you need to understand where these labels came from, what they can legitimately tell you, and what they cannot.

The suffering described by these diagnoses is real. If you cannot sleep because your mind remains on patrol, you are not imagining your distress. If you repeatedly see the face of a child you could not save, you are not merely having a bad week. If you have become emotionally numb, angry, withdrawn, or profoundly depressed, you are not weak. You may be experiencing serious psychological, relational, physical, and spiritual consequences of trauma.

But the reality of your suffering does not automatically establish the scientific precision of every diagnostic label used to describe it.

A diagnosis is not who you are. It is not your identity, your character, your destiny, or your complete story. At its best, a diagnosis is a working description: a structured attempt to organize a collection of

symptoms, communicate with other professionals, guide treatment planning, support research, and establish eligibility for insurance reimbursement, disability benefits, or other services. At its worst, it can reduce you to a billing code, become a justification for reflexive medication, or gradually consume your identity.

The distinction matters. There is an enormous difference between being told, "You are experiencing symptoms consistent with post-traumatic stress disorder," and being told, "You are PTSD." The first statement describes a pattern of suffering. The second allows that pattern to define you.

What Is the DSM?

The *Diagnostic and Statistical Manual of Mental Disorders*, commonly called the DSM, is published by the American Psychiatric Association. It provides standardized names, definitions, and diagnostic criteria for mental disorders. Clinicians use it to communicate with one another, researchers use it to define study populations, insurance companies use it to determine medical necessity and reimbursement, government agencies use it in disability determinations, and pharmaceutical companies rely upon its diagnostic categories when studying and marketing medications (American Psychiatric Association, 2022; Hansen, 2022).

The current version is the DSM-5-TR, the text revision published in 2022. The DSM is related to the World Health Organization's *International Classification of Diseases*, or ICD, although the ICD covers the full range of medical conditions and is used more broadly throughout the world (American Psychiatric Association, 2022; Hansen, 2022).

The DSM did not begin as a discovery of natural diseases in the same way that physicians discovered tuberculosis, diabetes, or cancer. Its distant ancestors were administrative systems created to count and classify people. The 1840 United States census included a category for "insane and idiotic." By 1880, the census recognized several classifications, including mania, melancholia, dementia, and epilepsy. In 1917, an early statistical manual was developed to standardize information collected from mental hospitals (American Psychiatric Association, n.d.; Hansen, 2022).

World War II changed the landscape. Military psychiatrists encountered thousands of service members whose difficulties could not be adequately captured by classifications designed primarily for institutionalized patients. The United States Army and Veterans Administration developed broader systems that included acute reactions to combat and other forms of psychological disturbance. These systems influenced the World Health Organization's ICD-6 and, ultimately, the first DSM, published in 1952 (American Psychiatric Association, n.d.; Kawa & Giordano, 2012).

DSM-I was influenced by psychodynamic and psychobiological thinking. It frequently used the term *reaction*, reflecting the view that psychological symptoms could represent your reaction to biological, psychological, and social circumstances. DSM-II, published in 1968, retained much of this general orientation, although it removed the term *reaction* from many diagnoses (American Psychiatric Association, n.d.; Kawa & Giordano, 2012).

Then came the revolution.

DSM-III and the Transformation of Distress into Disorder

By the 1970s, American psychiatry faced a credibility problem. Clinicians often disagreed about diagnoses, American and European psychiatrists sometimes assigned different diagnoses to similar patients, and studies raised troubling questions about the reliability of psychiatric classification. If two competent clinicians could interview you and arrive at very different conclusions, the profession lacked a dependable common language (Kawa & Giordano, 2012; Kutchins & Kirk, 1997).

The DSM-III task force, led by psychiatrist Robert Spitzer, attempted to solve this problem. Published in 1980, DSM-III introduced explicit symptom checklists, more clearly defined thresholds, and a supposedly theory-neutral approach. Instead of requiring clinicians to agree about why you were suffering, the manual sought agreement about what symptoms could be observed or reported (American Psychiatric Association, n.d.; Davies, 2017).

This was a genuine achievement. DSM-III helped clinicians speak a more consistent language and improved the ability of researchers to study groups of people who appeared to have similar symptoms. It also helped establish more uniform standards for insurance reimbursement, disability evaluation, clinical trials, and communication across treatment settings (American Psychiatric Association, n.d.; Kawa & Giordano, 2012).

But consistency is not the same thing as truth.

Two clinicians can reliably agree that you meet a checklist without establishing that the checklist represents a distinct biological disease. Reliability asks, "Can we agree about what to call this?" Validity asks the deeper question: "Does the category accurately represent

something real, distinct, and scientifically established?" DSM-III made substantial progress toward reliability. The question of validity remained far less settled (Kutchins & Kirk, 1997).

In his lecture, *The Origins of the DSM*, British social anthropologist and psychotherapist James Davies describes how many DSM-III decisions were reached through committee deliberations, professional consensus, and voting (Council for Evidence-Based Psychiatry, n.d.). Davies later supported this argument through examination of archival materials and interviews with DSM task-force members. Votes helped determine which categories would be included, what they would be called, and where diagnostic thresholds would be placed (Davies, 2017).

This does not mean the committee members were incompetent or dishonest. Classification systems inevitably require judgment. Nor does it mean that every diagnosis was arbitrarily invented. It does mean, however, that the final categories should not be mistaken for laboratory discoveries handed down from an objective and infallible science.

If you receive a psychiatric diagnosis, it will not generally rest upon a definitive blood test, brain scan, genetic marker, or tissue sample. Psychiatric diagnoses are primarily syndromes: recognizable clusters of symptoms that frequently occur together. Those clusters may be clinically meaningful and still have uncertain boundaries, overlapping causes, and enormous variation from one person to another (American Psychiatric Association, 2022; Kutchins & Kirk, 1997).

DSM-III also changed the cultural imagination of psychological suffering. Once distress was divided into increasingly specific disorders, those categories began to appear more concrete than they actually were. A descriptive classification system gradually took on the authority of a disease catalogue. The label was reified: an abstract

category began to be treated as though it were a clearly bounded object inside you (Davies, 2017; Hansen, 2022; Kutchins & Kirk, 1997).

When a Description Becomes Your Identity

Labels do not merely describe experience. They can influence how we notice, organize, interpret, and express it.

Receiving a diagnosis can bring genuine relief. At last, there is a name for what has been happening. The diagnosis may reduce self-blame, help family members understand, guide treatment, and establish eligibility for benefits that have been rightfully earned.

That is the label functioning well.

The danger comes when a useful description becomes an identity. *I have PTSD* quietly becomes *I am broken.* A diagnosis that initially helps explain suffering can gradually begin to dictate what you believe about yourself and your future.

The answer is not to reject the diagnosis, but to put it in its proper place.

You are not PTSD, depression, or alcohol use disorder. You are a human being with a history, relationships, values, wounds, strengths, courage, and the capacity for restoration. A diagnosis may describe part of what has happened to you. It does not define the totality of who you are.

In the next chapter, we will look more closely at PTSD, what it means, what it captures, and what it may leave out. For now, remember this:

The Cultural Power of Diagnostic Labels

Ethan Watters explored this problem in his 2010 book, *Crazy Like Us: The Globalization of the American Psyche*. Watters argued that the United States has exported not only its medications and treatment models but also its culturally shaped ways of understanding and expressing psychological suffering (Watters, 2010).

His argument is not that people in other cultures do not suffer. They clearly do. His concern is that cultures provide different languages, meanings, symptoms, and rituals through which suffering is experienced and communicated. When one culture exports its diagnostic categories as universal truths, it may unintentionally replace local understandings with its own.

Watters examined four major examples. In Hong Kong, he described changes in the presentation and public understanding of anorexia nervosa after Western explanations of the disorder became widely circulated. In Sri Lanka, he examined the arrival of Western trauma specialists after the 2004 tsunami and questioned whether importing an American model of PTSD always matched what survivors and communities most needed. In Zanzibar, he considered the role of family and culture in the course of schizophrenia. In Japan, he described the commercial expansion of depression awareness alongside the marketing of antidepressant medication (Watters, 2010).

The lesson is not that anorexia, schizophrenia, depression, or post-traumatic suffering are imaginary. The lesson is that you do not experience distress outside your culture. The diagnostic language offered to you can influence which symptoms you notice, how you explain those symptoms, what help you seek, and what you come to expect from your future (Watters, 2010).

A diagnostic system can therefore do more than recognize a pattern in your suffering. It can help create the social pathway through which you live that pattern.

Diagnosis, Medication, and the Market

The DSM does not prescribe medications, and it would be unfair to blame the manual for every excess of the pharmaceutical industry. Medication can reduce your suffering, stabilize dangerous symptoms, restore sleep, lower debilitating anxiety, and save your life. For some people, it is an essential part of responsible care.

Nevertheless, you deserve to understand the relationship between diagnosis and medication.

Once a form of distress is established as a discrete disorder, it becomes easier to build an industry around it. Researchers can study a medication for that category. Regulatory agencies can approve it for that indication. Pharmaceutical companies can market it to clinicians and, in the United States, directly to you as a consumer. Insurers can reimburse treatment according to the diagnostic code. Continuing-education programs can teach practitioners how to recognize it. Awareness campaigns can encourage you to ask whether you have it (Kutchins & Kirk, 1997; Watters, 2010).

This can bring previously neglected suffering into the light. It can also widen diagnostic boundaries, medicalize ordinary but painful human experiences, and encourage you to believe that every troubling emotion represents a disorder requiring a pharmaceutical answer (Hansen, 2022; Kutchins & Kirk, 1997).

The problem is not medication itself. The problem is reductionism: the assumption that because your suffering has been given a medical-sounding name, it has therefore been proven to be a discrete brain disease best treated primarily through medication.

Trauma is rarely so simple. You may be contending with conditioned fear, autonomic dysregulation, disrupted sleep, chronic pain, traumatic grief, shame, moral injury, addiction, damaged relationships, spiritual disorientation, and loss of community. Medication may help with part of that picture. It cannot, by itself, restore your identity, repair trust, resolve grief, rebuild relationships, recover purpose, or answer the question, "Who am I now?"

Friend or Foe?

Is the DSM your friend or your foe?

It can be either, depending on how it is used.

It is your friend when it gives language to your suffering, improves communication, guides thoughtful assessment, supports research, opens access to treatment, and helps you understand that your reactions are recognizable and treatable.

It becomes your foe when it is treated as infallible, when a symptom checklist replaces curiosity about who you are, when culturally shaped categories are presented to you as timeless biological facts, when diagnosis is driven by reimbursement or marketing, when medication

replaces comprehensive treatment, or when the label becomes your identity.

The DSM should remain a tool in the clinician's hand. It should never become a stamp placed upon your soul.

As we examine PTSD, depression, anxiety, addiction, and related diagnoses in this chapter, we will use these categories carefully. We will neither dismiss them nor worship them. We will ask what each diagnosis helps you see, what it may cause you to overlook, and how it can be used without allowing it to define you.

You should not be expected to fit the mental health industry. The mental health professions should be working to see you more truthfully and completely. Good science should serve you. You should never be forced to serve the label.

Most importantly, no diagnosis gets the final word.

The label may describe your wound. It does not define the warrior.

The Wound Before It Had a Name

Post-traumatic stress disorder is a relatively new name for a very old wound. Warriors have been carrying war home for as long as human beings have gone off to fight. What changed over time was not the reality of the suffering, but the language used to describe it.

During the Civil War, physicians used terms such as *soldier's heart* to describe men who returned with pounding hearts, difficulty breathing, exhaustion, anxiety, and an inability to settle. During World War I, it became *shell shock*. Some soldiers trembled, became mute, experienced paralysis, suffered nightmares, or appeared emotionally absent. Physicians initially wondered whether exploding artillery shells had physically damaged their brains. When similar symptoms appeared in soldiers who had not been close to an explosion, it became clear that something more complicated was happening (Crocq & Crocq, 2000).

By World War II, the language had changed again. We began hearing terms such as *battle fatigue* and *combat exhaustion*. The most memorable image from that era may be the vacant gaze commonly called the *thousand-yard stare*. The famous 1944 painting by war correspondent Tom Lea was actually titled *That 2,000 Yard Stare*. It portrays a Marine who is still physically present but appears to be looking through the world rather than at it. No diagnostic manual was needed to tell us that this man had seen and carried more than any human being should be expected to carry (National WWII Museum, 2016).

Following Vietnam, veterans and clinicians pushed for clearer recognition of the lasting psychological effects of combat. In 1980, *post-traumatic stress disorder* formally entered the DSM-III. Today, the DSM-5-TR describes PTSD through recognizable groups of symptoms involving intrusive memories, avoidance, negative changes in thoughts and emotions, and a nervous system that remains prepared for danger (American Psychiatric Association, 2022).

Across the years, the language moved from *soldier's heart* to *shell shock*, from *battle fatigue* to *PTSD*. The names changed. The wounds remained.

That brief history raises an interesting question. Were warriors in earlier wars suffering differently, or did they simply have different ways of understanding and expressing the same basic human wound? The answer is probably a little of both. Warfare has changed. Culture has changed. Medicine has changed what it looks for. But fear, grief, guilt, horror, helplessness, and your body's instinct to survive are not modern inventions.

When a Useful Label Becomes an Identity

We use the term *PTSD* because it gives us a common language. It can help you and your family understand a complicated collection of symptoms. It can guide treatment, support research, and open doors to care and benefits you have rightfully earned.

The diagnosis has real value.

But it is still a label.

Well-meaning systems use labels because systems need categories. Well-meaning professionals use them because they were trained to

diagnose, communicate, and develop treatment plans. Most are trying to help. We are not interested in disparaging them or questioning their motives.

However, even well-meaning professionals can forget what a label may do to you.

You may gradually become "the PTSD patient." If you are a firefighter, you may become "the trauma case." If you are a police officer, you may become "the one with anger problems." A description of certain symptoms quietly becomes a description of your entire humanity.

That is where we need to slow down.

Your diagnosis may tell us something important about what happened to you and how your mind and body responded. It cannot tell us everything about who you are. It cannot measure your courage, loyalty, humor, faith, love, sacrifice, relationships, or capacity to heal. It may identify a wound, but it cannot capture the person carrying it.

In fact, much of what we call PTSD is normal human shit.

That may not be the language used in most clinical textbooks, but perhaps it should be said more plainly. If you have watched people die, feared for your life, carried broken bodies, entered burning buildings, responded to horrific accidents, or made decisions that no human being should ever have to make, your mind and body may respond.

Of course they may respond.

You may remember what you desperately want to forget. You may scan a room because scanning once helped keep you alive. You may awaken at the slightest sound because deep sleep once felt dangerous. You may avoid certain places because they awaken something inside you that you

are not ready to face. You may shut down emotionally because feeling everything at once would be unbearable.

Those responses did not emerge because you were weak. They emerged because your mind and body were attempting to protect you.

The problem is that your survival system may remain on duty after the danger has passed. The war ends, the fire is extinguished, the shift is over—but some part of you does not receive the message. That is when understandable survival responses can begin disrupting your sleep, relationships, work, health, and ability to feel at home in your own life.

Calling this a disorder can be useful, but it can also be misleading. It can make it sound as though your mind simply malfunctioned. Often, it did something much more understandable: It adapted to a world of danger and then had difficulty returning to a world that expected it to feel safe again.

One of us—Jeff—has the modest advantage of being old as dirt. Age does not guarantee wisdom. Sometimes it merely guarantees an expanding assortment of reading glasses and the occasional surprise that your physician looks young enough to be selling candy for a school fundraiser. But age does offer perspective. After enough years in this profession, you begin to notice that diagnostic language changes while human suffering remains remarkably human.

We are therefore going to use the diagnosis of PTSD in this book, but we will hold it lightly. We will look at what the DSM-5-TR says, break down the symptoms, and help you recognize how they may appear in your life. But we will never grant the diagnosis the authority to define you.

You may have PTSD. You are not PTSD.

The label may help us understand your wound. It does not define the warrior, the first responder, or the human being carrying it.

What PTSD Is Today

Now that we have briefly traced how our understanding of combat trauma evolved, let us look at what PTSD means today.

The DSM-5-TR provides the formal diagnostic criteria used by mental health professionals. We are not going to reproduce the manual or bury you beneath clinical terminology. Instead, we are going to translate those criteria into ordinary language without watering them down. We want you to understand what these symptoms may actually look and feel like in your everyday life.

The current diagnosis begins with exposure to death, threatened death, serious injury, or sexual violence. You may have experienced the event directly. You may have witnessed it happening to someone else. You may have learned that something violent or catastrophic happened to someone close to you. You may also have been repeatedly exposed to disturbing details as part of your work (American Psychiatric Association, 2022).

That last form is especially relevant if you are a first responder. If you are a paramedic, you may have repeatedly treated dying children or people whose bodies were terribly damaged. If you are a firefighter, you may have recovered bodies from homes or vehicles. If you are a police officer, you may have encountered violence, abuse, suicide, and human cruelty again and again. If you served as a military medic, corpsman, mortuary specialist, or in another high-exposure role, you may have worked repeatedly with severe injuries or human remains.

PTSD does not always begin with one dramatic event. Sometimes your nervous system is worn down call by call, deployment by deployment, or body by body.

Exposure alone does not mean that you have PTSD. Many people experience traumatic events without developing the full disorder. PTSD is diagnosed when that exposure is followed by a particular pattern of symptoms that persists, causes significant distress, or begins interfering with your life.

The Memory Will Not Stay in the Past

The first major group of symptoms involves *intrusion*. Something from the past continues forcing its way into your present.

You may experience unwanted memories, nightmares, or moments when you feel as though the event is happening again. Sometimes this takes the form of a vivid flashback. At other times, it may be less dramatic: a sudden image, a familiar smell, a sound, or a physical sensation that pulls you back toward the event.

A helicopter overhead may return you to a deployment. Fireworks may awaken your body before you have time to remind yourself that you are home. The smell of diesel fuel, burning rubber, smoke, or blood may bring back a scene you have worked hard to bury. A particular ringtone may remind you of the call that changed everything. If you are a paramedic or firefighter, the sound of a child crying may return you to one child you could not save.

Your body may react before your thinking mind has identified the connection. You may begin sweating or shaking. Your heart may race. You may feel nauseated, short of breath, or flooded with adrenaline.

You may suddenly become intensely alert without immediately understanding why.

Traumatic memory is not always experienced as an ordinary story from your past. It can arrive with the emotional and physical force of something happening *now*.

That is one reason people sometimes say, "I know I am safe, but my body does not believe it."

Staying Away From What Wakes It Up

The second group of symptoms involves *avoidance*.

When a memory is painful, it is understandable that you would try to stay away from whatever brings it back. You may avoid talking about the event or even allowing yourself to think about it. You may stay away from particular places, movies, reunions, roads, crowds, hospitals, news stories, or people connected to what happened.

Perhaps there is a highway exit you no longer take because it leads toward the location of a fatal call. Perhaps you avoid fireworks because they wake up too much inside you. Perhaps you stopped attending military reunions because seeing people from your unit awakens memories, guilt, or grief that you do not feel prepared to carry.

Avoidance can also occur inside you. You may stay constantly busy because stillness allows memories to surface. You may work excessive hours, drink, isolate, exercise compulsively, gamble, use pornography, or disappear into your phone. These behaviors may not be the original problem. They may be ways of keeping unwanted memories, sensations, and emotions at a distance.

Avoidance works—at least briefly. That is why you continue doing it.

If you do not drive that road, you do not have to remember. If you keep working, you do not have to feel. If you drink enough, you may sleep for a few hours without dreaming. If you do not become emotionally close to anyone, you may not have to risk another painful loss.

But avoidance carries a cost. Your life may become progressively smaller. The more time and energy you devote to avoiding the wound, the more authority the wound may acquire over your life.

Trauma Changes the Story You Tell Yourself

The third group of symptoms involves changes in your thoughts, emotions, and beliefs.

You may have difficulty remembering important parts of what happened. This does not necessarily mean that you deliberately suppressed the memory. During overwhelming stress, your memories may have been stored in fragmented or disorganized ways. You may remember one image with astonishing clarity while being unable to reconstruct what happened immediately before or afterward.

Trauma may also change how you see yourself, other people, and the world:

I should have done more.
It was my fault.
I cannot trust anyone.
The world is not safe.
I am weak.
I am damaged.
I do not deserve to be alive.

These conclusions may feel like objective truth. Yet they may have been shaped by guilt, grief, shame, hindsight, and the impossible standards you imposed upon yourself after the event.

You know now what you did not know then. You can see options in retrospect that may not have existed in the chaos of the moment. You may hold yourself responsible for outcomes you could not control. You may judge decisions made in seconds as though you had possessed unlimited time, perfect information, and the perspective you gained years later.

You may carry persistent fear, anger, guilt, or shame. Activities that once mattered to you may lose their appeal. You may no longer enjoy hunting, riding your motorcycle, going to the gym, attending church, spending time with friends, or playing with your children or grandchildren. You may continue doing some of these things but feel as though you are going through the motions.

Emotional connection may also become difficult. You may still love your family deeply but struggle to *feel* that love. You may be surrounded by people who care about you while feeling strangely separated from them.

You may find positive emotions difficult to access. Joy, peace, tenderness, hope, and gratitude may feel distant, unfamiliar, or even unsafe. Part of you may believe that relaxing invites danger or that allowing yourself to be happy somehow betrays those who did not come home.

This does not necessarily mean that you have stopped caring. Emotional numbing may have become another form of protection.

The Alarm System Stays On

The fourth group of symptoms involves changes in arousal and reactivity. In plain language, your mind and body remain prepared for danger.

You may sit where you can see the door. You may scan crowds, notice exits, watch people's hands, check locks repeatedly, or become uneasy when someone approaches from behind.

If you served in combat or law enforcement, these behaviors may once have been entirely appropriate. Watching hands, checking rooftops, noticing vehicles, and identifying exits may have helped keep you and others alive. If you were a firefighter or paramedic, constant readiness may have allowed you to move instantly from an ordinary moment into a life-or-death emergency.

Back home, however, remaining continuously prepared for danger becomes exhausting.

You may startle easily. A dropped object, unexpected touch, slamming door, firework, or car backfire may produce a full-body reaction before your thinking brain has determined that there is no threat. You may feel embarrassed by the intensity of your response, but your nervous system is not waiting for a committee meeting. It is reacting first and asking questions later.

Your sleep may suffer. You may have difficulty falling asleep, awaken repeatedly, experience nightmares, or remain lightly asleep because some part of your nervous system refuses to stand down. You may sleep better in a chair or with the television on. You may need to check the house before going to bed. You may awaken at a small sound and immediately feel prepared to respond.

Your concentration may become difficult. You may lose track of conversations, forget what you were doing, or struggle to read. This can be especially frustrating if you once prided yourself on remaining calm and mentally sharp under pressure.

You may also become more irritable. Anger may emerge rapidly and with an intensity that surprises you and frightens the people who love you. Sometimes anger becomes the emotion that stands guard over fear, grief, guilt, helplessness, or shame. It feels stronger and safer than the pain underneath it.

You may also engage in reckless or self-destructive behavior. This does not always mean that you consciously want to die. Danger may have become familiar. Ordinary life may feel emotionally flat. You may be trying to feel something, outrun something, punish yourself, or re-create the intensity in which you once felt most fully alive.

None of these reactions is random. Your alarm system learned that danger could appear without warning. It is now trying, sometimes desperately, to make sure you are never caught unprepared again.

When Does It Become PTSD?

To meet the current diagnostic definition, these symptoms must persist for more than one month. They must also cause significant distress or interfere with important areas of your life, such as work, relationships, health, sleep, or everyday functioning. Your symptoms also cannot be better explained by medication, alcohol, drugs, or another medical condition (American Psychiatric Association, 2022).

Your symptoms may begin almost immediately. For some of you, however, the full pattern may not become evident until months or even years later.

You may have functioned remarkably well during deployment because your training, structure, purpose, and team kept everything moving. You may have continued answering calls because other people depended upon you. You did not have the time or psychological space to fall apart. There was always another mission, another alarm, another patient, or another person who needed you.

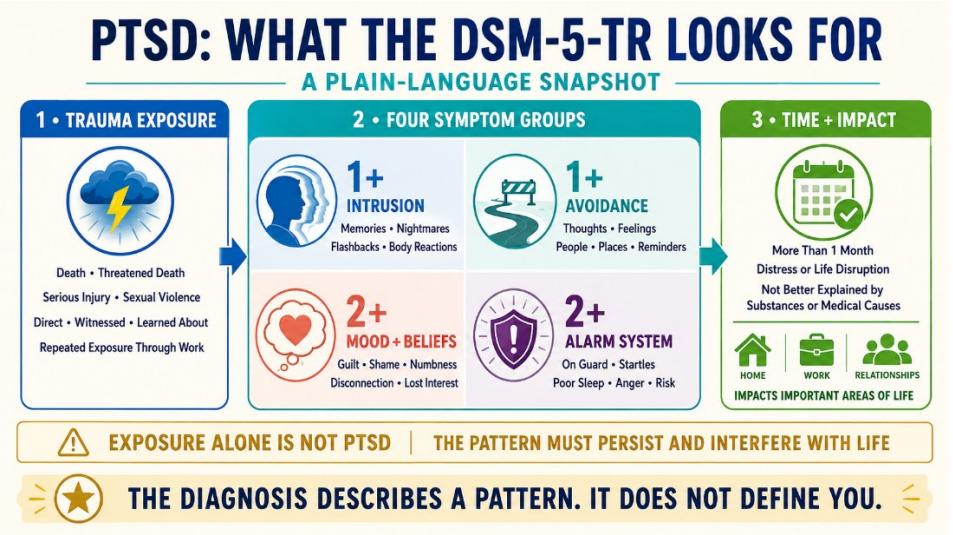
Your symptoms may become more visible after you return home, retire, leave the service, or lose the intense sense of mission and belonging that once organized your life. When the pace finally slows down, everything you held at a distance may begin catching up with you.

You may also experience dissociation. You might feel detached from your own body or as though you are observing your life from the outside. The world may seem unreal, distant, foggy, or dreamlike. You may drive somewhere and have little memory of the trip. You may participate in a conversation while feeling that you are not fully present.

You do not need to experience every symptom to have PTSD. Your experience may not look like anyone else's.

You may struggle primarily with nightmares and hypervigilance. Another veteran may be consumed by guilt and emotional numbness. If you are a firefighter, you may function exceptionally well at work but become detached at home. If you are a police officer, you may not experience obvious flashbacks but may be unable to sleep, trust, relax, or stop scanning for danger. If you are a paramedic, you may continue performing competently while one particular call intrudes into quiet moments with painful clarity.

The diagnosis provides a general pattern. Your lived experience remains deeply personal.



A Description, Not a Definition

In practical terms, PTSD may mean:

- Your past continues intruding into your present.
- You avoid what awakens the wound.
- Trauma has changed some of your thoughts, emotions, and beliefs.
- Your body remains prepared for danger.
- This pattern persists and begins interfering with your life.

These symptoms can become profoundly painful and disruptive. Calling them understandable does not mean they are insignificant. Calling them adaptations does not mean they should be ignored. It means they developed for a reason.

This is the caution we want you to carry forward: The DSM describes a pattern of symptoms. It does not describe the totality of who you are.

PTSD may help explain why you cannot sleep, why you scan the room, why certain memories will not leave you alone, or why you sometimes feel separated from people you love. It cannot tell us who you are. It cannot measure your character, faith, courage, loyalty, humor, love, or future.

Use the diagnosis to understand what may be happening inside you. Use it to find effective help. Use it to give language to experiences that may have been confusing or frightening.

But do not hand it your identity.

You have lived through something that changed you. Some of your reactions may be the normal responses of a human mind and body exposed to profoundly abnormal circumstances. Those responses may now require attention, care, and healing.

The wound is real.

But the wound is not all that you are.

References

CHAPTER FOUR
WHEN THE BATTLE MOVES INSIDE
Depression and Anxiety After Trauma

You can be exhausted and still unable to rest. You can feel emotionally dead while some part of you remains intensely alert. You may have little energy to get off the couch, yet you still check the locks three times before bed. You may avoid people because conversation feels like work, but once you are alone, your mind refuses to shut up. Your body feels heavy. Your thoughts keep moving. You are worn out and wound up at the same time.

If that sounds contradictory, it is not. It is one of the ways trauma can express itself through depression and anxiety.

You may have returned from combat, left the firehouse, retired from law enforcement, or finished a long career in emergency medicine. The immediate danger may be over, but your body may not have received the memo. Part of you remains prepared for the next call, the next explosion, the next threat, the next body, or the next moment when everything goes terribly wrong.

At other times, the opposite happens. Instead of remaining on high alert, your system seems to run out of fuel. You lose interest in people

and activities that once mattered. You stop answering the phone. You withdraw from your family. You sleep too much or barely sleep at all. The disciplined, competent person you once knew seems to have disappeared beneath a fog of exhaustion, irritability, numbness, and hopelessness.

We call these experiences *anxiety* and *depression*. Those names can help us organize what is happening, but they are descriptions, not identities. You may be experiencing depression. You may have an anxiety disorder. You are not depression, and you are not anxiety.

As we discussed in the previous chapter, depression and anxiety often occur alongside PTSD, but they can also develop independently. You can experience depression without having PTSD. You can develop an anxiety disorder without having survived combat or another clearly defined traumatic event. You can also experience all three together. Human suffering does not always respect the boundaries drawn in a diagnostic manual.

Our purpose here is not to repeat what we have already said about PTSD. This chapter belongs to depression and anxiety: what they are, how they may develop after trauma, how they affect your energy and your body, and how they may look different in veterans, service members, and first responders.

We will begin introducing a nervous-system understanding of these emotional states, but we are not going to bury you in neuroanatomy yet. In an upcoming chapter on the neuroscience of trauma, we will take you beneath the symptoms. We will examine what prolonged threat can do to your brain, autonomic nervous system, stress hormones, sleep, memory, attention, energy, and capacity to recognize safety. We will

also introduce polyvagal theory as one helpful way of understanding alarm, mobilization, shutdown, safety, and connection.

By the time we are finished, what is happening inside you will not seem nearly as mysterious. More importantly, it will not look like weakness or personal failure. It will begin to make sense.

Old Wounds With New Names

Depression and anxiety did not arrive with the DSM, antidepressants, social media, or the evening news. Human beings have wrestled with fear and despair for as long as we have been capable of reflecting upon our lives.

Ancient Greek physicians used the word *melancholia* to describe states involving persistent sadness, fear, withdrawal, and changes in thought and behavior. The word came from the Greek terms for "black bile," because physicians such as Hippocrates believed melancholia resulted from an imbalance in bodily fluids. Their biology was wrong, but their basic observation was important: profound despair affected the mind and body together.

Over the centuries, melancholia was understood in medical, philosophical, moral, and religious ways. By the nineteenth century, the word *depression* increasingly entered medical language and eventually replaced melancholia as the more common term. With the development of modern psychiatry, depression became divided into increasingly specific diagnostic categories (Telles-Correia et al., 2015).

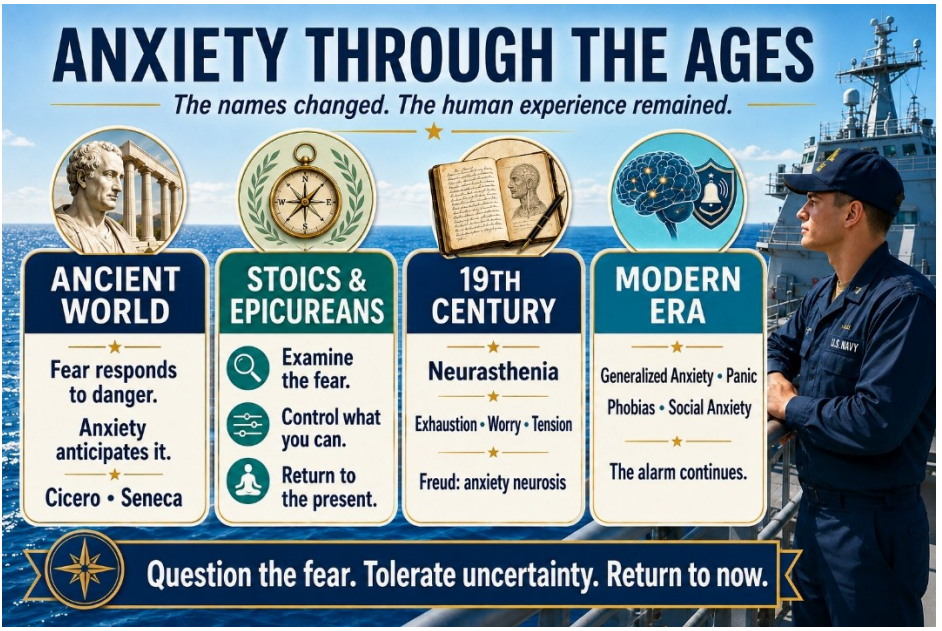
Anxiety has an equally interesting history. Ancient Greek and Roman thinkers recognized a difference between fear in response to an immediate danger and a more persistent state of apprehension. The Romans used words such as ***anxietas*** and ***angor*** to describe ongoing uneasiness, constriction, and dread. Cicero wrote about anxiety as a continuing state of distress, while Seneca described the very human tendency to suffer in advance by imagining what might go wrong.

The Stoics and Epicureans developed practices intended to quiet unnecessary fear. They encouraged people to examine frightening thoughts, distinguish what could be controlled from what could not, tolerate uncertainty, and return their attention to the present. Some of their methods sound remarkably similar to modern cognitive and acceptance-based therapies, although the ancients managed to practice them without treatment plans, diagnostic codes, or prior authorization.

During the centuries that followed, anxiety was variously interpreted as a medical condition, a spiritual struggle, a weakness of character, or an aspect of melancholia. In the nineteenth century, physicians began describing conditions such as *neurasthenia*, a broad diagnosis involving

exhaustion, irritability, headaches, worry, and physical tension. Sigmund Freud later separated what he called *anxiety neurosis* from neurasthenia and attempted to describe anxiety as a distinct clinical problem.

Modern diagnostic systems continued dividing anxiety into more specific patterns, including generalized anxiety, panic, phobias, and social anxiety. The names changed, the theories changed, and the categories multiplied. The essential human experience remained recognizable: your mind anticipates danger, your body prepares to respond, and the alarm continues even when no immediate threat is visible (Crocq, 2015).



The history matters because it reminds us that depression and anxiety are not modern inventions. Our current diagnostic categories are modern, but fear, dread, exhaustion, despair, and loss of hope are ancient human experiences.

Depression: When Life Begins to Go Dim

Depression is sometimes mistaken for ordinary sadness, but the two are not the same. Sadness is a natural response to loss, disappointment, and pain. It can be deep and still remain connected to something specific. Depression is often broader. It can drain the color from your entire life.

You may not necessarily feel sad. You may feel nothing.

You may wake up exhausted before the day has begun. Things that once gave you satisfaction no longer register. You may stop riding, exercising, fishing, attending church, seeing friends, working around the house, or spending time with the people you love. You know these things used to matter, but you cannot make yourself care.

For service members, veterans, and first responders depression does not always look like crying or openly expressing despair. It may look like irritability, isolation, cynicism, anger, reckless behavior, drinking, working constantly, or refusing to ask for help. It may appear in the sentence, "I'm fine," spoken through clenched teeth by someone who has not felt fine in years.

You may still perform well. You may continue paying the bills, helping everyone else, and doing what needs to be done. Competence can conceal enormous suffering. Some of the most depressed people remain remarkably functional until the energy required to maintain that appearance finally runs out.

Depression following trauma can have many roots. You may be grieving people you could not save. You may be carrying guilt about a decision made in seconds under impossible conditions. You may have lost your military unit, department, team, mission, physical abilities, career, marriage, or sense of purpose. You may have returned to a civilian world

that seems preoccupied with matters that feel trivial compared with what you have seen.

Sometimes the injury is not only what happened to you. It is what happened to your understanding of yourself, other people, and the world.

You may once have believed that courage would be rewarded, leadership could be trusted, innocent people would be protected, or good people would generally do the right thing. Combat, betrayal, traumatic loss, and moral injury can fracture those assumptions. When the story that organized your life collapses, depression can enter through the opening.

How the DSM-5-TR Describes Major Depression

The DSM-5-TR uses the diagnosis *major depressive disorder* when a particular group of symptoms occurs together, usually for at least two weeks, and causes meaningful distress or interferes with your ability to function. At least one of the central symptoms must involve a persistently depressed or irritable mood, or a significant loss of interest and pleasure (American Psychiatric Association, 2022).

- In everyday language, clinicians look for some combination of the following:
- You feel sad, empty, hopeless, emotionally flat, or unusually irritable.
- You lose interest or pleasure in activities, relationships, work, sex, recreation, or other parts of life that once mattered.
- Your appetite or weight changes noticeably.
- You sleep too little, awaken repeatedly or far too early, or sleep much more than usual.

- Your movements and speech become visibly slowed, or you feel restless and unable to settle.
- You experience persistent fatigue or loss of energy.
- You carry excessive guilt, shame, worthlessness, or the belief that other people would be better off without you.
- You have difficulty concentrating, remembering, organizing, or making decisions.
- You think repeatedly about death, wish you would not wake up, consider suicide, or make plans to end your life.

The DSM generally requires at least five symptoms, but human suffering does not suddenly become real when symptom number five walks through the door. You can have four symptoms and be suffering profoundly. You can meet the official threshold and still function outwardly.

Similar symptoms can also arise from grief, chronic pain, sleep deprivation, medication effects, alcohol or drug use, hormonal disturbance, neurological illness, or another medical condition. This is why a thoughtful evaluation should involve more than counting symptoms.

A word about suicide. If you are thinking about suicide, making a plan, or beginning to believe that your family would be better off without you, please tell someone directly. Do not soften it, joke about it, or wait for someone to guess. Call someone you trust, contact your clinician, call the Veterans Crisis Line by dialing 988 and pressing 1, or go to the nearest emergency department. Strength is not remaining silent while your mind

is trying to kill you. Strength is bringing someone else into the fight.

Anxiety: When the Alarm Will Not Stand Down

Anxiety begins with something necessary. You need an alarm system.

When danger approaches, your attention narrows, your heart rate changes, your muscles prepare for action, and your senses search the environment for threat. In combat, law enforcement, firefighting, and emergency medicine, that rapid mobilization can keep you and the people around you alive.

The problem begins when the alarm continues sounding after its job is finished.

You may be driving on an ordinary road, yet every object on the shoulder captures your attention. You may sit facing the door in a restaurant without consciously deciding to do so. You may be watching television when fireworks, a helicopter, a particular smell, or a sudden knock at the door sends a jolt through your body. You may understand intellectually that you are safe while your physiology votes otherwise.

Anxiety can also become disconnected from any obvious source. Instead of worrying about a specific event, you begin worrying about everything: your health, finances, family, job, future, or the possibility that something terrible is about to happen. You cannot always identify the danger, but you feel certain that it is out there somewhere.

This is more than careful planning. It is a mind that has learned to stay ahead of danger by imagining every possible way life could go wrong.

Your body may express anxiety through muscle tension, headaches, gastrointestinal problems, chest pressure, shallow breathing, trembling, sweating, dizziness, fatigue, restlessness, and interrupted sleep. You may

become short-tempered because your system has no remaining margin. A minor inconvenience feels like one more incoming round.

You may also begin avoiding whatever activates the alarm. Crowds, traffic, unfamiliar places, conflict, medical appointments, social events, driving, flying, loud noises, or being too far from home gradually disappear from your life. Avoidance brings immediate relief, which teaches your nervous system to avoid even more. Before long, the world becomes smaller and smaller.

What Do We Mean by an Anxiety Disorder?

The DSM-5-TR does not contain one single diagnosis called simply "anxiety." It describes several anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder, specific phobias, and others.

For this book, the most useful starting point is generalized anxiety disorder. In everyday language, this means that worry has become excessive, difficult to control, present much of the time for at least six months, and disruptive to your life. It is generally accompanied by symptoms such as restlessness, fatigue, irritability, muscle tension, poor concentration, and disturbed sleep (American Psychiatric Association, 2022).

Once again, the diagnostic time limits and symptom counts create consistency, but they do not determine whether your suffering deserves attention. If you have been miserable for five months and three weeks, you do not need to wait another week before asking for help. The nervous system does not own a calendar.

When Panic Takes Over

Panic is anxiety arriving like an ambush.

A panic attack can produce a sudden surge of terror accompanied by a pounding heart, chest pressure, shortness of breath, shaking, sweating, dizziness, nausea, numbness, chills, or a feeling that you are losing control, going crazy, or about to die. The attack may peak quickly, but afterward you can remain exhausted and frightened by what happened.

The first panic attack is terrifying because you may not know what it is. Many people reasonably believe they are having a heart attack or another medical emergency. New or unexplained chest pain and similar physical symptoms should be medically evaluated rather than automatically attributed to anxiety.

After panic occurs, another fear may develop: fear of the next attack. You begin monitoring your heart, breathing, balance, or other bodily sensations. Places associated with the original attack may begin to feel dangerous. The fear of panic can eventually become more restrictive than the panic itself.

When Depression and Anxiety Travel Together

Depression and anxiety may look like opposites. Depression can pull you toward exhaustion, numbness, withdrawal, and despair. Anxiety can leave you restless, vigilant, tense, and unable to stand down.

Yet they often travel together.

You may be too anxious to sleep and too exhausted to function. You may worry constantly about your family while withdrawing from them. You may feel emotionally numb until something activates the alarm, at which point your entire system erupts. You may spend the day pushing through on adrenaline and collapse when you arrive home.

Anxiety consumes energy. When your mind and body remain prepared for danger day after day, exhaustion eventually follows. Depression then makes it harder to exercise, connect with other people, solve problems, or use the strategies that once helped you manage anxiety. Each condition begins feeding the other.

Alcohol and other substances may enter the picture because they briefly quiet the alarm or numb the despair. Unfortunately, they eventually disrupt sleep, worsen mood, increase anxiety, damage relationships, and create another wound layered on top of the first.

The purpose of identifying depression and anxiety is not to force you into separate diagnostic boxes. It is to understand the different forces operating inside your life so that each can be addressed.

When Trauma Is Carried in the Body

People often say that trauma is "stored in the body." That phrase captures something important, but it can also sound mysterious.

Trauma is not stored inside you like a photograph placed in a filing cabinet. It is carried through learned patterns of survival. It can influence how quickly you detect threat, how your muscles brace, how deeply you breathe, how well you sleep, how your heart responds to stress, how much energy you have, how easily you connect with other people, and how rapidly your system moves into protection.

Your body learns from repetition.

If you spent months or years in an environment where relaxing could get you or someone else killed, your body learned not to relax. If danger arrived without warning, your attention learned to scan constantly. If emotional detachment helped you continue functioning around death and suffering, your system learned how to numb. If resistance or escape repeatedly became impossible, your system may have learned to conserve energy through withdrawal, immobilization, or shutdown.

These patterns can continue long after the original environment is gone.

Anxiety often carries the energy of mobilization. Your system is preparing to act, even when no action is necessary. You may feel restless, tense, watchful, impatient, or driven. Depression often carries the opposite experience: diminished energy, heaviness, disconnection, slowed movement, and withdrawal.

These are not rigid categories. Depression can include agitation and intense anxiety. Anxiety can end in exhaustion, freezing, numbness, or collapse. You

may move between high-energy alarm and low-energy shutdown, sometimes within the same day.

This does not mean depression is simply a shutdown state or anxiety is merely an alarm state. Both are more complicated. It does mean that your emotional life cannot be fully understood without considering the body and nervous system carrying those emotions.

We will explain this much more fully in our upcoming chapter on the neuroscience of trauma. We will discuss how your brain and body detect danger, how traumatic experiences shape memory, how the stress-response system can become altered, and how prolonged survival states affect mood, energy, attention, sleep, relationships, and physical health. We will introduce polyvagal theory as one helpful lens for understanding mobilization, shutdown, safety, and connection.

It will not remain a mystery. You will be able to see that many reactions you have interpreted as weakness, craziness, laziness, or personal failure are understandable adaptations within a system that has worked extraordinarily hard to protect you.

You Are Not Failing

If you are depressed, people may tell you to get moving, think positively, show some gratitude, go to the gym, pray harder, or simply stop dwelling on the past. Some of those activities may eventually become part of healing. But when your system is deeply depleted, even helpful advice can sound like one more accusation that you are failing.

If you are anxious, people may tell you to calm down, stop worrying, or recognize that nothing bad is happening. You may already know that. Your thinking brain may understand perfectly well that you are safe. The problem is that another part of your system has not yet learned the same lesson.

You are not weak because your body adapted to danger. You are not defective because those adaptations continued after the danger ended. You are not

beyond recovery because depression or anxiety has occupied your life for months or years.

Your survival system learned these patterns, and learned patterns can change.

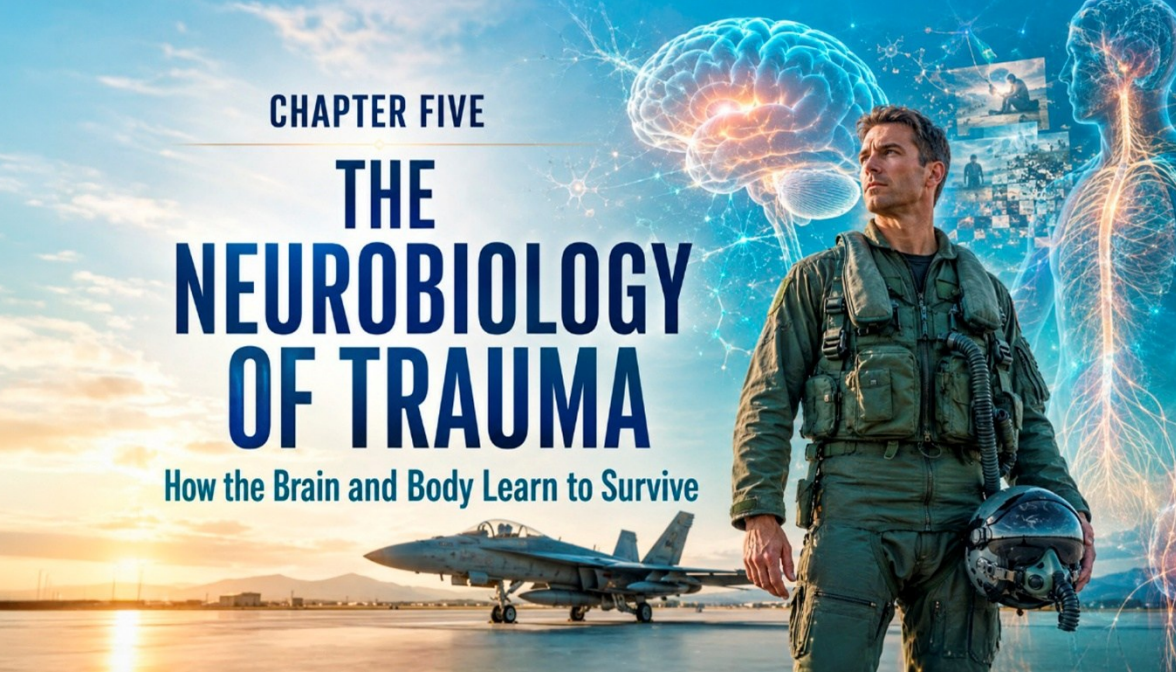
Healing will involve more than commanding yourself to feel differently. It will involve helping your mind and body experience safety, energy, connection, meaning, and choice again. It may include careful psychotherapy, medical evaluation, movement, improved sleep, renewed relationships, grief work, attention to moral injury, spiritual restoration, and practices that help regulate the nervous system.

We will get there.

For now, begin with this understanding: depression and anxiety are not evidence that you have failed to handle what happened. They can emerge after trauma, develop independently, or become entangled with other emotional and physical wounds. The diagnostic categories may be imperfect, but your suffering is real.

More importantly, your future is not settled.

The battle may have moved inside, but it is not beyond reach. Understanding what is happening is one of the first steps toward coming home.



Your nervous system is not your enemy. It learned to protect you in places where protection was necessary. Healing begins when you stop treating your body as the problem and start helping it discover that the battle is no longer everywhere.

The Body That Kept You Alive

If you have lived through combat, entered burning buildings, worked a fatal crash, responded to domestic violence, recovered a child's body, or stood beside a partner who did not make it home, your nervous system has done exactly what it was designed to do. It noticed danger, mobilized energy, narrowed attention, reduced hesitation, and helped you act. In the moment, those changes were not symptoms. They were survival.

The trouble begins when the danger ends but your biology does not receive the message. You may be home, yet your body remains on patrol. A slammed door can sound like a gunshot. A crowded restaurant can feel tactically impossible. Sleep can seem unsafe. Silence can leave too much room for memory. You may become irritable, restless, numb,

detached, or exhausted without fully understanding why. Your body is not turning against you. It is using a survival plan that worked before, even though that plan may now be costing you sleep, peace, health, or connection.

> The central truth of this chapter: What looks like pathology is often protection that has outlived the danger for which it was created

That distinction matters. Shame says, "Something is wrong with me." Neurobiology offers a more accurate explanation: "Something happened to me, and my brain and body adapted." This does not minimize suffering or excuse destructive behavior. It gives you a place from which change becomes possible. You cannot understand, befriend, and retrain a body you only condemn.

We Are Built in Connection

Your brain did not develop in isolation. From birth, your nervous system depended upon other nervous systems. As an infant, you could not regulate fear, distress, hunger, temperature, and overwhelming stimulation alone. You borrowed calm from a caregiver through voice, facial expression, touch, rhythm, attention, and reliable presence. Across thousands of ordinary interactions, your developing brain began to learn a basic lesson: distress can be survived, help can be found, and calm can return (Schore, 1994, 2003).

Attachment researchers John Bowlby and Mary Ainsworth helped establish that early relationships become a blueprint for later emotional regulation and connection (Ainsworth et al., 1978). Allan Schore's work takes us deeper into the neurobiology of that process. Early right-brain-

to-right-brain communication between caregiver and infant helps organize the developing systems responsible for emotional regulation, stress response, and relationship (Schore, 1994, 2003). Long before you could explain what you felt, your nervous system was learning what to expect from other people and from the world.

You did not need perfect parenting for healthy development. You needed enough repeated experiences of attunement, repair, protection, and connection. A caregiver misread you and then returned to make it right. You became upset and someone helped you settle. Fear rose and then fell. Through that rhythm, your nervous system developed flexibility. It learned that activation could be temporary and that connection could help bring your body home (Ainsworth et al., 1978; Schore, 2003).

From Excitement to Soothing

Schore describes early attachment as a right-brain-to-right-brain regulatory process. Before language was available, you read the caregiver's face, eyes, melody of voice, touch, timing, and movement as biological communications. When you became joyful and energized, an attuned caregiver could join that positive state without overwhelming you. When you became distressed, that caregiver could help reduce arousal and restore organization. Attachment became your first classroom for learning how to move up and down in energy without becoming lost at either extreme (Schore, 1994, 2003).

Within Schore's developmental account, the earliest phase places substantial emphasis on positively charged, dopamine-related activation: interest, pleasure, excitement, expectancy, and the energizing experience of being met by another person. As development continues, serotonin-related inhibitory and calming capacities become

increasingly important. Put simply, the developing child needs help learning both how to come alive and how to settle. Healthy regulation is not flatness. It is the growing ability to tolerate energy, joy, frustration, and distress while remaining organized and connected (Schore, 1994, 2003).

Your caregiver did not have to get it right every time. Misattunement is inevitable; the critical experience is repair. A caregiver notices that you have become overwhelmed, adjusts a face or voice, slows the interaction, offers comfort, and reconnects. Repeated repair teaches you that relational disruption is survivable and does not have to become abandonment. "Good enough" attunement, not flawless attunement, builds resilience (Schore, 2003).

If care was frightening, chronically absent, emotionally unavailable, chaotic, or unpredictable, your nervous system may have learned a different lesson: other people cannot be trusted, vulnerability is dangerous, needs bring rejection, or safety depends upon staying invisible and self-contained. These lessons are rarely conscious. They become embodied expectations that influence breathing, muscle tension, attention, sleep, relationships, and the speed with which you shift into defense (McLaughlin et al., 2012; Schore, 2003; Shields & Cicchetti, 1997).

Without consistent help regulating your early states, high arousal may have remained too high and low arousal too low. Intrusive or frightening care can drive a child toward hyperarousal; neglect and emotional absence can pull a child toward hypoarousal and shutdown. Either pattern can limit flexible self-regulation. Years later, you may still rely on urgency, intensity, withdrawal, substances, or compulsive

behavior to do what safe connection was originally meant to help your nervous system learn (Schore, 1994, 2003).

Small-t Trauma and Large-T Trauma

Trauma is often described in two broad forms. Large-T trauma refers to events that clearly threaten your life, bodily integrity, or safety: combat, assault, catastrophic injury, disaster, a deadly crash, a shooting, or the violent death of another person. Small-t trauma refers to experiences that may appear less dramatic when viewed individually but become damaging through repetition: chronic criticism, humiliation, bullying, emotional neglect, parental volatility, rejection, instability, or the persistent absence of comfort and attunement (McLaughlin et al., 2012; Schore, 2003).

The words small and large can be misleading. They describe broad patterns of exposure, not the depth of a person's pain. There is nothing small about spending years in a home where you never knew who would explode, whether your needs mattered, or whether anyone would protect you. Repeated experiences of fear, shame, abandonment, or emotional isolation can teach the body that connection is dangerous, safety is temporary, and vulnerability carries a cost.

Developmental trauma is especially powerful because it occurs while your brain and nervous system are being organized. Your body can learn to expect danger before you have words for danger. You may learn to scan faces, silence your needs, stay invisible, become self-sufficient, or prepare for rejection because those responses help you survive the environment in which you are growing (Schore, 1994, 2003).

Large-T and small-t trauma are not competing explanations. They can accumulate. Early adversity may tune your nervous system toward vigilance, mistrust, rapid mobilization, or collapse. Later shock trauma

can then land on a system already carrying a substantial defensive load. What happens during combat or emergency service is consequential in its own right, but it may also activate patterns your body learned much earlier. The current wound and the older wound can become linked.

The landmark Adverse Childhood Experiences study helps make this cumulative burden visible. Felitti and his colleagues examined categories of childhood adversity that included psychological, physical, and sexual abuse; violence in the home; and living with family members affected by addiction, serious mental illness, suicidality, or incarceration. They found a graded relationship between the number of adversity categories participants reported and their risks for later difficulties. As the number of ACE categories increased, risks for emotional distress, health-risk behavior, addiction, and chronic medical problems also tended to increase (Felitti et al., 1998).

Among participants reporting four or more ACE categories, the researchers found markedly elevated risks for depression, suicide

attempts, alcohol and drug misuse, and several other health-risk behaviors. Greater ACE exposure was also associated with adult medical problems, including ischemic heart disease, cancer, chronic lung disease, liver disease, and skeletal fractures (Felitti et al., 1998). Childhood adversity has likewise been associated with later difficulties in emotional regulation and psychiatric functioning (McLaughlin et al., 2012; Shields & Cicchetti, 1997).

One striking finding was the relationship between ACE scores and intravenous drug use. The percentage of participants reporting injected drug use rose as ACE scores increased (Felitti et al., 1998). This does not mean that childhood adversity automatically causes addiction. It means that substance use may sometimes be connected to pain and dysregulation that began long before the substance use itself.

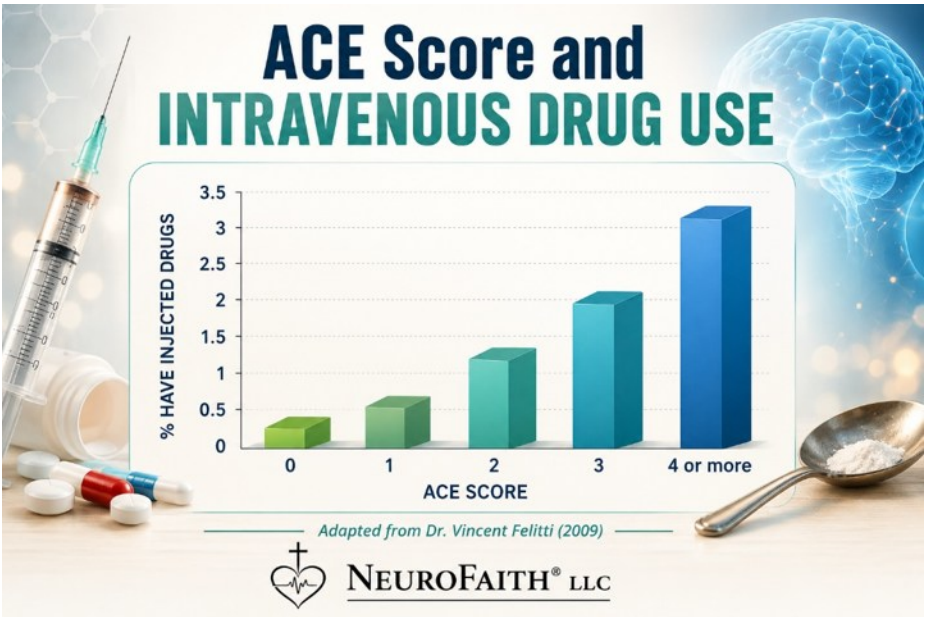


Figure. Intravenous drug use increased as ACE scores rose, illustrating the graded relationship between cumulative childhood adversity and later health-risk behavior (Felitti et al., 1998).

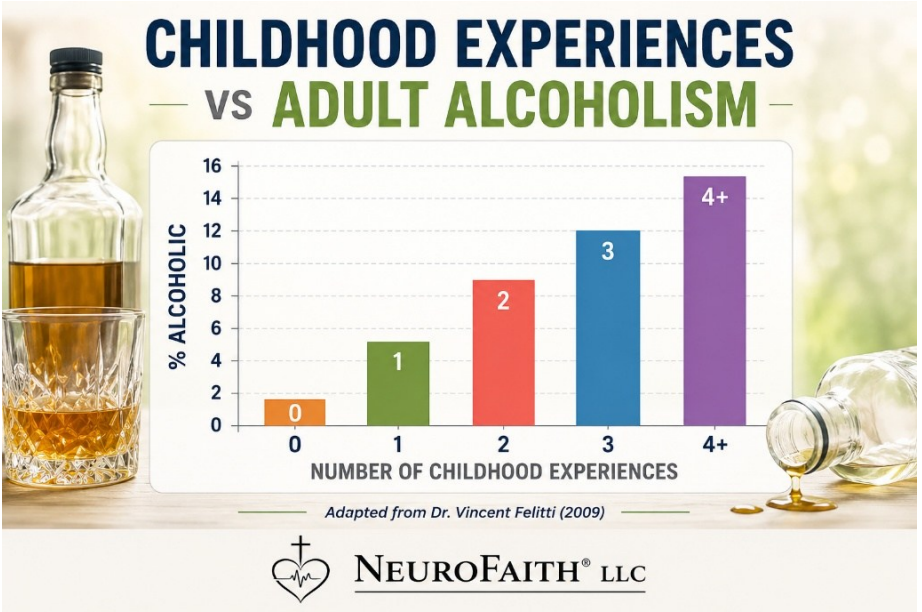


Figure. Adult alcohol use increased as ACE scores rose, illustrating the graded relationship between cumulative childhood adversity and later health-risk behavior (Felitti et al., 1998).

This relationship becomes easier to understand when you ask what a substance may be doing for the nervous system. If you grew up surrounded by threat, instability, neglect, or humiliation, you may have learned to live with chronic activation, emotional pain, emptiness, or shutdown. Alcohol or other drugs may later offer temporary relief, energy, numbness, sleep, confidence, or escape. What is eventually labeled addiction may have begun as an attempt to regulate a body carrying more distress than it knew how to manage.

Understanding that function does not make drug use safe or remove personal responsibility. It helps explain why simply telling someone to stop is often insufficient. If a substance has become your fastest route out of terror, shame, agitation, or collapse, recovery must provide safer ways to regulate those states. The behavior must be addressed, but so must the pain the behavior has been managing.

An ACE score is not a diagnosis, a complete account of your childhood, or a prediction of your future. It measures exposure, not destiny. It also cannot fully capture the people and experiences that may have protected you. A trustworthy adult, a grandparent, a coach, a teacher, a chaplain, a strong unit, effective treatment, faith, community, or a safe relationship can provide experiences that support resilience and new learning. Early adversity may increase vulnerability, but it does not erase your capacity to heal.

This helps explain why you and another person can endure the same call, firefight, explosion, or loss and emerge differently. The difference is not courage or character. You did not arrive with the same history, relationships, biology, accumulated losses, sleep, support, or prior burden. The event may be a terrible injury by itself, or it may strike an older wound and confirm what your body learned long ago: no place is safe, nobody will come, and I must never let my guard down.

Recognizing this layered history changes the questions we ask. Instead of asking, "Why am I reacting this way when others seem fine?" you can ask, "What has my nervous system lived through, and what has it learned to expect?" Your reactions can then be understood not as weakness or failure, but as protective responses shaped across time. This does not excuse harmful behavior. It replaces condemnation with clarity and creates a more honest starting point for change.

Healing may therefore need to address more than the most recent event. The firefight, assault, crash, rescue, or loss that brought you into treatment may be the injury you recognize most clearly, but not the only injury your body carries. Present-day triggers can awaken older experiences of helplessness, rejection, humiliation, or abandonment. A conflict, criticism, or silence may then carry emotional force far beyond the present moment.

This does not mean that every problem must be traced to childhood or that treatment requires endlessly revisiting the past. It means that effective care should remain curious about the whole story. Healing may begin with safety, sleep, stabilization, and nervous-system regulation before moving toward painful memories. It may also require learning that closeness can be safe, needs can be spoken, limits can be respected, and help can arrive without humiliation.

For service members, veterans, and first responders, this broader understanding protects against two damaging conclusions: that you should have handled the event better because someone else did, or that your symptoms prove you are permanently broken. Neither conclusion is warranted. Your response reflects the interaction of what happened, what came before it, what followed it, and what support was available when you needed it.

Early adversity can increase the burden of later shock trauma, but it does not determine your future. Your nervous system learned through relationship and experience, and it can continue learning in the same ways. Treatment can help separate the current wound from the older one, strengthen your capacity to remain present, and create new pathways toward safety, connection, and choice. The goal is not to erase your history. It is to help your history stop commanding every moment of your present life.

The central truth of this chapter: What looks like pathology is often protection that has outlived the danger for which it was created.

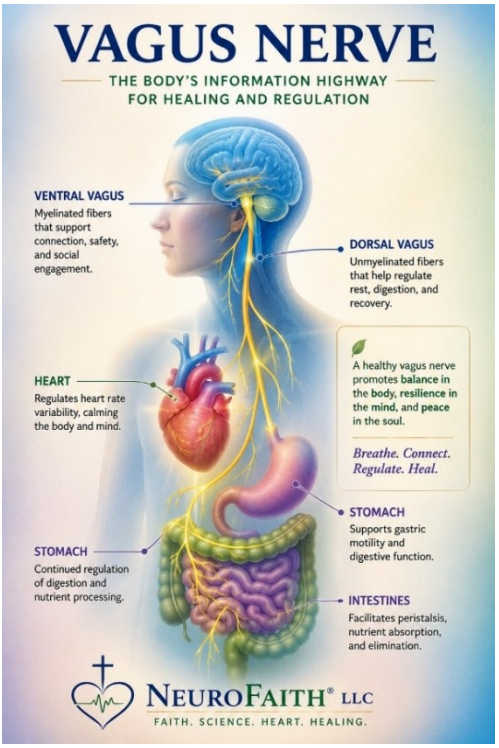
Your Autonomic Nervous System

The autonomic nervous system manages the functions that operate largely outside conscious control: heart rate, breathing, digestion, blood pressure, sweating, energy conservation, and many features of the stress response. It is constantly evaluating what is happening inside you, around you, and between you and other people. Stephen Porges uses the term neuroception to describe the nervous system's detection of cues of safety, danger, and life threat without requiring conscious thought (Porges, 2011, 2017). Your body can therefore begin reacting before your thinking mind has decided that anything is wrong.

Polyvagal theory gives us a useful way to understand three broad physiological states. These states are not moral categories, diagnoses, or personality types. They are adaptive platforms from which the brain and body organize behavior. A healthy nervous system is not one that remains calm every moment. It is one that can move into defense when necessary and then return when the danger has passed (Porges, 2011, 2017).

The Wandering Nerve: A Brain–Body Conversation

Before we look at those states, it helps to meet the nerve at the center of this discussion. Vagus comes from a Latin word meaning "wandering," an appropriate name for a nerve that travels widely through your body. The vagus is your tenth cranial nerve, often called cranial nerve X. It begins in the brainstem and travels through the neck into the chest and abdomen, communicating with many major organs, including the heart, lungs, and digestive tract. It does not literally touch every organ, but its reach is remarkable (Porges, 2011, 2017).



The vagus nerve carries information in both directions. Roughly 80 percent of its fibers are afferent, carrying sensory information upward from the body toward the brain, while roughly 20 percent are efferent, carrying instructions from the brain toward the body. That ratio does not mean your brain matters only 20 percent. It means the conversation is heavily informed by what is happening below your neck. Your heartbeat, breathing, gut, inflammation, and other internal conditions are continually sending reports upward, shaping how you feel and how safe the world seems before you put those sensations into words (Porges, 2011, 2017).

This two-way traffic helps explain why trauma cannot be understood as "all in your head." Your brain influences your body, and your body constantly influences your brain. A tightening chest, a churning stomach, a change in breathing, or a sudden drop in energy is not meaningless noise. It is information moving through a living brain–body system. Learning to notice that information without immediately fearing or fighting it is one way you begin to befriend your nervous system.

Porges describes two vagal pathways that support different forms of regulation. The newer **ventral vagal pathway** is closely associated with social engagement, connection, and flexible calm. The older **dorsal**

vagal pathway is involved in basic organ regulation and, under overwhelming threat, can contribute to immobilization and shutdown. These pathways have different brainstem origins; it is more accurate to think of them as distinct branches of the vagal system than as a single nerve that suddenly splits at one point. Along with the sympathetic system, they give us a user-friendly map of how your body moves among connection, mobilization, and conservation (Porges, 2011, 2017).

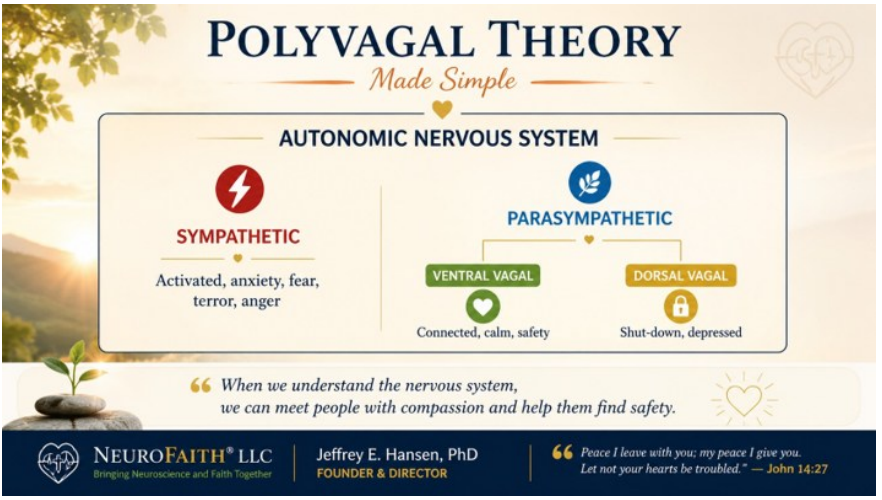


Figure. A simplified overview of autonomic defense and connection states.

Ventral Vagal: Safety, Connection, and Growth

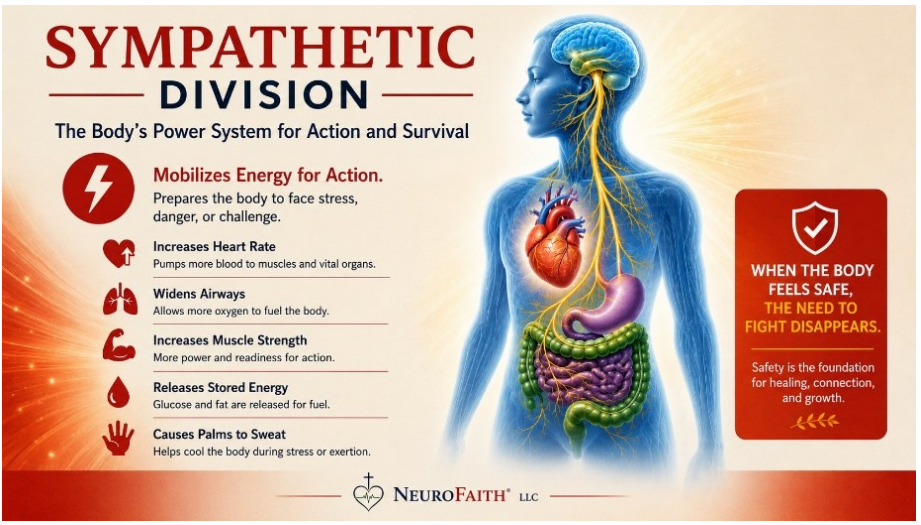
The ventral vagal system supports social engagement, connection, curiosity, flexible thinking, and the capacity to be present with other people. In this state, your face is more expressive, your voice carries greater warmth and variation, you can take in more of the environment, and you can think beyond immediate survival. You can rest without becoming defenseless and act without being consumed by urgency (Porges, 2011, 2017).

This is the physiological ground in which growth becomes possible. Children develop through repeated experiences of safe connection.

Adults continue to need connection to regulate, recover, create meaning, and heal. Ventral vagal regulation does not mean weakness, passivity, or the absence of readiness. A seasoned soldier, police officer, firefighter, or paramedic can remain alert while still being relationally present and physiologically flexible. The goal is not to eliminate mobilization. The goal is to prevent mobilization from becoming the only state your body trusts (Porges, 2011, 2017; Schore, 2003).

Sympathetic: Mobilization for Action

When danger is detected, the sympathetic nervous system mobilizes the body. Heart rate increases. Breathing changes. Blood is redirected toward large muscles. Attention narrows. Digestion becomes less important. Adrenaline and related stress chemicals help produce speed, force, vigilance, and rapid decision-making. This is the physiology of fight and flight, and it can be lifesaving (Porges, 2011, 2017).



In combat or emergency work, sympathetic activation can help you move toward danger when every ordinary instinct would tell you to move away. It can help you carry weight, ignore pain temporarily, scan for threat, and act within seconds. The problem is not that this system

activates. The problem is that repeated exposure can teach it to remain activated, to fire too easily, or to treat ordinary life as an extension of the operational environment.

At home, persistent sympathetic activation may look like anger, impatience, pacing, insomnia, startle responses, controlling behavior, excessive exercise, overwork, or an inability to sit with quiet. You may tell yourself that you simply do not tolerate foolishness anymore. Sometimes that is partly true. But sometimes your window for frustration has narrowed because your body is already operating close to the edge.

Dorsal Vagal: From Healthy Conservation to Protective Shutdown

Your autonomic nervous system includes sympathetic and parasympathetic pathways, and you need both. The sympathetic system mobilizes you for action. It increases energy, sharpens attention, and prepares you to fight, flee, protect others, or complete the mission. The parasympathetic system helps you slow down, digest food, sleep, restore energy, and repair after exertion. In healthy regulation, these systems work together. You mobilize when action is required, and when the danger passes, your body receives permission to stand down and recover.

The dorsal vagal pathway is part of this parasympathetic system, and it is not inherently bad. It contributes to the ongoing regulation of internal organs, particularly those involved in digestion and energy conservation. Healthy slowing allows you to rest, recover, and rebuild. It helps your body conserve resources after demanding physical or emotional effort. Without parasympathetic regulation, you would remain mobilized continuously, and your body would have little

opportunity for sleep, digestion, restoration, or healing (Porges, 2011, 2017).

The difficulty arises when conservation becomes extreme defensive shutdown. If your nervous system detects overwhelming danger and determines that fighting or escaping will not work, it may move beyond sympathetic mobilization into immobilization. Energy drops sharply. Your body may become heavy, numb, distant, or collapsed. Thinking can slow, emotion may disappear, and connection can feel unreachable. You may withdraw, sleep excessively, stare into space, feel unreal, or lose interest in people and activities that once mattered. Within polyvagal theory, this protective reaction is associated with dorsal vagal shutdown (Porges, 2011, 2017).

This response is not evidence that the dorsal vagal system is defective. It is evidence that a useful survival system has been recruited under extreme conditions. When action cannot change what is happening, reducing energy, sensation, and awareness may help you endure the unbearable. On a battlefield, during captivity, after a catastrophic loss, or in a situation in which you cannot fight, flee, or rescue someone, shutting down may be the only defensive option your nervous system has left.

The problem comes when your body carries that wartime solution into a world in which the original danger is no longer present. You may be physically home while your nervous system continues to conserve energy as though movement, emotion, or connection would expose you to danger. What once helped you survive can then leave you isolated, exhausted, and unable to participate fully in the life you returned home to protect.

Shutdown is often mistaken for laziness, indifference, weakness, or a lack of discipline. For service members, veterans and first reponders, that judgment can be especially painful because competence, endurance, and action have been central to your identity. Yet shutdown is not the absence of a survival response. It is a survival response. Your nervous system is not refusing to work; it is working from an old conclusion that mobilization is no longer possible or safe.

You may also move between sympathetic activation and dorsal shutdown. You can go from agitation into collapse, from rage into numbness, or from intense productivity into complete exhaustion. You may appear highly functional while feeling detached inside. These shifts are not contradictions. They are different defensive strategies being used by the same nervous system.

Recognizing the difference between healthy parasympathetic restoration and defensive dorsal shutdown gives you a more useful map. Healthy restoration leaves you rested, present, and increasingly able to reconnect. Shutdown leaves you numb, disconnected, depleted, or unable to respond. Instead of asking, "What is wrong with me?" you can begin asking, "What state is my nervous system in? What is it trying to protect me from? What might help it recognize that I am safe enough to return?" (Porges, 2011, 2017).

Your body is not betraying you when it shuts down. It is applying a powerful survival strategy beyond the circumstances for which that strategy was designed. Healing does not require you to fight or condemn this response. It involves helping your nervous system distinguish between danger that requires defense, safety that permits restoration, and connection that makes returning to life possible.

The Chemistry of Survival

Adrenaline and cortisol are frequently described as harmful stress hormones, but that description is incomplete. They are part of a sophisticated survival system. Adrenaline helps mobilize immediate action. Cortisol helps make energy available, supports vigilance, and temporarily reallocates resources away from functions that are less urgent during danger. In an emergency, this is exactly what you want your body to do (McLaughlin et al., 2012; Porges, 2011).

Short-term survival, however, has different biological priorities than long-term health. The body can postpone digestion, sleep, repair, reproduction, and some immune functions for a short period because

surviving the next five minutes matters more. It cannot postpone them indefinitely without cost. When threat activation becomes chronic, stress chemistry can contribute to disrupted sleep, impaired concentration, irritability, metabolic strain, inflammation, cardiovascular burden, changes in appetite, and difficulty regulating mood (Felitti et al., 1998; McLaughlin et al., 2012).

Cortisol is not a toxin that must be eliminated. You need it. The destructive force comes from dysregulation: too much for too long, poorly timed release, or a stress system that no longer rises and falls in a healthy rhythm. Chronic activation can also alter how memory is encoded and retrieved. The brain becomes highly efficient at remembering danger while having difficulty placing the danger firmly in the past (McLaughlin et al., 2012; Schore, 2003).

This is one reason traumatic memory can feel present rather than historical. A smell, sound, road condition, facial expression, or time of day may activate the same survival network that was active during the original event. The body responds to the cue as if the danger is happening now. Your reasoning brain may know that you are in Arizona, at home, in a grocery store, or driving a familiar road. Your survival brain may be responding to Afghanistan, the fire scene, the emergency department, or the night your partner died (Porges, 2011; Schore, 2003).

When the Alarm Becomes the Baseline

Repeated exposure changes what the nervous system considers normal. A firefighter may become accustomed to entering structures that everyone else is fleeing. A police officer may spend years watching hands, doors, waistbands, traffic flow, and blind corners. A medic may learn to function while surrounded by blood, grief, chaos, and

helplessness. A soldier may live for months in an environment where missing one cue can cost lives. The brain adapts through repetition (Porges, 2011, 2017).

Those adaptations can become deeply ingrained. Hypervigilance is valuable downrange and exhausting in a shopping center. Emotional compartmentalization can help you complete the mission and make it difficult to be emotionally present with your spouse. Rapid threat assessment can save a partner and can also cause you to misread ordinary disagreement as danger or disrespect. The very skills that made you effective may create suffering when the operational context is gone.

This is not because the training was wrong. It is because the nervous system generalizes. It would rather produce a false alarm than miss a lethal threat. From a survival standpoint, that bias makes sense. From the standpoint of marriage, parenting, sleep, friendship, and peace, it can become costly.

Trauma, Relief, and Addiction

When your nervous system remains trapped in activation or collapse, relief becomes biologically compelling. Alcohol may quiet sympathetic arousal. Opioids may soften emotional and physical pain. Stimulants may temporarily lift shutdown. Pornography, gambling, food, work, risk, gaming, or compulsive exercise may change your state quickly enough to feel like rescue. What begins as a search for relief can gradually become a trap.

This is why addiction and trauma so often travel together. A substance or behavior can become an external regulator, changing your body when you do not yet have a reliable way to change it through connection, awareness, movement, breathing, grief, truth, or safe relationship.

Over time, the solution creates another injury. Tolerance grows, freedom narrows, shame deepens, and the nervous system becomes even less flexible (Felitti et al., 1998).

Understanding what the behavior does for you does not make it harmless or remove responsibility. It changes the doorway through which recovery begins. If your primary method of regulation is taken away before you develop safer ways to regulate, you are left face-to-face with the pain it was managing. Recovery therefore involves more than stopping a behavior. It helps your body rediscover safety, connection, and choice.

Why Earlier Trauma Can Make Later Trauma Heavier

Imagine your nervous system as a smoke detector. In a stable early environment, the detector learns to distinguish burnt toast from a house fire. It sounds when necessary and quiets when the danger is resolved. In a chaotic or frightening environment, it may be calibrated to extreme sensitivity. That sensitivity is not foolish. It accurately reflects the world in which it developed.

Later combat or first-response trauma can intensify that calibration. You do not enter the event as a blank slate. You bring a lifetime of implicit expectations about danger, trust, helplessness, responsibility, and whether other people will respond. A present-day event can therefore carry its own terror and the emotional weight of earlier experience. The current wound and the older wound become linked.

This can help you understand a reaction that seems out of proportion to one incident. The incident may not be the whole story. A supervisor's public humiliation can activate years of childhood degradation. A partner's withdrawal can awaken the terror of emotional abandonment. Being physically trapped in a vehicle can connect with an earlier

experience of helplessness. Your body recognizes patterns, not just dates.

This is not a contest over whose trauma was worse. It is an explanation of load. The more weight your nervous system has carried, the less reserve may be available when another burden arrives. That cumulative burden deserves compassion and careful treatment, not guilt.

The Brain Is Changed Through Experience

Trauma can shape your attention, emotion, memory, stress physiology, relationships, and even patterns of gene expression. Adverse childhood experiences research shows that early adversity is associated not only with psychological distress but also with addiction, chronic illness, and premature mortality (Felitti et al., 1998). Epigenetic research adds another layer: experience can influence which biological instructions are more or less active without changing the underlying DNA sequence (Moore et al., 2013).

This sounds ominous, but the same principle carries hope. A brain changed through experience remains capable of new experience. A nervous system trained by danger can be trained through safety. This is not quick positive thinking, and it is not pretending that terrible things did not happen. It is repeated biological learning. The body experiences activation and then return. You feel distress and remain connected. You remember without being completely overtaken. You set a boundary without losing the relationship. You discover that calm is not the same as vulnerability and that connection is not the same as surrender.

Neuroplasticity does not erase history. It allows history to stop dictating every present response. Over time, the nervous system can become more flexible. The goal is not permanent ventral vagal calm. No living person stays in one state, and no warrior or responder should lose

the ability to mobilize. The goal is range: the ability to respond to real danger, recover when it is over, remain connected when connection is safe, and avoid being pulled automatically into old defense patterns by every reminder (Porges, 2011, 2017; Schore, 2003).

From Survival to Regulation

Healing begins by learning to notice your state without judging it. Before you can change a pattern, you must recognize it. What happens in your body before anger? Does your chest tighten? Does your jaw set? Does your vision narrow? What happens before shutdown? Do sounds become distant? Does your body feel heavy? Do you stop making eye contact? These signals are not failures. They are information.

The next step is developing reliable pathways back toward regulation. Because trauma is embodied and relational, healing must involve more than intellectual insight. Your nervous system learns through experience: predictable relationships, safe eye contact, voice tone, paced breathing, movement, sleep, appropriate touch, prayer, honest grief, boundaries, and repeated moments in which connection does not lead to harm. Your entry point should match your state. If you are highly activated, you may need grounding and a safe discharge of mobilized energy. If you are shut down, you may need gentle activation before quiet breathing is useful.

Connection is especially important. Schore's work reminds us that regulation develops in relationship, and Porges' work helps explain why cues carried through face, voice, proximity, and reciprocity can tell the nervous system that safety is possible (Porges, 2011; Schore, 2003). You may have survived by becoming radically self-sufficient. Healing often requires learning that dependence and connection can be wise, bounded, and safe.

For active duty members, veterans, and first responders, this is not a call to become less strong. It is an invitation to broaden the meaning of strength. Strength includes the capacity to mobilize, but it also includes the capacity to stand down. It includes tolerating tenderness, receiving help, staying present with grief, and allowing the people who love you to know where you are.

Your Biology Did Not Betray You

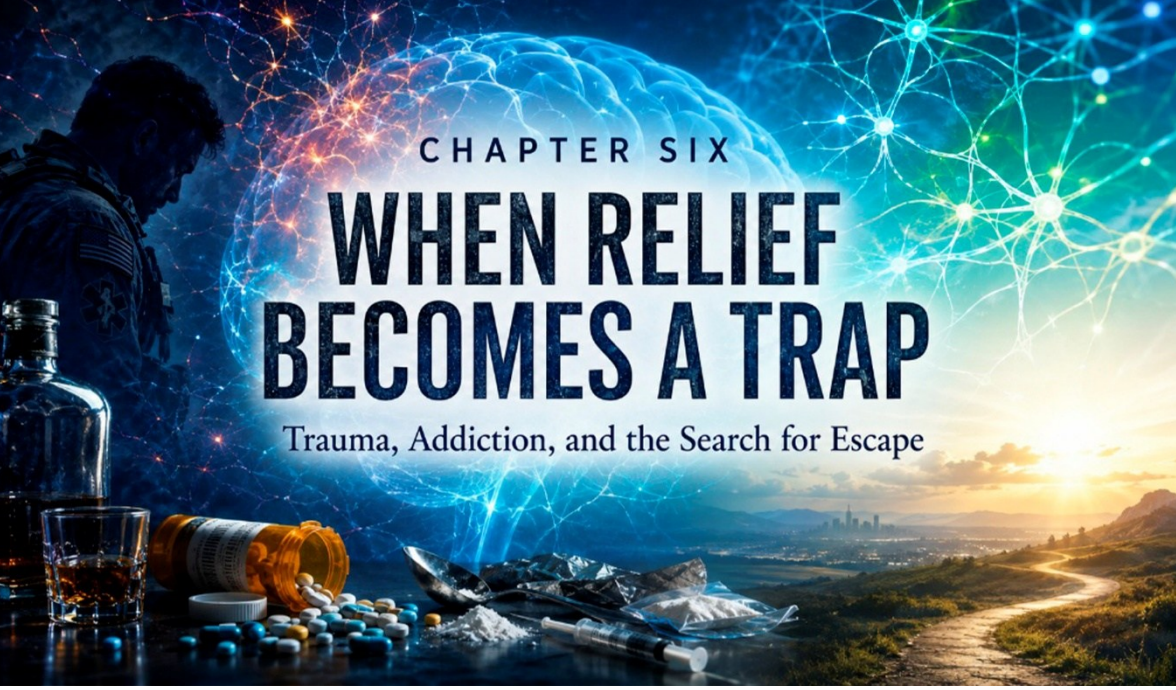
Your nervous system learned from every environment in which you had to survive: childhood homes, school hallways, training grounds, deployment, fire scenes, patrol cars, emergency rooms, funerals, marriages, losses, and long nights when nobody knew what you carried. Those lessons helped you endure. Some of them may now separate you from the life you fought to preserve.

You do not have to make your body the enemy in order to change. You can befriend your survival system, honor what it did, and still teach it something new. You can say, in effect, "Thank you for keeping me alive. I need you to recognize that we are here now. The people in this room are not the enemy. Rest is not negligence. Love is not an ambush. I can remain strong without remaining at war."

Healing is not forgetting the battlefield. It is helping your brain And body recognize that the battlefield is not everywhere.

Understanding is not the whole of healing, but it changes the direction of the fight. Instead of battling your body, you can become curious about its signals and help it update its map of the present. The work ahead will build on that foundation. We will approach symptoms as

meaningful adaptations, create enough safety for your nervous system to become flexible, restore connection to your body and to other people, and integrate faith without using faith to deny pain. What happened to you matters. What your body did to survive makes sense. And what your nervous system learned can continue to change.



"For what I want to do I do not do, but what I hate I do."
—Romans 7:15

The Relief Came Before the Trap. If addiction has touched your life, you may already know the contradiction in Paul's words. Part of you wants to stop. Another part reaches again for the drink, pill, drug, screen, bet, or behavior you promised yourself you would leave alone. That conflict can make you feel dishonest, weak, or divided against yourself. But condemnation does not explain what happened, and it rarely creates a path out.

For many veterans, service members, and first responders, the addictive behavior did not begin as a desire to destroy your life. It began as a way to get through it. Alcohol may have quieted the vigilance that followed you home. An opioid may have softened physical pain and, for a while, emotional pain with it. A stimulant may have helped you stay awake, feel capable, or rise out of numbness. Cannabis may have slowed racing thoughts. Gambling, pornography, gaming, work, or risk may have changed your internal state when you did not know how else to change it.

In other words, what later became the problem may once have felt like the solution. It worked—until it began demanding more than it gave. Relief became reliance. Reliance became repetition. Repetition changed the brain and body. Eventually, you may have found yourself using not to feel good, but simply to feel less bad, less restless, less empty, or more normal (Grisel, 2019; Koob & Volkow, 2016).

That history matters. It does not erase the harm addiction can cause, and it does not remove your responsibility for what you do next. It does, however, replace a moral caricature with a more truthful question: What pain, state, or need was this behavior trying to manage—and what has repeated use now done to your capacity to choose?

Did You Inherit a Disease?

You will often hear addiction described as a disease. That language has value when it reminds us that severe addiction is not simply bad character or a failure to try hard enough. A substance use disorder can involve genuine changes in reward, stress, learning, habit, and executive-control systems. Those changes can become persistent, life-threatening, and difficult to reverse without help (Koob & Volkow, 2016).

But the phrase can become misleading if it leaves you believing that you inherited a fully formed addiction that was waiting inside you from birth. You do not inherit an addiction in the same simple way you inherit eye color. You may inherit a degree of vulnerability: differences in temperament, stress sensitivity, impulsivity, metabolism, or the way reward feels. Heritability describes probability within a population; it does not announce your destiny.

Your vulnerability also meets a life. Trauma, family patterns, military or public-safety culture, chronic pain, sleep deprivation, availability of substances, isolation, loss, relationships, opportunity, and repeated learning

all matter. For many people, the sequence is not disease first and behavior second. The sequence is vulnerability and distress, followed by an available form of relief, followed by repetition, adaptation, and an increasingly entrenched disorder.

> **A useful distinction**
>
> Addiction can become a real disease-like disorder without having been a fully formed disease that caused your first use. Biology may influence your susceptibility; trauma and context may help initiate the search for relief; repeated use can then alter the system that makes future choice possible.

This is not a word game. It changes how you understand yourself. If you believe you were born broken and will always be controlled by an inherited disease, you may feel powerless. If you believe addiction is only a bad decision, you may drown in shame when willpower alone fails. A more complete account holds both truths: your choices matter, and repeated addictive behavior can progressively constrain choice. Your biology is involved, but biology is not a verdict.

Your Reward System Was Built to Teach You

As we discussed in the neurobiology of trauma, your brain and body are built to learn from what helps you survive. The reward system is part of that learning machinery. It helps you notice what is important, move toward it, remember it, and repeat it. Food, attachment, achievement, novelty, intimacy, and belonging all recruit this system because they matter to life.

Dopamine is often called the brain's pleasure chemical, but that description is incomplete. Dopamine is strongly involved in motivation, salience, anticipation, learning, and seeking. It tells you, in effect, Pay attention—this

may matter; go get it again. The pleasure or satisfaction of the experience involves a broader network, including the brain's own opioid systems. A useful shorthand is that dopamine contributes heavily to wanting, while endogenous opioids contribute to liking (Weinschenk, 2009; Wilson, 2014).

Addictive substances and behaviors exploit this teaching system. They can deliver an unusually rapid, reliable, or intense change in state without the ordinary delay and effort built into natural rewards. Your brain is not asking whether the relief will cost your marriage, career, health, freedom, or peace five years from now. It is learning from what changed your state now.

Wanting More and Liking It Less

With repetition, cues linked to the addiction gain power. A time of day, a route home, a paycheck, an argument, a familiar bar, a prescription bottle, loneliness, pain, or the end of a shift can begin to trigger anticipation before you consciously decide anything. Neural pathways that are repeatedly activated become easier to activate again. This is sensitization: the system becomes increasingly responsive to the substance or behavior and to the cues surrounding it (Didinger, 2018; Wilson, 2014).

At the same time, the brain tries to protect its balance. Repeated overstimulation can reduce responsiveness, leaving ordinary sources of satisfaction muted. Family, friendship, worship, exercise, work well done, and quiet moments may seem flat beside the intensity of the addictive reward. You need more to produce less. This is desensitization and tolerance—the cruel progression in which wanting grows even while liking fades (Wilson, 2014).

The brain changes described by proteins such as DeltaFosB and CREB offer a microscopic view of this learning and adaptation. You do not need to memorize the molecules to grasp the pattern. One set of changes strengthens the message that the behavior is important and must be

repeated; another tries to dampen an overloaded reward system. The combined result can be stronger cue-driven craving, less pleasure from normal life, and escalating use in the effort to recover an effect that is slipping away (Wilson, 2014).

Repeated use also affects the networks that help you pause, weigh consequences, inhibit an impulse, and keep a future goal in mind. The prefrontal cortex does not disappear, but its braking influence can lose ground when powerful reward, habit, and stress systems are repeatedly rehearsed. That is one reason sincere promises made in a calm moment may collapse when pain, opportunity, withdrawal, or a conditioned cue arrives (Didinger, 2018; Koob & Volkow, 2016).

When Pleasure Turns Into the Avoidance of Pain

Judith Grisel's discussion of opponent processes helps explain one of addiction's most painful reversals. Your nervous system works to maintain balance. When a substance pushes the system strongly in one direction, the body generates an opposing response. At first, the desired effect is prominent and the aftereffect is modest. With repetition, the desired effect weakens and the opposing state grows stronger (Grisel, 2019).

The drink that once brought relaxation may be followed by greater anxiety and disturbed sleep. The stimulant that produced energy may leave exhaustion, depression, and agitation. The opioid that created warmth and relief may be followed by pain, sickness, and dread. Eventually, you may return to the substance less to reach heaven than to escape the hell that follows its absence.

This is the shift from positive reinforcement—using because something desirable happens—to negative reinforcement—using because an unbearable state temporarily stops. You may say, I need it to sleep, to face people, to stop shaking, to quiet my mind, to work, or just to feel normal.

By then, the substance is no longer merely adding an experience. Your system has adapted around it (Grisel, 2019; Koob & Volkow, 2016).

Trauma, Autonomic State, and the Search for Regulation

Earlier, we explored how trauma can pull you out of a regulated state and into sympathetic mobilization or dorsal vagal shutdown. We do not need to repeat that physiology here. What matters now is the connection: addictive substances and behaviors can become fast, dependable tools for changing an autonomic state.

If you live in sympathetic overdrive, you may reach for something that slows you down. If you live with collapse, deadness, or disconnection, you may seek intensity to feel awake and alive. If your body alternates between the two, you may alternate substances or behaviors as well—one to activate, another to come down. The nervous system learns the shortcut because the shortcut works quickly, even when its long-term price is devastating (Porges, 2011, 2017).

This is why simply removing the substance, though essential, may leave a frightening vacancy. The original pain, vigilance, loneliness, shame, injury, or shutdown may still be there, now joined by craving and withdrawal. Lasting recovery therefore asks more than What must I stop? It also asks What did this do for me, what state was I trying to change, and how can I learn to meet that need without destroying myself?

A Brief Field Guide to Common Traps

The Different Roads Into the Same Trap

Every addictive substance changes your state in its own way. Alcohol broadly slows and disinhibits. Opioids quiet pain and produce warmth. Stimulants accelerate energy, attention, and confidence. THC changes perception, memory, and emotional distance. Compulsive behaviors can create anticipation, novelty, intensity, or escape without introducing a drug into the bloodstream. Those differences matter because the substance or behavior you choose often tells a story about the state you are trying to leave.

At the same time, the roads begin to converge. The brain learns the cue. Wanting grows. The desired effect becomes less reliable. The aftereffect becomes stronger. The next use is increasingly driven by discomfort, habit, and urgency. The details below are more than a catalog of dangers. They are an invitation to recognize the bargain each substance offers, why that bargain may feel irresistible after trauma, and how the terms change once your nervous system adapts.

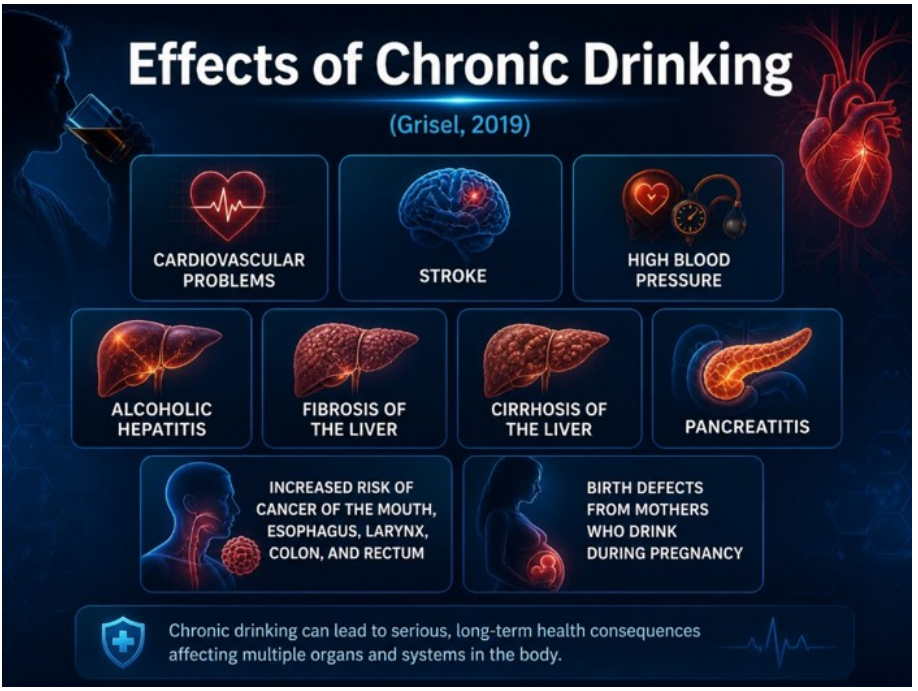
Alcohol: The Socially Accepted Downshift

Alcohol is often the most culturally available route into addiction. It is legal, familiar, and woven into celebrations, unit traditions, retirement ceremonies, post-shift gatherings, sporting events, and the ordinary language of taking the edge off. That familiarity can hide the transition from social use to self-medication. You may not think of yourself as using a drug. You may simply believe you are having a few drinks so you can finally relax.

Unlike a substance that acts primarily at one receptor, alcohol spreads its effects across several neurotransmitter systems. It enhances GABA, the brain's major inhibitory messenger, and suppresses glutamate, a major excitatory messenger. The result can feel like a welcome lowering of internal volume. Your shoulders drop. Your thoughts slow. Social fear recedes. The memories remain farther away. For a nervous system that has spent the day, or years, on watch, alcohol can feel like permission to stand down (Grisel, 2019).

That downshift is especially seductive after trauma. Hypervigilance can make quiet feel impossible. You may scan a restaurant, sit facing the door, wake at the smallest sound, or feel unable to stop reviewing the call, firefight, crash, or face you could not save. Alcohol can suppress some of that activation quickly. It can also reduce inhibition, which may temporarily make connection, laughter, affection, or emotional

disclosure easier. The drink does not heal the wound; it changes your awareness of it.

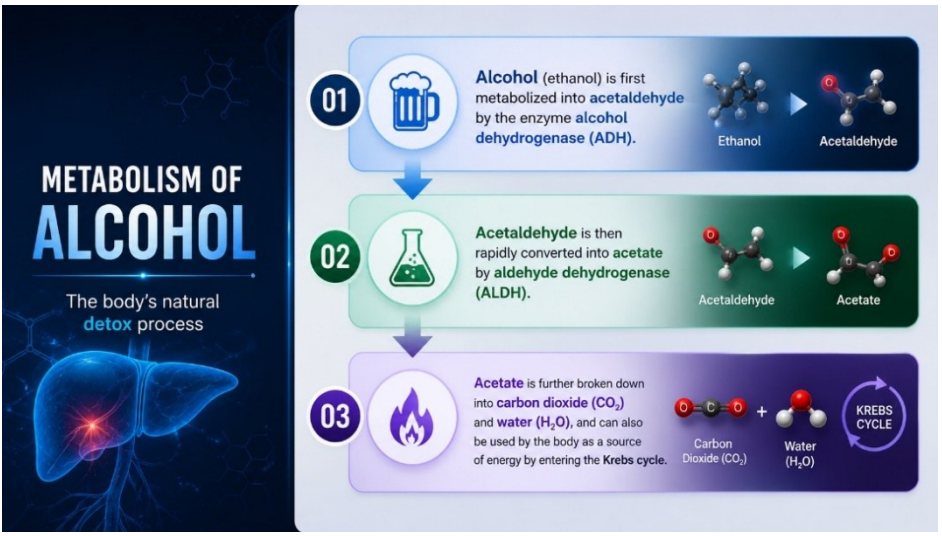


The same broad slowing that provides relief also impairs judgment, coordination, reaction time, and memory. You may say something you would not have said sober, drive when you should not, become more irritable, misread another person's intentions, or lose pieces of the night. Because trauma has already sensitized the threat system, alcohol-related disinhibition can release anger that was being tightly controlled. What felt like calming at the beginning of the evening may end in an argument, risky behavior, shame, or another traumatic event.

Alcohol can also deceive you about sleep. It may help you fall asleep faster, but sedation is not the same as restorative sleep. As the alcohol is metabolized, sleep becomes more fragmented and the nervous system can rebound toward activation. You may wake early with a pounding heart, anxiety, sweating, or dread. The next evening, another drink

seems to solve the problem the previous drinking helped create. This is the opponent process in everyday form: the borrowed calm is followed by a nervous system that is less calm when the drug is gone (Grisel, 2019).

Your liver first converts alcohol into acetaldehyde, a toxic compound, and then into acetate. Repeated heavy exposure places strain not only on the liver but also on the cardiovascular, gastrointestinal, immune, and nervous systems. Over time, the risks can include high blood pressure, cardiac problems, pancreatitis, fatty liver, hepatitis, fibrosis, cirrhosis, several cancers, and cognitive impairment. These consequences often develop quietly, allowing a person to remain outwardly operational while the body is absorbing a growing cost.



Tolerance can make the risk harder to see. Being able to hold your liquor does not mean alcohol is harming you less. It means your system has adapted, so you may need more alcohol to notice the same subjective effect even while judgment, sleep, organs, and relationships continue to be affected. If you become physically dependent, drinking may shift from something you choose at night to something your body begins to

demand. Tremor, sweating, nausea, agitation, insomnia, or anxiety may appear when the alcohol level falls.

What alcohol may promise

I will turn down the alarm, help you sleep, make you less guarded, and give you a few hours away from yourself. The trap is that repeated use can worsen the alarm, damage sleep, weaken control, and make your body require the very substance that is destabilizing it.

For an active duty service member, veteran, or first responder, the warning sign is not simply how many drinks you consume. It is what role alcohol has assumed. Do you need it to come down, enter a room, tolerate closeness, stop remembering, or become someone your family can approach? Are you planning around it, hiding it, recovering from it, or breaking promises because of it? If heavy or prolonged drinking has created dependence, do not assume that courage means stopping abruptly on your own. Alcohol withdrawal can be medically dangerous and may require supervised care.

Opioids: The Comfort That Can Become Captivity

Opioids often enter a life through a legitimate door. You may have been injured in training, combat, a crash, a fire, a pursuit, or years of carrying gear and asking your body to do more than it was designed to do. A trusted clinician prescribed medication, and the medication worked. The pain receded. Perhaps you slept. Perhaps, for the first time in months, both your body and your memories became quiet.

Opiates such as morphine and codeine originate from the opium poppy. Opioid is the broader term and includes natural, semisynthetic, and synthetic drugs such as oxycodone, hydrocodone, heroin, methadone, and fentanyl. Although potency and duration vary, these drugs act on opioid receptors distributed through the brain, spinal cord, and body. Mu-opioid receptor activation is especially important in pain relief, euphoria, reward, and respiratory suppression (Kosten & George, 2002).

Opioids do more than block a pain signal. Pain has a sensory component, where it hurts and how much, and an emotional component, how alarming, intolerable, and consuming it feels. Opioids can soften both. That is why the relief may feel larger than the prescription's stated purpose. The medication may not only quiet your back, knee, burns, or nerve injury. It may soften grief, loneliness, moral injury, fear, and the strain of living in a body that never quite feels safe.

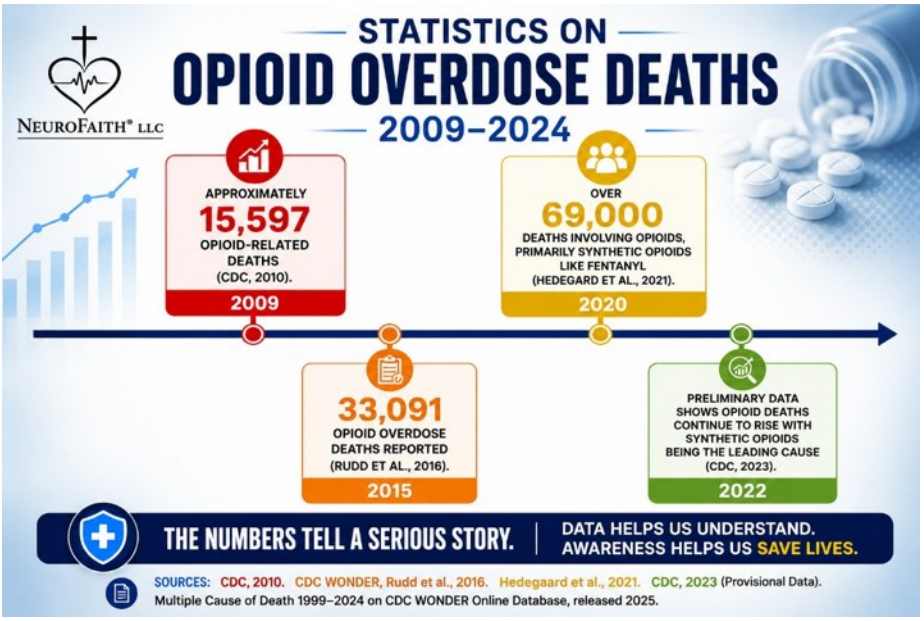
That combination is powerful. Your brain learns that one substance can rapidly replace pain with warmth, distress with distance, and vigilance with a sense that everything is finally all right. Dopamine-related learning marks the experience as important, while the opioid effect itself contributes to comfort and liking. The relief is real. So is the danger that your nervous system will begin treating the drug as essential (Koob & Volkow, 2016).

Tolerance means the same dose produces less of the desired effect. Physical dependence means your body has adapted to the drug's presence and reacts when it is removed. Neither condition by itself tells the entire story of addiction, but together they can accelerate the trap. You may increase the dose, take it sooner than prescribed, seek additional prescriptions, or turn to a cheaper and more available opioid when legitimate access closes. What began as pain care can become a daily effort to prevent withdrawal.

Opioid withdrawal is often experienced as the return of everything the drug suppressed, amplified. Pain rises. The body aches. Anxiety surges. Sleep disappears. Nausea, diarrhea, sweating, gooseflesh, and restlessness can make it feel as if every cell is demanding relief. At that point, using is no longer mainly about euphoria. It is about ending a state that feels impossible to endure (Kosten & George, 2002; Volkow & McLellan, 2016).

The most lethal opioid effect is respiratory depression. Opioids can slow the brainstem systems that keep you breathing automatically. The transition from sedation to fatal oxygen deprivation may be quiet. Risk increases with potent or unpredictable opioids and when opioids are combined with alcohol or other sedating drugs. Tolerance is also uneven: after abstinence, detoxification, hospitalization, or

incarceration, a dose previously survived may become fatal because tolerance has fallen.



Fentanyl intensifies this danger because very small amounts can be powerful and illicit supplies may be unpredictable. A person may believe they are taking one drug while unknowingly taking an opioid mixture. This is one reason the modern overdose risk is not limited to people who identify as opioid users. The substance in front of you may not be what you think it is.

What opioids may promise

I will take away the pain—not only in your body, but in the part of you that is tired of carrying it. The trap is that relief can become dependence, dependence can become compulsion, and the same drug that makes the world feel safe can quietly stop your breathing.

Treatment can include methadone, buprenorphine, or naltrexone, combined with counseling, structure, and attention to the underlying pain and trauma. Methadone and buprenorphine can reduce withdrawal and craving; naltrexone blocks opioid receptors after detoxification. These medications differ, and each requires competent medical evaluation. Their use is not simply replacing one moral failure with another. For many people, medication reduces the immediate biological pressure enough for honesty, relationships, therapy, and a life outside the drug to become possible (NIDA, 2021; SAMHSA, 2021).

Stimulants: Fast, Focused, and Running on Borrowed Energy

Stimulants appeal to a different need. Instead of promising to slow the nervous system, they promise to make you faster, sharper, stronger, more confident, and less tired. That can be compelling in professions where fatigue is dangerous, performance is identity, and asking your body to stop may not feel like an option. A stimulant can seem to restore the operational version of you.

Cocaine, methamphetamine, and prescription stimulants are not identical, but they all increase activity in systems involving dopamine and norepinephrine. Cocaine primarily blocks the reuptake of dopamine, norepinephrine, and serotonin, leaving more of these messengers active between neurons. Methamphetamine enters nerve terminals, drives the release of large amounts of dopamine and other monoamines, and interferes with their normal recycling. The result can

be intense salience, energy, wakefulness, and euphoria (Koob & Volkow, 2016).

If trauma has left you numb or collapsed, that surge can feel like resurrection. You can feel present, interested, sexual, social, capable, and alive. If depression has slowed you, the drug may appear to return motivation. If exhaustion has accumulated across shifts or deployments, it may seem to provide the fuel you no longer have. If shame has hollowed out your confidence, a stimulant may create a temporary sense of invincibility.

But the drug is not creating sustainable energy. It is forcing systems into a high-output state. Heart rate, blood pressure, temperature, vigilance, and muscular tension rise. Appetite and sleep fall. The same intensity that initially feels like focus can become rigidity, irritability, impulsivity, aggression, panic, suspiciousness, or paranoia. Your threat system and the drug can begin amplifying one another.

Cocaine: The Short, Intense Chase

Cocaine's effect is relatively rapid and short-lived, especially when smoked or injected. That speed teaches the brain a tight association between action and reward: use, surge, decline, repeat. The high may bring confidence, alertness, sociability, sexual energy, and a sense of control. The fall can bring fatigue, irritability, anxiety, emptiness, and craving. Because the effect fades quickly, a night of intended use can turn into repeated dosing as you try to hold the state in place.

Cocaine places acute stress on the cardiovascular system. It can constrict blood vessels, accelerate the heart, disrupt electrical rhythm, and increase the risk of heart attack, stroke, seizure, or sudden death. Feeling physically fit does not eliminate that risk. In fact, the sensation of power can mask how hard the body is being driven. When cocaine is

combined with alcohol or appears in an unpredictable drug supply, the danger becomes still more difficult to judge.

For someone with trauma, the crash may be especially punishing. The borrowed confidence disappears, and the original anxiety, depression, or shame returns alongside neurochemical depletion and sleep loss. You may then use again not because the high is still wonderful, but because the contrast between the stimulated state and the crash has become unbearable.

Methamphetamine: Intensity That Can Consume the System

Methamphetamine generally produces a longer and more forceful stimulant state. Wakefulness can extend far beyond the body's natural limits. Appetite may disappear. Thoughts may move rapidly, and repetitive activities can absorb hours. At first, this may be interpreted as productivity, clarity, confidence, or extraordinary stamina. But prolonged wakefulness and escalating exposure can destabilize perception and judgment.

As sleep disappears, the brain loses one of its primary means of emotional and physiological restoration. Suspicion can grow into paranoia. Shadows, sounds, or ordinary behavior may be interpreted as threat. Hallucinations, fixed false beliefs, aggression, and stimulant-induced psychosis can emerge. For a person whose trauma system is already prepared to detect danger, methamphetamine can turn vigilance into a closed loop in which nearly everything confirms the sense of threat.

Long-term use can be associated with severe weight loss, dental disease, skin injury from repetitive picking, cardiovascular damage, mood disturbance, cognitive impairment, and profound disruption of relationships and daily life. When the drug stops, exhaustion and

depression can be overwhelming. The contrast between artificial intensity and the depleted baseline helps drive return to use.

Prescription Stimulants: Medication Can Still Become a Trap

Prescription stimulants have legitimate medical uses, and taking a prescribed medication as directed is not the same as addiction. The risk grows when the medication is taken in larger doses, more often, by a faster route, or for purposes other than the treatment plan. A pill used to remain awake, lose weight, intensify work, overcome emotional flatness, or feel more confident can gradually assume the same regulatory role as an illicit stimulant.

The key question is not whether the drug came from a pharmacy. It is whether your relationship with it is becoming secretive, escalating, compulsive, and organized around changing your state. If you are using a prescription to override sleep, grief, fear, exhaustion, or collapse, the original need deserves attention before the shortcut takes control.

What stimulants may promise

I will make you alert, powerful, confident, interested, and able to keep going. The trap is that the energy is borrowed, sleep and judgment deteriorate, threat intensifies, and the crash can make the next dose feel like the only route back to life.

THC: Hazy Relief and Heavy Consequences

Cannabis occupies a confusing place in modern culture. It is described as natural, medicinal, recreational, harmless, dangerous, healing, and addictive—sometimes in the same conversation. Those slogans are not enough. The relevant questions are what THC does in your nervous system, how potent the product is, how often you use it, why you use it, when you began, and what vulnerabilities you bring to it.

THC is the primary psychoactive compound in cannabis. It acts within the endocannabinoid system, a signaling network involved in memory, appetite, stress regulation, pain, mood, and perception. In the short term, THC can alter time, sensory experience, attention, and memory. It may create relaxation, amusement, emotional distance, or sleepiness. For a person with intrusive memories or chronic tension, that altered state can feel like welcome space between you and the pain.

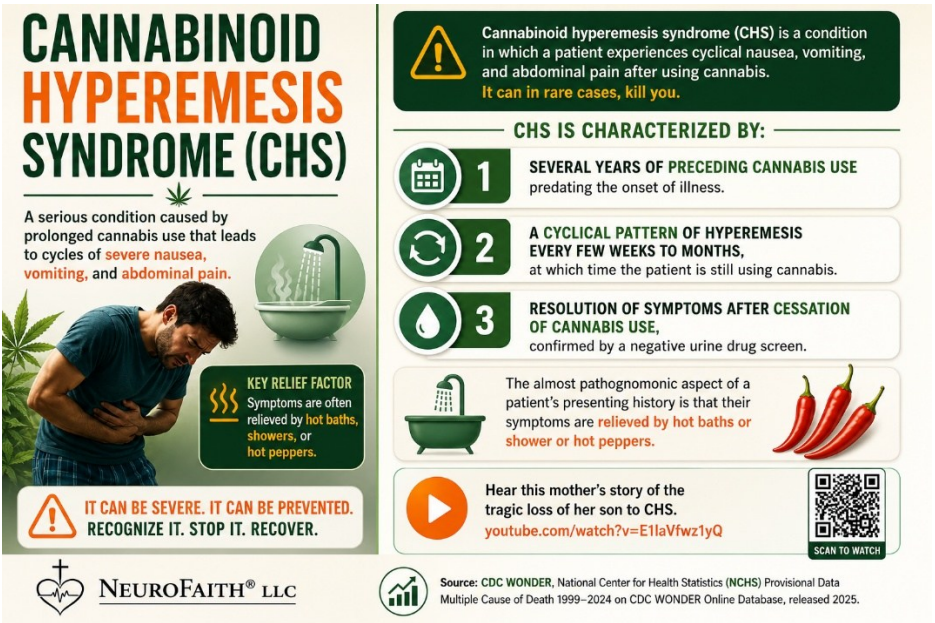
Judith Grisel compares this kind of drug effect to splashing vivid color across experience. Under the influence, music, food, ideas, and ordinary moments may seem more interesting or meaningful. But when the drug is repeatedly used to provide salience, unaltered life can begin to feel pale. Connection, achievement, work, and quiet pleasure may not compete well with the reliable change produced by THC. The user returns to the drug partly because sober life now seems flatter by comparison (Grisel, 2019).

The trap can be difficult to recognize because intoxication may not look dramatic. You may still work, talk, laugh, and complete routine tasks. Yet frequent use can affect attention, short-term memory, learning, motivation, reaction time, and judgment. Plans are postponed. Emotional problems are blurred rather than processed. A person can spend years believing cannabis is treating anxiety while never discovering how much rebound anxiety, avoidance, or cognitive fog the pattern is creating.

THC does not calm everyone. Higher-potency products can produce panic, suspiciousness, paranoia, or psychotic symptoms, particularly in vulnerable people. Research has associated frequent and high-potency cannabis use with increased risk of psychotic disorder, though risk is not identical for every person (Di Forti et al., 2019; Volkow et al., 2014). The fact that many people use cannabis without psychosis does not make the risk imaginary for the person whose biology and history place them closer to that threshold.

Adolescence is an especially sensitive period because the systems supporting judgment, impulse control, and emotional regulation are still developing. Beginning early and using frequently can turn cannabis into part of how the young brain learns to handle boredom, social discomfort, sleep, and emotion. Instead of practicing regulation, the person repeatedly practices escape. That learning can follow them into adulthood even if the original circumstances change.

Physical consequences are also possible. Smoke and vapor expose the lungs and cardiovascular system to stress. Some chronic users develop cannabinoid hyperemesis syndrome, marked by recurring nausea, abdominal pain, and severe vomiting that is often temporarily relieved by hot showers. Because cannabis is still widely perceived as harmless, people may undergo repeated medical evaluations before recognizing that the substance used for relief is producing the illness (Simonetto et al., 2012).



What THC may promise

I will quiet the thoughts, soften the memories, make ordinary life more interesting, and put distance between you and pain. The trap is that avoidance can deepen, sober life can lose color, cognition can dull, and the drug used for anxiety or sleep can begin worsening the very problems it was meant to solve.

Compulsive Behaviors: Chemistry Without a Bottle

A substance does not have to enter your bloodstream for seeking to become compulsive. Gambling, pornography, gaming, scrolling, shopping, food, work, sex, exercise, and risk-taking can all change internal state. The biology is not identical across every behavior and drug, and it is important not to call every strong interest an addiction. The warning sign is the pattern: loss of control, narrowing of life,

escalating intensity, continued behavior despite harm, and repeated failure to stop.

Behavioral addictions often recruit anticipation as powerfully as reward. The next hand, image, level, message, purchase, notification, mission, or risk holds possibility. Because the reward is uncertain, seeking may continue longer than satisfaction would. Dopamine supports the pursuit: perhaps the next one will finally deliver what the last one promised. You can spend hours wanting without ever arriving at enough (Kardaras, 2016; Weinschenk, 2009; Wilson, 2014).

Trauma can make these behaviors especially useful in the short term. Gaming provides a world with clear missions, immediate feedback, predictable rules, and repeated chances to win. Pornography can offer arousal without the vulnerability of mutual intimacy. Gambling can replace numbness with urgency. Work can protect you from stillness and earn admiration at the same time. Risk can recreate the intensity in which your nervous system learned to feel most alive.

Because some of these behaviors are legal, admired, or necessary, the trap can hide in plain sight. Work is good, until you cannot stop working because home, grief, or quiet feels intolerable. Exercise is healthy, until injury and relationships become irrelevant beside the compulsion. Technology connects you, until every empty second must be filled and sustained attention becomes unfamiliar. Sexuality is part of human life, until secrecy, escalation, objectification, and repeated use reshape your ability to be present with a real person.

The same wanting-more, liking-less pattern can emerge. Novelty becomes more extreme. Time devoted to the behavior expands. Ordinary pleasure weakens. The prefrontal promise to stop is repeatedly defeated by cue, opportunity, and distress. Shame then

drives secrecy, and secrecy protects the cycle. The behavior becomes both the escape from painful emotion and a new source of painful emotion (Didinger, 2018; Wilson, 2014).

What compulsive behavior may promise

I will give you intensity without danger, connection without vulnerability, achievement without uncertainty, or escape without a drug. The trap is that the behavior can train attention, consume time, distort relationships, and leave you more isolated from the life you were trying to make bearable.

PART II

PATHWAY TO HEALING

CHAPTER 7

Welcome to the Road Home

A Pathway to Healing

You have already traveled a long way with us.

In the first half of this book, we entered some difficult territory. We examined the wounds carried by active duty service members, veterans, and first responders and explored what happens when combat, military service, emergency response, repeated exposure to suffering, and moral injury become embedded within the brain, body, relationships, and spirit.

We looked at post-traumatic stress, depression, anxiety, addiction, traumatic grief, anger, shame, emotional numbing, and the lingering effects of living too long in survival mode. We examined how the nervous system learns to remain prepared for danger even after the danger has passed. We considered what happens when the warrior returns home physically but discovers that some part of him or her remains on the battlefield.

That journey was necessary. Before we can begin moving toward healing, we must understand what has been wounded. We must name what happened without reducing the person who endured it to a diagnosis. We must recognize that many of the reactions now causing

pain were once intelligent and courageous adaptations to overwhelming circumstances.

Understanding the wound, however, is not the same as healing it. There comes a point when we must turn our attention from what happened to what happens next.

That is where we are now.

Welcome to the road home.

Coming Home Is More Than Geography

For many active duty service members, veterans, and first responders, coming home is not a single event. It is not simply the moment the aircraft lands, the deployment ends, the uniform comes off, or the final shift is completed. You can return to your house without fully returning to your life.

You can sit at the dinner table with the people you love while some part of you remains vigilant, distant, or prepared for danger. You can sleep in your own bed while your nervous system continues to stand watch. You can be surrounded by family and still feel profoundly alone. You can leave the battlefield, fireground, patrol car, ambulance, emergency department, or dispatch center and discover that these places have not entirely left you.

The body may be home while the mind remains at war. The uniform may be hanging in the closet while the nervous system continues to wear it.

This is why the road home must take us deeper than geography.

To come home psychologically is to begin feeling safe within your own mind again. It is to understand your reactions without being controlled

by them and to remain present rather than being repeatedly pulled into memories of what happened or fears of what might happen next.

To come home relationally is to allow yourself to be known again. It is to risk connection, rebuild trust, receive love, and rediscover that vulnerability is not the same as weakness. It means learning to remain emotionally present when every survival instinct tells you to withdraw, shut down, become angry, or leave.

To come home physically is to help the body recognize that the threat has passed. It is learning to breathe more freely, rest more deeply, sleep more peacefully, and live without remaining perpetually braced for impact.

To come home spiritually is to wrestle honestly with questions of meaning, guilt, forgiveness, identity, suffering, and purpose. It is to examine what war, violence, death, betrayal, and loss have done to your understanding of yourself, other people, the world, and whatever you understand to be sacred.

Coming home means gradually gathering the scattered pieces of your life and bringing them back together. It means becoming more fully present to yourself, to the people you love, to your deepest values, and to the purposes that still call you forward.

You Were Built to Survive

Before we move into treatment and recovery, we want to remind you of something essential: your nervous system did not betray you. It adapted.

The vigilance that now makes it difficult to relax may once have helped keep you alive. The emotional numbing that now interferes with intimacy may once have allowed you to complete the mission. The

ability to compartmentalize pain may have made it possible for you to function while others depended upon you.

Anger may have mobilized you when fear could not be acknowledged. Isolation may have protected you from the risk of losing someone else. Alcohol, medication, work, adrenaline, pornography, gambling, or other forms of escape may have offered temporary relief when you did not know how else to quiet what was happening inside.

None of this means that every behavior was healthy or harmless. Survival responses can eventually wound the person they once protected. They can damage marriages, frighten children, destroy careers, erode physical health, and separate people from everything they value. Understanding why these responses developed does not remove responsibility for the choices you make today. It gives you a compassionate and truthful place from which to begin making different choices.

Shame will not lead you home. You cannot hate yourself into healing or punish your nervous system into feeling safe.

The question is no longer simply, "What is wrong with me?" A more useful question is, "What happened to me, how did I learn to survive it, and what do I need now?"

Healing Is Not Forgetting

The road home does not require you to forget. It does not demand that you erase the faces, silence the memories, deny the losses, or pretend that what happened did not matter. Some experiences become permanent parts of our stories. Some people will always be missed, and some images may never disappear completely.

Healing means that the past no longer controls the present in the same way. The memory remains, but it does not possess you. The loss remains meaningful, but it no longer makes life meaningless. The scar remains, but the wound is no longer bleeding.

Healing is also not a return to who you were before everything happened. That person may no longer exist. You have seen too much, carried too much, and learned too much to simply go backward. The road home is therefore not a retreat into the past. It is a movement toward integration.

You are taking the courage, discipline, loyalty, sacrifice, pain, grief, wisdom, and survival strength of your past and allowing them to become part of a larger and more complete life. The goal is not to become less of a warrior. It is to discover that the strength required to survive can also become the strength required to heal.

The Road Home Requires Discernment

Not every intervention is helpful. Not every medication is harmless. Not every therapist is competent, and not every treatment described as "trauma-informed" is truly capable of helping someone with complex trauma, moral injury, addiction, or the cumulative wounds of military and first responder service.

You have the right to understand what a medication is intended to do, what risks it carries, what alternatives may exist, and how its effects will be monitored. Medication can be helpful and, in some circumstances, life-saving. It can also be prescribed too quickly, continued without adequate reassessment, or used to suppress symptoms without addressing the deeper wounds beneath them.

You also have the right to know whether a therapist possesses the experience, humility, cultural understanding, and clinical competence necessary to help you. A good therapist can become a trusted ally on the road home. A poorly trained, careless, or ideologically driven therapist can deepen wounds, reinforce helplessness, or push you into traumatic material before you are prepared to face it.

Good intentions are not enough. Your life is too important to surrender unquestioningly to someone merely because that person has a professional title.

The chapters ahead will help you approach treatment with wisdom rather than desperation. We want you to become an informed participant in your recovery. You are not a passive recipient of care. You have a history, a voice, a set of values, and the right to help determine the direction of your treatment. You are not handing over command of your life; you are assembling the right team to help you reclaim it.

The NeuroFaith® Road Home

In the chapters ahead, we will introduce the NeuroFaith® framework for healing. This approach begins with the conviction that lasting restoration must address the whole person. Trauma affects the brain, nervous system, emotions, relationships, identity, and spirit, and meaningful healing must be broad enough to reach all of them.

The NeuroFaith® model brings together modern neuroscience, nervous-system regulation, relational healing, internal integration, and faith. It recognizes that healing occurs from the bottom up as well as from the top down. We must work not only with what you think but also with what your body has learned, what your heart carries, what the

wounded parts of you still fear, and what you believe about yourself and the meaning of your life.

We will explore how the autonomic nervous system shapes your experience of safety, danger, connection, and withdrawal. You will learn why your body may react before your conscious mind understands what is happening and how you can begin teaching your nervous system that the battle is no longer occurring in the present.

We will examine the relationship between the heart and brain and consider how practices that increase physiological coherence may support emotional regulation, clarity, and resilience. We will also explore the different parts within you: the warrior, the protector, the wounded child, the angry defender, the grieving survivor, the one who feels shame, and the one who still longs to be known and loved. Rather than trying to destroy or silence these parts, we will seek to understand what they have been protecting and help them discover that they no longer have to carry these burdens alone.

Faith will also have an important place in this journey, but we use that word broadly and respectfully. For some, faith is grounded in a specific religious tradition. For others, it is expressed through spirituality, deeply held values, a sense of the sacred, or a connection to something greater than oneself. Research suggests that healthy forms of faith and spiritual practice can support meaning, hope, connection, forgiveness, and resilience. It also shows that spiritual struggle can deepen distress, particularly when people feel abandoned, condemned, betrayed, or unable to reconcile what happened with what they once believed.

For that reason, we will not use faith to dismiss pain, impose easy answers, or pressure you toward a predetermined conclusion. We will treat it as a deeply personal dimension of human life that can be

wounded by trauma and can also become an important source of healing.

Questions of faith and meaning are not peripheral to combat trauma and moral injury. They often lie near the center of the wound:

Who am I now?

How do I live with what I did, what I witnessed, or what I could not prevent?

- Can I forgive myself?
- Can I receive forgiveness from others?
- Is my life still meaningful?
- Do I still have a purpose?

We will not pretend that these questions have simple answers. We will, however, create room to face them honestly.

You Do Not Have to Walk Alone

Perhaps you have tried before. You may have entered treatment and left disappointed, received a diagnosis without ever feeling understood, or taken medication that dulled the pain without helping you reclaim your life. Perhaps you shared part of your story with someone who did not know how to receive it, and you began to believe that this was simply how life would always be.

We do not believe that.

We will not insult you with promises of an easy road. Healing rarely moves in a straight line. There may be setbacks, difficult memories, painful conversations, and days when familiar survival strategies feel

easier than continuing forward. But difficulty does not mean impossibility. You have already survived things you once believed you could not survive.

The courage that carried you through combat, crisis, danger, loss, and responsibility can now be turned toward the work of restoration. This is a different kind of mission, requiring honesty, patience, humility, endurance, and the willingness to receive help.

The road home may include a skilled therapist, a trusted physician, a chaplain, a spiritual leader, a spouse, a battle buddy, a fellow first responder, a recovery community, or a family willing to learn how to walk beside you. Healing often occurs within relationships because many of our deepest wounds occurred within relationships or through the loss of them.

Isolation may have helped you survive, but connection will help you heal.

Welcome Home

There is more to you than what happened, more than the diagnosis written in your medical record, and more than your worst day, greatest regret, deepest wound, or the things you did to survive. You are not broken beyond repair, disqualified from love, or too damaged to experience peace. You are not too far away to find your way home.

The chapters ahead will not ask you to deny your wounds. They will invite you to stop allowing those wounds to define the boundaries of your life. We will talk honestly about treatment, examine medication with both respect and caution, and help you recognize what a capable therapist looks like. We will explore the brain, body, heart,

relationships, identity, and spirit as interconnected pathways toward restoration.

Most importantly, we will walk with you—not backward toward the person you once were, but forward toward the person you are still becoming.

Welcome to the road home!

This chapter is not an argument against medication. It is an argument for you: your right to understand what you are taking, why you are taking it, what it may help, what it may cost, and how you and your prescriber will know when the plan should change.

The Question Is Not "Medication or No Medication"

You may have reached for help after months or years of carrying more than one person should have to carry. Perhaps you stopped sleeping. Perhaps you could function on the job but fell apart when the shift ended. Maybe you became irritable with the people you love, withdrew from everyone, or found yourself wondering whether life was still worth the effort. In that condition, a prescription can feel like a lifeline. Sometimes it is.

Antidepressants can reduce suffering, restore sleep or functioning for some people, and create enough breathing room to keep a person safe. In a crisis, medication may be stabilizing or lifesaving. Some people make a thoughtful, informed decision to remain on medication for years or for the duration of their lives. That decision deserves respect.

Many physicians, psychiatrists, nurse practitioners, pharmacists, and other prescribers do careful and compassionate work. They listen, explain uncertainty, monitor closely, and change course when the evidence in front of them changes. Nothing in this chapter is meant to diminish them. The concern is not that antidepressants or antipsychotics exist. The concern is what happens when a prescription is treated as the whole treatment plan, when a brief appointment replaces a careful understanding of your story, or when you are not given enough information to make a genuinely informed choice.

The most useful question is therefore not, "Are antidepressants good or bad?" The useful questions are more personal: What problem are we trying to solve? What is the likely benefit for you? What are the risks? What else belongs in the plan? How long will we try this? How will we monitor it? And if you later decide to stop, what is the exit strategy?

Why This Matters for Active Duty Service Members, Veterans, and First Responders

Medication is common in trauma care. In a national study of 274,297 veterans diagnosed with post-traumatic stress disorder who received Department of Veterans Affairs care during fiscal year 2004, 80% were prescribed at least one psychotropic medication. Among those who received medication, 89% were prescribed an antidepressant and 34% an antipsychotic (Mohamed & Rosenheck, 2008). Those figures are historical, not a description of every veteran or of current prescribing, but they explain why this chapter concentrates on these two medication classes.

That central role is understandable. Antidepressants may be offered for depression, anxiety, panic, intrusive symptoms, irritability, or sleep-related distress. A prescriber may be trying to help you function while appointments are limited, life is unraveling, or trauma-focused care is

not yet available. You may also prefer medication at first because talking about the event feels impossible. None of that makes you weak, uninformed, or resistant to deeper healing. It makes you a person searching for relief.

But the conditions that bring veterans and first responders into treatment are rarely simple. A combat deployment, a fatal call, moral injury, chronic sleep disruption, pain, concussion, grief, relationship strain, alcohol use, and earlier trauma can overlap. A medication may affect some symptoms without touching the meaning of what happened, the loss of trust, the ruptured relationship, or the nervous system that still expects danger. Symptom relief and healing can support one another, but they are not automatically the same thing.

Antidepressants: The Briefing You Should Have Received

Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) change signaling involving serotonin, or serotonin and norepinephrine. That is a description of a drug action. It is not proof that your depression or trauma symptoms were caused by a pre-existing shortage of serotonin.

For years, many people were told a simple story: depression is caused by a chemical imbalance, and an antidepressant corrects it much as insulin corrects a biological problem in diabetes. The simplicity of that story made it memorable and reassuring. It also exceeded what the science could establish. A major umbrella review found no consistent evidence that depression is caused by low serotonin activity or concentration (Moncrieff et al., 2022). That finding does not demonstrate that antidepressants never help. It means that benefit, when it occurs, should not be explained as proof that a hidden serotonin deficiency has been corrected.

Psychotropic medications introduce a change into a living nervous system, and the brain adapts to repeated exposure. Hyman and Nestler (1996) described psychotropic drug action as an initiating chemical effect followed by adaptations in neural function. This matters because the effect you experience is not simply a missing chemical being poured back into an empty tank. You are experiencing the interaction among a medication, an adaptive brain and body, your symptoms, your expectations, your relationships, and the circumstances of your life.

There is dignity in a more accurate explanation. If a medication helps you, you do not need a chemical-imbalance story to validate that benefit. If it does not help, you have not failed treatment. And if the source of your suffering includes trauma, grief, moral conflict, isolation, chronic pain, or a life that no longer feels safe, recognizing those realities can return agency to you. It opens the treatment plan instead of shrinking your experience to one presumed defect.

A Drug-Centered Question

Joanna Moncrieff's work asks clinicians and patients to consider a drug-centered question: What altered physical, emotional, and mental state does this medication produce, and might that state be useful—or

harmful—for this person at this time? This differs from assuming that the drug targets a known disease mechanism (Moncrieff, 2008, 2013). The question is practical. It invites you and your prescriber to observe what actually changes in your life.

Perhaps you cry less, ruminate less, or feel less easily startled. Perhaps you can leave the house and attend therapy. Those changes may be valuable. But perhaps you also feel detached, sexually numb, slowed, foggy, or less able to experience affection, joy, urgency, or grief. Those changes matter too. A complete evaluation counts both relief and cost.

When Less Distress Also Means Less Feeling

Emotional numbing can be particularly complicated after trauma because trauma itself can make you feel shut down or unreal. If numbness increases after a medication is started or a dose is raised, it may be difficult to know whether the trauma, the medication, or both are contributing. Horowitz and Taylor (2024) summarize patient-reported experiences that include emotional numbness, feeling foggy or detached, not feeling like oneself, drowsiness, and a reduction in positive feelings. Across the studies they review, emotional blunting appears common and may be dose dependent.

For you, that tradeoff may show up in ordinary but important moments. You may be less overwhelmed by grief yet also unable to feel close to your spouse. You may be less reactive but also less motivated. You may stop having panic attacks but wonder where your laughter went. People around you may say you seem better because you are quieter, while you feel as though you have disappeared behind glass.

This is not an argument that every strong feeling must remain unmedicated. If distress is so intense that you cannot sleep, stay safe, concentrate, or remain present in therapy, stabilization may be necessary before deeper work is possible. At the other extreme, if you

are so sedated or emotionally blunted that you cannot recognize what you feel, connect with your therapist, or learn from your body's signals, medication may be interfering with the work it was meant to support. The target is not maximum numbing. The target is enough stability and enough emotional access for healing to occur.

Your feelings are not always literal instructions, and trauma can produce alarms when the present is safe. Even so, feelings carry information. Fear may tell you that your body detects threat. Anger may point toward violation or helplessness. Grief may reveal what mattered. Therapy helps you approach those signals without being swallowed by them. A thoughtful medication plan should support that capacity, not automatically erase it.

Benefits Deserve a Fair Trial; Risks Deserve Equal Attention

Informed consent requires more than a hurried list of possible side effects. It requires a conversation about the outcomes that matter to you. Can you sleep? Can you work safely? Are you less suicidal? Are you more connected to your family? Can you think clearly? Has the medication affected weight, blood pressure, bleeding, sexual functioning, or your ability to feel? The answer is not contained in a symptom checklist alone.

Sexual Effects

Sexual side effects are easy to minimize and hard for many patients to raise. SSRIs and SNRIs may reduce desire, sensation, arousal, or the ability to reach orgasm.

SSRIs and Sexual Side Effects

SSRIs can cause sexual side effects during treatment.
In some cases, these effects may persist after stopping the medication (PSSD).

Common During Treatment

- Decreased libido
- Erectile dysfunction / decreased lubrication
- Delayed ejaculation
- Delayed or absent orgasm

Also seen with depression and other conditions.

More Specific to SSRIs

- Genital numbness (anesthesia)
- Nipple insensitivity
- Orgasms with reduced pleasure

Reported by some people and may persist after discontinuation (PSSD).

Discuss potential sexual side effects before starting an SSRI.
Monitor and address symptoms—other treatment options are available.

References

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2. Clayton AH, Pradipta A, Croft HA, et al. Persistent sexual dysfunction after SSRI antidepressant exposure. *J Sex Med*. 2019;16(7):1077-1088.
3. European Medicines Agency (EMA). PRAC recommends new measures to avoid sexual dysfunction with antidepressants. EMA/PRAC/313487/2019. April 2019.

Horowitz and Taylor (2024) describe a wide range of estimates across studies, from roughly one-quarter to a large majority of patients, depending on the medication, method, and population studied. For a minority of people, sexual difficulties have been reported to persist

after the medication is stopped, a condition often called post-SSRI sexual dysfunction, or PSSD.

This is not a trivial quality-of-life issue. Intimacy may already be strained by deployment, hypervigilance, shame, pain, relationship separation, or the emotional distance that can follow trauma. You deserve to know before treatment that sexual effects are possible, and you deserve a prescriber who can discuss them without embarrassment or dismissal.

Weight, Energy, and Cognitive Performance

Long-term antidepressant use can be associated with weight gain for some people, and the amount seen over time may exceed what short clinical trials reveal (Horowitz & Taylor, 2024). Weight change can affect physical readiness, sleep apnea, pain, cardiovascular health, self-image, and willingness to remain on treatment. It should be monitored rather than treated as an unavoidable price you are expected to accept in silence.

Some people also report drowsiness, slowed thinking, memory difficulty, reduced concentration, or a foggy, detached quality. For active duty service members, veterans, and first responders, cognitive and motor performance may have immediate consequences: driving, operating equipment, carrying a weapon, making rapid decisions, or caring for others. These experiences do not occur in everyone, and depression, trauma, insomnia, pain, and other medications can cause similar problems. That is precisely why baseline observations and follow-up matter.

Bleeding and Other Medical Considerations

SSRIs and SNRIs can affect serotonin uptake in platelets, which may increase bleeding risk (Horowitz & Taylor, 2024). The relevance

depends on your medical history and on what else you take, including anti-inflammatory medications, aspirin, anticoagulants, supplements, and alcohol. This is a medication-review issue, not a reason to panic. Your prescriber and pharmacist need a complete list of what you use so they can judge the combination rather than each item in isolation.

The same caution applies to claims about possible long-term outcomes such as dementia. Horowitz and Taylor (2024) discuss observational research reporting associations between cumulative antidepressant exposure and later dementia diagnoses. Observational findings cannot establish that antidepressants caused dementia; depression severity, medical illness, age, and other factors may contribute to the association. The responsible conclusion is not certainty or fear. It is that long-term treatment deserves periodic review instead of automatic renewal without reassessment.

Activation and Suicidal Thinking

Antidepressants carry a boxed warning about an increased risk of suicidal thinking and behavior in children, adolescents, and young adults through age 24, particularly early in treatment and around dose changes (U.S. Food and Drug Administration, 2004). Although the formal age-specific warning does not extend to every adult veteran or responder, any new or worsening suicidal thinking, severe agitation, impulsivity, or abrupt behavioral change deserves immediate attention.

If you are in immediate danger or believe you may act on suicidal thoughts, do not wait for a routine medication appointment. Seek emergency help, contact the Veterans Crisis Line by dialing 988 and pressing 1 if you are in the United States, or use the emergency service available where you live. Medication decisions are important; immediate safety comes first.

Antipsychotics: Powerful Medications With a Broader Reach

The name antipsychotic suggests a medication reserved for hallucinations, delusions, or severe disorganization. These drugs can indeed be indispensable when a person is acutely psychotic, dangerously manic, profoundly agitated, or unable to care for basic needs. In those situations, reducing the intensity of symptoms may protect life, restore reality testing, and give a person and family a way back from chaos.

Yet antipsychotics are also prescribed outside psychotic disorders. An active duty service member, veteran, or first responder may receive one as an addition to an antidepressant, or for severe agitation, insomnia, intrusive thoughts, irritability, mood instability, or trauma-related distress. That is called off-label prescribing when the use is not among the medication's specific regulatory approvals. Off-label use is common in medicine and is not automatically improper. It does, however, make the informed-consent conversation especially important: What exactly are we targeting, what evidence supports this use, and are the likely benefits worth the risks for you?

First-generation medications, sometimes called conventional antipsychotics or neuroleptics, include older drugs such as haloperidol. Second-generation or atypical antipsychotics include drugs such as risperidone, quetiapine, olanzapine, aripiprazole, and clozapine. The groups differ, and individual drugs within each group differ. The word atypical does not mean harmless. Newer medications may produce fewer of some movement effects at certain doses while creating substantial metabolic or other burdens.

Dopamine Blockade Is an Action, Not a Diagnosis

Most antipsychotics reduce signaling through dopamine D2 receptors, although their full pharmacology is more complicated. As with serotonin and antidepressants, the fact that a medication changes

dopamine signaling does not prove that you began with a simple dopamine excess or that the drug is correcting a known chemical imbalance. Moncrieff (2008, 2013) urges a drug-centered understanding: the medication creates an altered state that may suppress or reduce certain experiences, and clinicians must evaluate whether that altered state is useful for the person receiving it.

That distinction does not deny benefit. If frightening voices become quieter, persecutory beliefs loosen, or dangerous agitation settles, the change can be enormously valuable. But the same dampening may also affect alertness, curiosity, initiative, emotional range, movement, sexual function, or the mental energy needed to work and relate. Your treatment team should ask not only whether a symptom score fell, but whether you are becoming more able to live the life you value.

The brain also adapts to sustained receptor blockade. Hyman and Nestler (1996) described psychotropic drugs as initiating changes to which the nervous system then makes compensatory adaptations. With antipsychotics, dopamine-receptor changes have led researchers to investigate dopamine supersensitivity and whether it may contribute to breakthrough symptoms or vulnerability during withdrawal in some patients (Chouinard & Jones, 1980). This remains a clinical and scientific question, not a reason to assume that every recurrence is medication-induced. It is a strong reason to avoid abrupt discontinuation and simplistic interpretations of what follows.

Short-Term Control and Long-Term Recovery Are Different Questions

Antipsychotics have strong evidence for reducing acute psychotic symptoms and the risk of short-term relapse for many people diagnosed with schizophrenia-spectrum disorders. The more difficult question is what happens over years: Who benefits from continued maintenance,

who can do well on a lower dose, and who might eventually function better after a carefully supervised reduction?

Your slide-deck sources bring this tension into focus. In a long-term observational study, Martin Harrow and colleagues reported that some people with schizophrenia who were not taking antipsychotics during follow-up showed better recovery and functioning than those who remained medicated (Harrow & Jobe, 2007, 2013). That finding cannot prove that stopping medication produced the better outcome. People who were able to remain off medication may have differed in illness severity, resilience, support, or other ways from those who required continued treatment. Still, the study challenges the belief that lifelong full-dose treatment is automatically the best course for every person.

A randomized study led by Lex Wunderink offers a different and important piece of the picture. People recovering from a first episode of psychosis were assigned either to standard maintenance treatment or to an early dose-reduction or discontinuation strategy. The reduction group initially experienced more relapse. At seven years, however, the dose-reduction group had a higher recovery rate, driven largely by better functional outcomes (Wunderink et al., 2013). The study did not show that everyone should discontinue medication. It showed that short-term relapse prevention and long-term functional recovery are not identical outcomes, and that dose and duration deserve individualized review.

These studies involved people with psychotic disorders, not veterans receiving a low dose for sleep or trauma-related irritability. We should not transplant their results carelessly. But they sharpen the informed-consent question. If a powerful medication is being used for a nonpsychotic symptom, your prescriber should be able to explain why this drug was selected, why its expected benefit outweighs less burdensome alternatives, and how long the trial is intended to last.

When Calming Becomes Constriction

A medication can make you appear calmer while also making you feel slowed, flattened, or disconnected. This distinction matters in trauma therapy. Hyperarousal can make it impossible to sit still, sleep, or tolerate memory work. Reducing it can open a therapeutic window. But too much sedation or emotional constriction can close that window from the other side.

You may notice that you are no longer exploding, yet you also have little drive to exercise, reconnect, or complete therapy assignments. You may sleep more but awaken unrestored. Your family may appreciate the reduction in conflict while worrying that your humor, warmth, or initiative has faded. These observations do not by themselves determine whether the medication should continue. They are essential clinical data and belong in the decision.

For a veteran, police officer, firefighter, pilot, paramedic, or other responder, slowed reaction time and reduced alertness can have occupational consequences. If you drive, fly, operate machinery, carry a weapon, work at heights, or make rapid safety decisions, ask specifically how sedation, orthostatic dizziness, tremor, visual effects, and slowed processing may affect duty. "Take it at night" may help with drowsiness, but it is not a complete safety assessment.

Metabolic and Cardiovascular Effects

Some second-generation antipsychotics can increase appetite and weight and can adversely affect glucose and lipid regulation. The degree of risk differs across medications and individuals, but it can be substantial. Weight gain is not simply cosmetic. It may worsen sleep apnea, joint pain, diabetes risk, cardiovascular risk, physical readiness, self-confidence, and the fatigue that already accompanies depression or trauma.

This is one reason monitoring cannot be optional. Before treatment and at appropriate intervals, you and your prescriber should discuss weight and waist changes, blood pressure, fasting glucose or A1C, and lipids. If changes emerge, the response should not be limited to telling you to try harder. The medication, dose, alternatives, diet, movement, sleep, and overall medical risk all deserve review. A treatment that reduces one danger while quietly building another must be reconsidered as a whole.

Movement Disorders: What Your Body May Be Telling You

Antipsychotics can produce movement-related effects because dopamine pathways help regulate movement as well as thought and emotion. You may experience stiffness, tremor, slowed movement, muscle spasms, restlessness, or an internal sense that you cannot remain still. That severe inner restlessness is called akathisia. It can feel like panic in the muscles and may be mistaken for worsening anxiety, agitation, or noncompliance.

Tardive dyskinesia involves repetitive, involuntary movements that may affect the mouth, tongue, face, trunk, or limbs and can sometimes persist. Risk generally rises with cumulative exposure, although it can occur earlier. You should be told what early signs look like and should receive periodic movement assessment. New pacing, rocking, facial movements, tongue movements, stiffness, or unbearable restlessness should be reported promptly rather than endured in silence.

Hormonal, Sexual, and Other Effects

Some antipsychotics raise prolactin, a hormone that can affect sexual desire and performance, menstrual function, breast tissue, fertility, and bone health. Others may cause dry mouth, constipation, urinary difficulty, dizziness when standing, or changes in heart rhythm. Rare reactions can be medical emergencies. The point is not to frighten you with a catalog. It is to make clear that "you may feel tired" is not

sufficient informed consent for a medication with effects across several body systems.

Veterans, active duty personnel, and first responders sometimes minimize side effects because they have learned to push through pain, avoid appearing difficult, or complete the mission without complaint. In medical care, silence can hide the very information needed to keep you safe. Reporting a side effect is not whining. It is part of the mission.

Brain-Volume Findings: Serious, but Easy to Overstate

Your slide deck also reviews research associating cumulative antipsychotic exposure with reductions in brain-tissue volume, including a longitudinal imaging study by Ho and colleagues (2011) and an animal study in macaque monkeys (Dorph-Petersen et al., 2005). These findings deserve attention, but they require precision. Imaging studies in people are vulnerable to confounding by illness severity and other factors, and animal findings do not translate automatically into a prediction for an individual patient. A change on an image is also not, by itself, a complete description of thinking, functioning, or quality of life.

The appropriate response is neither denial nor alarmism. It is proportionate caution: use a powerful medication for a clear reason, seek the lowest effective burden consistent with safety, monitor function and health, and periodically revisit whether the original indication still applies.

Never Turn Long-Term Outcome Research Into a Do-It-Yourself Experiment

The Harrow and Wunderink findings should not be read as instructions to throw medication away. Abruptly stopping an antipsychotic can produce severe insomnia, agitation, anxiety, movement symptoms,

rebound phenomena, or rapid return of psychosis or mania. For someone who has experienced dangerous psychosis, the consequences can be catastrophic.

If you want to reconsider an antipsychotic, the first step is a careful conversation, not a sudden dose change. Review why it was started, whether you have a history of psychosis or mania, what happened during previous reductions, how stable your housing and relationships are, whether alcohol or other drugs are involved, and who can recognize early warning signs. A responsible tapering plan includes pace, monitoring, contingency steps, and a clear route back to urgent care if sleep, judgment, reality testing, or safety begins to deteriorate.

For some people, continuing medication is the safer and freer choice because it protects reality testing and preserves relationships, housing, or work. For others, a lower dose or supervised discontinuation may eventually improve energy and functioning. Informed consent means neither outcome is assumed in advance.

Physical Dependence Is Not the Same as Addiction

Antidepressants and antipsychotics are not typically described as addictive in the way alcohol, opioids, stimulants, or benzodiazepines can be. They do not ordinarily produce intoxication, craving, or compulsive reward-seeking. But your nervous system can become physically adapted to them. That adaptation means that reducing or stopping a medication can produce withdrawal symptoms. Calling a medication "nonaddictive" should never be used to imply that stopping will necessarily be easy.

Withdrawal may include dizziness, electric-shock sensations, nausea, sleep disruption, vivid dreams, anxiety, agitation, low mood, flu-like symptoms, sensory changes, or a feeling that the original problem has returned with unusual force. Because withdrawal can resemble relapse,

the distinction may be missed. Timing, symptom pattern, dose changes, prior withdrawal experiences, and what happens when the taper is paused all help a knowledgeable clinician think through the difference (Horowitz & Taylor, 2024).

The practical rule is simple: do not stop an antidepressant or antipsychotic abruptly on your own. Tapering should be individualized, collaborative, and adjusted to your response. A pace that is comfortable for one person may be far too fast for another. Horowitz and Taylor (2024) emphasize that smaller reductions may become especially important near the end of an antidepressant taper because equal milligram cuts do not necessarily produce equal changes in drug effect. Antipsychotic reduction requires its own careful plan, especially when psychosis or mania has been present.

Your Exit Strategy Begins Before the First Dose

An exit strategy does not mean you have already decided to stop. It means you and your prescriber have agreed that the medication will be reviewed with the same care used to start it. Before the first dose, or at your next review if you are already taking it, you have the right to ask:

1. What specific symptoms are we targeting, and how will we measure whether this medication is helping me?
2. What benefits are realistic, how long might they take, and what would count as an unsuccessful trial?
3. What common, serious, sexual, emotional, cognitive, movement-related, metabolic, and medical effects should I watch for?
4. Could this medication interact with alcohol, pain medication, sleep medication, supplements, or anything else I use?
5. What nonmedication treatments should be part of the plan now—not only if the medication fails?

6. When will we review the dose and the need for continued treatment?
7. What should I do if I miss doses, feel worse, become agitated, or develop suicidal thoughts?
8. If I later want to reduce or stop, how will we distinguish withdrawal from relapse, and what tapering support will be available?

A good prescriber may not have a perfect answer to every question. Medicine contains uncertainty, and an honest "I do not know, but I will help you find out" can be a sign of integrity. What matters is whether your questions are welcomed, your priorities are taken seriously, and the plan is revisited. If a prescriber repeatedly dismisses reasonable questions, refuses to discuss risks or withdrawal, or cannot explain the goal and monitoring plan, it is appropriate to respectfully request another prescriber or a second opinion.

Medication Should Be Part of a Plan, Not the Plan

Whitaker (2010) and Whitaker and Cosgrove (2015) have argued that psychiatric care can become too medication-centered and that industry and institutional pressures can distort how benefits and harms are communicated. Their critique is contested, but the question it raises is worth keeping: Is the system helping you build a life, or only helping you tolerate the symptoms of a life that still needs attention?

For trauma-related suffering, medication works best when it is placed inside a broader plan. That plan may include a well-vetted therapist, trauma-focused or polyvagal-informed work, neurofeedback, treatment of pain or sleep apnea, movement, nutrition, reduction of alcohol or other substances, reconnection with family and peers, moral-injury work, spiritual care, and the rebuilding of meaning. Medication

may help you enter that work. It cannot do the relational and experiential work for you.

There is also no virtue in suffering needlessly. You do not have to prove strength by refusing medication, and you do not have to prove compliance by remaining on a medication that is not serving you. The disciplined position is neither automatic acceptance nor automatic rejection. It is careful observation, honest conversation, and shared decision-making.

Long-Term Use: Reassess, Do Not Assume

Some people experience clear, durable benefit and decide with their clinicians that continued treatment is the wisest choice. Others remain on a medication because no one revisited the original decision, because every attempt to stop was too rapid, or because withdrawal was interpreted as proof that the underlying illness had returned. Still others discover that what helped during crisis now blunts the emotional range they need for recovery.

Long-term use therefore should not be framed as success or failure. It should be a clinical decision that is periodically renewed. The questions remain the same: What is the medication doing for you now? What is it costing you now? What has changed in your safety, therapy, relationships, sleep, health, and support? Would continuing, adjusting, switching, or carefully tapering best serve the next phase of your recovery?

A Partnership Worth Expecting

You have spent parts of your life in systems where orders mattered, speed mattered, and hesitation could cost lives. Medical care requires a different kind of discipline. You are not disobeying by asking a question. You are not being difficult by reporting a sexual side effect, emotional

numbness, withdrawal symptom, or fear about long-term use. You are supplying the information your clinician needs to care for you well.

Your prescriber brings training, experience, and knowledge of medication. You bring knowledge no one else has: what it feels like to live in your body, what you value, what you must be able to do safely, what you have survived, and what kind of life you are trying to rebuild. Informed consent joins those forms of knowledge. It is not a signature on a form. It is an ongoing conversation.

The central message is reassuring you have choices. If medication steadies you enough to sleep, remain alive, reconnect, and begin therapy, that is meaningful help. If it leaves you too numb to feel your way through work, that matters. If you need it for a long time, you deserve continued monitoring. If you want to stop, you deserve a careful taper rather than shame or haste. Your body is not betraying you when it responds to trauma, when it responds to a drug, or when it reacts to a rapid dose reduction. It is adapting. The task is to understand that adaptation and work with it wisely.

A prescription can be a tool. It should never take away your story, your voice, or your right to participate in the decisions that shape your healing.

CHAPTER 9

Choosing the Right Therapist

Your Life Is Too Important to Entrust to the Wrong Person

Finding the right therapist may be one of the most important decisions you make in your recovery.

That is not an exaggeration.

A skilled, trustworthy therapist can help you understand what has happened to you, regain control of your nervous system, reconnect with the people you love, and begin building a life that no longer revolves around survival. The right therapist can help restore hope when you have nearly lost it.

The wrong therapist can do real damage.

A poorly trained therapist may misunderstand your symptoms, assign the wrong diagnosis, push you too quickly into traumatic material, reinforce helplessness, foster dependency, or interpret normal survival responses as evidence that something is fundamentally wrong with you. A therapist who does not understand military or first responder culture may judge behaviors that once kept you alive without appreciating the environments in which those behaviors developed.

Some therapists are compassionate and well-meaning but simply do not possess the training necessary to treat complex trauma. Some are inadequately trained and do not recognize the limits of their competence. A few appear more interested in maintaining a caseload than helping people recover. Others have become ideologically captured and may attempt to filter your experiences through their political, social, or cultural assumptions rather than taking the time to understand you.

Good intentions are not enough.

Your life, your family, and your future are too important to be entrusted to someone merely because that person has a license and an open appointment.

You Have the Right to Ask Questions

You are not applying for permission to receive treatment. You are interviewing someone for an important role in your recovery.

You have every right to ask about a therapist's education, clinical experience, treatment philosophy, and specific training. You have the right to know whether that person has successfully worked with veterans, active-duty service members, firefighters, law enforcement officers, paramedics, dispatchers, emergency medical personnel, or others who have repeatedly faced trauma.

You also have the right to ask how much experience the therapist has treating the conditions affecting you. Trauma is not the same as depression. Post-traumatic stress is not the same as ordinary anxiety. Moral injury is not simply a collection of distressing thoughts. Traumatic grief, substance misuse, chronic pain, panic, rage, emotional numbing, and suicidal thinking require more than general counseling skills.

A therapist who primarily treats uncomplicated adjustment problems may be an excellent clinician within that area and still be the wrong person to treat severe combat trauma, complex post-traumatic stress, addiction, dissociation, or moral injury.

- There is no shame in asking direct questions. In fact, a competent therapist should welcome them.
- Consider asking:
- How many active duty service members, veterans or first responders have you treated?
- What specialized training do you have in trauma treatment?
- How do you understand post-traumatic stress beyond the diagnostic checklist?
- What is your experience treating moral injury, traumatic grief, survivor guilt, addiction, dissociation, or suicidal thinking?

- How do you determine when a person is ready to process traumatic memories?
- What do you do if trauma treatment begins making symptoms worse?
- How will we know whether therapy is helping?
- How do you incorporate the body and nervous system into treatment?
- Are you comfortable discussing faith, military culture, duty, honor, guilt, and questions of meaning?
- How do you involve spouses or family members when appropriate?
- What do you believe the ultimate goal of therapy should be?

Pay attention not only to the therapist's answers but also to how those answers are given. A good therapist will not become defensive, dismissive, or irritated because you want to understand the treatment being offered.

Military and First Responder Experience Matters

Military personnel and first responders live and work within cultures that many civilian therapists do not fully understand.

Hypervigilance may have helped you detect danger before anyone else recognized it. Emotional compartmentalization may have allowed you to function while others were overwhelmed. Humor that sounds dark or inappropriate outside the profession may have helped your team survive circumstances that were nearly unbearable. Loyalty, self-sacrifice, courage, personal responsibility, and service may be central to how you understand yourself.

A therapist does not need to have served in the military, carried a badge, fought a fire, or worked a mass-casualty scene to help you.

However, that therapist must possess humility and a genuine willingness to understand your world.

Beware of therapists who immediately interpret your discipline as rigidity, your vigilance as paranoia, your faith as avoidance, your values as pathology, or your reluctance to disclose as resistance. Trust must be earned. A good therapist understands that.

You should never be treated as a stereotype, a diagnosis, a political category, or an interesting clinical case.

You are a human being who has carried responsibilities and witnessed realities that many people will never fully comprehend.

The Relationship Matters, but Competence Matters Too

Research and clinical experience consistently demonstrate that the therapeutic relationship matters. You are more likely to engage honestly when you feel respected, understood, and safe.

But connection alone is not enough.

You may genuinely like a therapist who lacks the clinical skill necessary to help you. Warmth without competence can leave you feeling understood but unchanged. Competence without human connection can make therapy feel mechanical, sterile, or unsafe.

You need both.

The right therapist should be someone you can gradually trust and someone who knows what to do with the trust you give.

You should experience the therapist as steady, emotionally regulated, honest, and capable of hearing difficult material without becoming overwhelmed. You should not feel responsible for protecting the therapist from your story. You should not have to minimize what

happened because the therapist appears shocked, frightened, fascinated, or uncomfortable.

Your therapist should be able to enter the darkness with you without becoming lost in it.

Trauma Treatment Must Be Properly Timed

Trauma therapy is not simply telling the story repeatedly until it stops hurting.

Moving too quickly into traumatic memories can overwhelm the nervous system, intensify nightmares, increase substance use, worsen emotional volatility, and destabilize relationships. Before entering the most painful material, a skilled therapist will usually help you develop sufficient safety, emotional regulation, body awareness, and support.

This does not mean spending years avoiding what happened. It means approaching trauma with wisdom.

A good therapist knows when to move forward, when to slow down, and when to stop. Treatment should challenge you, but it should not recklessly overwhelm you. There is an important difference between the discomfort that accompanies growth and the destabilization that results from poorly conducted therapy.

If you are becoming progressively worse, that should not automatically be dismissed as proof that therapy is working.

Sometimes treatment becomes more difficult before it becomes easier. However, persistent deterioration deserves careful attention. Your therapist should take worsening symptoms seriously, reassess the treatment plan, and make changes when necessary.

Therapy Should Strengthen You, Not Make You Dependent

Healthy therapy should gradually increase your capacity to live your life without the therapist.

You should become more able to regulate your emotions, understand your reactions, repair relationships, make thoughtful decisions, tolerate distress, and move toward the people and purposes that matter to you.

The therapist should not become the central figure in your life.

Be cautious if a therapist consistently undermines your family relationships, portrays nearly everyone around you as unsafe or toxic, encourages you to reinterpret every painful experience as trauma, or subtly communicates that you cannot function without ongoing therapy.

There are times when ending or limiting contact with a destructive person is necessary. There are also times when boundaries must become stronger. But those decisions should emerge from careful discernment, not from a therapist's reflexive suspicion of families, marriages, churches, institutions, or traditional values.

Good therapy expands your life. It should not progressively shrink your world.

Therapy Should Not Be Ideological Indoctrination

You have the right to receive therapy without being pressured to adopt your therapist's political, social, religious, or philosophical worldview.

Therapists are human beings. They have beliefs, biases, values, and blind spots. Ethical therapists recognize this and work hard not to impose those beliefs upon the people they serve.

Therapy should provide room for honest exploration. It should not steer you toward a predetermined conclusion.

A therapist should be able to respect your patriotism, religious faith, marriage, moral convictions, political beliefs, and understanding of duty even when those values differ from the therapist's own. You should not be shamed, patronized, or treated as psychologically unsophisticated because you hold traditional, conservative, or Christian beliefs.

Likewise, a therapist should not simply agree with everything you say. Good therapy sometimes involves respectful confrontation. The difference is that healthy confrontation is directed toward your healing, not toward remaking you in the therapist's image.

The therapy room belongs to your recovery, not to the therapist's ideology.

Look for Progress

Therapy should have a purpose.

That purpose is not necessarily the complete absence of painful memories or difficult emotions. Some experiences will always matter. Some losses will always hurt. The goal is not to erase your history but to help you carry it differently.

Over time, you should be able to identify meaningful signs of progress. You may sleep better, experience fewer nightmares, recover more quickly after being triggered, communicate more honestly, reduce your reliance on alcohol or other forms of escape, reconnect with your spouse or children, return to meaningful activities, or develop a greater sense of peace and purpose.

Progress is rarely a straight line. There will be difficult sessions, hard weeks, setbacks, and periods when change feels painfully slow. Even so, therapy should be moving somewhere.

You have the right to ask:

> ***What are we working toward?***
> ***How will we know whether this is helping?***

A good therapist should be able to answer.

Warning Signs That Deserve Attention

No therapist will be perfect, and one uncomfortable interaction does not necessarily mean the relationship should end. However, certain patterns should cause you to stop and take a closer look.

Be cautious if your therapist:

- Cannot clearly explain the treatment approach being used.
- Claims expertise in trauma without meaningful specialized training.
- Pushes you into detailed trauma processing before establishing safety and stability.
- Appears fascinated by combat, violence, death, or emergency scenes.
- Becomes defensive when you ask questions or express concerns.
- Talks excessively about personal beliefs, experiences, or political opinions.
- Dismisses your faith, values, military culture, or sense of duty.
- Labels disagreement as resistance, denial, fragility, or pathology.
- Encourages dependency rather than increasing your strength and independence.
- Repeatedly misdiagnoses or changes diagnoses without adequate explanation.
- Minimizes suicidal thoughts, substance use, aggression, or other serious risks.

- Treats every problem as trauma while overlooking medical, relational, spiritual, occupational, or substance-related factors.
- Discourages you from seeking a second opinion.
- Cannot acknowledge mistakes or reconsider the treatment plan.
- Promises certainty, rapid cures, or results that sound too good to be true.
- Violates professional boundaries or makes the relationship feel confusing, secretive, or inappropriate.

Trust your instincts. Veterans, active duty service members, and first responders are often skilled at reading people, even if trauma has sometimes made those instincts difficult to interpret. If something feels wrong, pause and examine it. Discuss it directly with the therapist if you feel safe doing so. Seek consultation from someone you trust. Obtain a second opinion.

You are allowed to leave.

Do Not Confuse Discomfort With Harm

Good therapy will not always feel comfortable.

A strong therapist may challenge your avoidance, confront destructive behavior, question the stories you tell yourself, or ask you to take responsibility for choices that have harmed others. You may leave some sessions tired, stirred up, or emotionally exposed.

That does not necessarily mean the therapy is harmful.

The question is whether the discomfort serves a clear therapeutic purpose within a relationship marked by competence, respect, honesty, and safety. Productive discomfort moves you toward greater freedom. Harmful therapy leaves you increasingly confused, dependent,

ashamed, destabilized, or disconnected from the people and values that matter most.

A good therapist will not merely tell you what you want to hear. But that therapist should always treat you with dignity.

You Are Not Broken, and You Are Not Powerless

Perhaps you have already had a discouraging experience with therapy. Maybe you sat across from someone who did not understand you. Maybe you were reduced to a diagnosis, placed on a treatment conveyor belt, pressured to disclose before you were ready, or given advice that made matters worse.

Do not allow one poor therapist to convince you that healing is impossible.

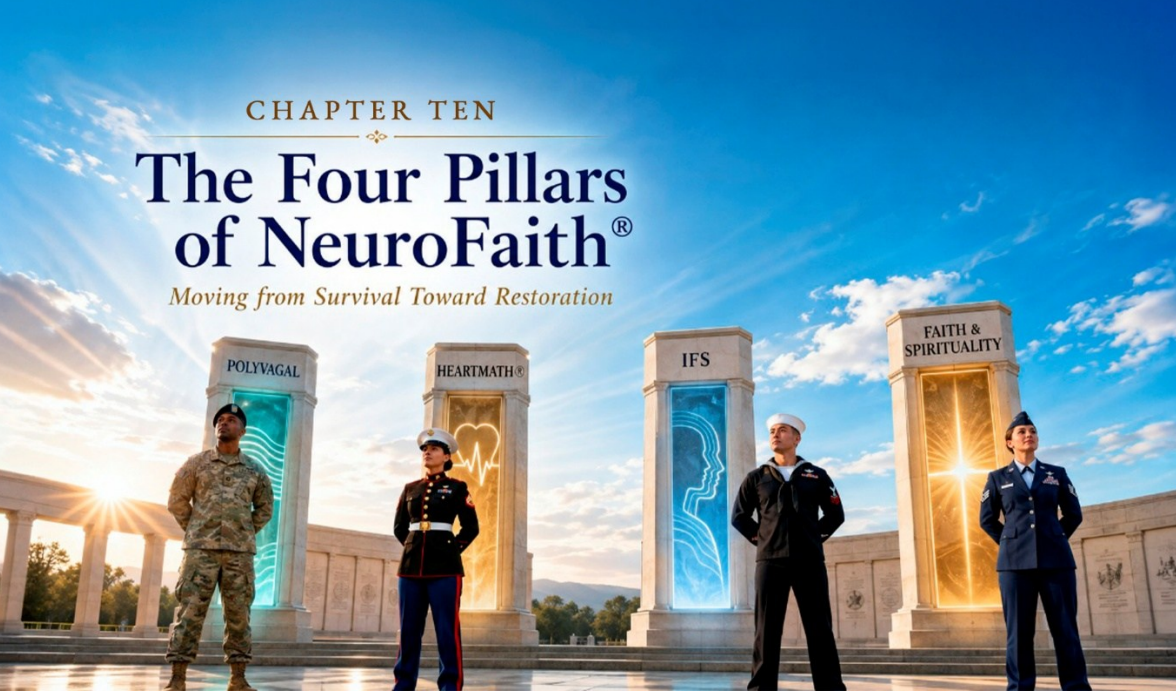
There are exceptional therapists doing courageous, thoughtful, life-changing work. There are clinicians who understand trauma, respect military and first responder culture, remain humble about what they do not know, and will stand beside you without trying to control you.

Keep looking until you find someone worthy of your trust.

The right therapist will not see you merely as a collection of symptoms. That person will recognize the courage it took to survive, the cost of carrying what you have carried, and the strength required to ask for help.

You are not surrendering your authority by entering therapy. You are choosing an ally.

Choose carefully. • Ask hard questions.
Expect competence. • Demand honesty.
Protect your values. • Watch for progress.
And never forget that the purpose of therapy is not to keep you in treatment forever. The purpose is to help you reclaim your life.



The Four Pillars of Healing A Restorative Pathway for Whole

We have reached an important turning point in this book. Until now, our purpose has been to help you understand the wounds you carry and make thoughtful decisions about the care you receive. We now turn from understanding trauma to participating actively in its healing.

Insight is essential, but insight alone may not calm a body that remains prepared for danger, restore trust after betrayal, release deeply rooted shame, or reconnect you with meaning and purpose. You may understand exactly why you react as you do and still feel unable to stop the reaction once it begins.

Lasting healing requires us to engage the whole person.

The Four Pillars of NeuroFaith® were developed for that purpose. Together, they address the nervous system, the heart-brain connection, the internal world, and the spiritual dimension of life. Each pillar offers

a different pathway into healing, yet all four are designed to work together as parts of one integrated model.

The goal is not merely to help you manage symptoms. It is to help you become more regulated, integrated, connected, and fully alive.

Healing Often Begins Incrementally

For someone living with nightmares, panic, rage, emotional shutdown, addiction, or relentless hypervigilance, even a modest reduction in symptoms can be life-changing. Sleeping through the night, interrupting a destructive thought, tolerating a painful emotion, returning to work, or remaining present during a difficult conversation may represent enormous victories.

Many established therapies, including Cognitive Behavioral Therapy and Dialectical Behavior Therapy, have helped countless people achieve these kinds of changes. They can provide essential skills for challenging destructive patterns of thinking, regulating overwhelming emotions, tolerating distress, and restoring stability. For many people, these approaches have been not only valuable but lifesaving.

We should never minimize the importance of stabilization. When your inner world feels chaotic, learning how to regain control is a vital beginning. Before deeper healing can occur, you may first need to sleep, breathe, think clearly, reduce dangerous behavior, and experience enough safety to remain present.

But stabilization is not always the end of the journey.

Many veterans and active duty personnel, and first responders eventually discover that even after their symptoms become more manageable, something deeper still needs attention. The nightmares may occur less often, but the body remains prepared for danger. Anger

may become more controlled, but intimacy still feels threatening. Life may appear stable from the outside while grief, shame, loneliness, or moral injury continues quietly beneath the surface.

You may learn to cope more effectively and still sense that you have not fully come home.

Incremental and Transformational Therapy

This is where the distinction between incremental and transformational therapy becomes important. These are not opposing approaches, and one should not be used to diminish the other. They describe different aims within the healing process.

Incremental therapy helps you make meaningful changes within the life you are currently living. It may reduce symptoms, improve functioning, develop coping skills, strengthen relationships, and restore stability. These changes matter deeply and often provide the foundation upon which everything else is built.

Transformational therapy asks a broader question: What would it mean not only to manage these reactions but also to heal the deeper system from which they arise?

Transformation reaches beneath symptoms into the places where trauma became encoded, where the nervous system learned to anticipate danger, where shame attached itself to identity, and where trust and connection were disrupted. It seeks more than improved control over symptoms. It seeks greater integration of the brain, body, heart, relationships, internal world, and spirit.

This does not mean that transformational therapy erases the past. Combat, loss, betrayal, violence, and moral injury cannot simply be removed from your history. Healing does not require forgetting. It means helping the past release its control over the present.

Transformation occurs as the body learns that it no longer has to remain continuously prepared for battle. It occurs as wounded and protective parts no longer have to carry their burdens alone. It occurs as relationships become safer, identity is no longer organized around shame, and meaning begins to emerge from experiences that once seemed capable only of destroying it.

Sometimes transformation unfolds through dramatic moments of insight or release. More often, it develops through a series of small but deeply connected changes. Incremental progress and transformation are therefore not separate roads. Incremental changes can become the steps through which transformation gradually takes place.

A Whole-Person Approach

NeuroFaith® does not reject established therapies or the essential work of stabilization. It expands the therapeutic field by addressing

dimensions of trauma that may not be reached through thought and behavior alone.

Trauma is not experienced in only one part of us. It can shape the way the brain interprets the world, the way the nervous system responds to perceived danger, the rhythms of the heart, the stories we believe about ourselves, the parts of us that remain burdened by the past, and the ways we understand meaning, purpose, and hope.

Healing should not be confined to one part of us either.

The Four Pillars offer four interconnected points of entry into this deeper work.

1. Polyvagal-Informed Therapy

Polyvagal-Informed Therapy helps us understand the language of the autonomic nervous system. It provides a compassionate framework for recognizing states of safety, mobilization, and shutdown and for understanding why the body may react before the conscious mind knows what is happening.

The purpose is not to eliminate the survival system that protected you. It is to recalibrate that system so it can respond appropriately to the life you are living now. Over time, the nervous system can become more flexible, more responsive to genuine safety, and more capable of returning to connection after being activated.

2. HeartMath® and Neurocardiology

The heart and brain are engaged in continuous, bidirectional communication. Breathing patterns, heart rhythms, attention, and emotional states influence how the body organizes itself and how clearly we are able to think, feel, and respond.

HeartMath® practices provide practical ways to work with this connection. They help develop greater physiological coherence, emotional regulation, and internal steadiness. For someone whose body has spent years preparing for the next crisis, learning to influence that internal state can become an important part of reclaiming a sense of control.

3. Internal Family Systems

Trauma can leave us feeling divided within ourselves. One part may want connection while another refuses to trust. One part may carry grief while another uses anger to prevent that grief from being felt. One part may want to move forward while another remains frozen in the moment everything changed.

Internal Family Systems offers a compassionate way to understand these different parts. Rather than treating them as enemies or evidence that something is wrong with you, we become curious about why they developed and what they have been trying to protect.

Healing does not require you to declare war upon yourself. It involves helping wounded and protective parts discover that they are no longer alone and do not have to continue carrying the same burdens in the same way.

4. Faith and Spirituality

Trauma frequently reaches into our deepest questions about identity, justice, goodness, suffering, meaning, and purpose. It may change what you believe about yourself, other people, the world, or whatever you understand to be sacred.

For some, faith is grounded in a particular religious tradition. For others, spirituality is expressed through deeply held values, service, community, connection with nature, or a relationship with something

greater than oneself. NeuroFaith® respects these differences. Its purpose is not to impose a predetermined belief system but to create room for honest exploration.

Healthy faith and spirituality can provide meaning, belonging, forgiveness, hope, and moral grounding. Spiritual struggle can also become part of the wound, particularly when someone feels abandoned, condemned, betrayed, or unable to reconcile what happened with what was once believed.

This pillar does not use faith to silence pain or provide easy answers. It creates a safe place to explore the questions trauma often leaves behind: Who am I now? How do I live with what I witnessed, did, or could not prevent? Can I forgive myself? What still gives my life meaning? Do I still have a purpose?

For many active duty service members, veterans, and first responders, these questions are not separate from trauma recovery. They are central to it.

One Integrated Pathway

The Four Pillars are not four unrelated techniques. They are different doorways into one interconnected human system.

Polyvagal-Informed Therapy helps the nervous system recognize safety. HeartMath® and neurocardiology help develop physiological coherence and emotional steadiness. Internal Family Systems brings compassion and integration to the wounded and protective parts within us. Faith and spirituality reconnect healing with meaning, values, hope, and purpose.

You may initially respond more strongly to one pillar than another. The language of the nervous system may immediately make sense to you.

HeartMath® may provide your first direct experience of influencing what is happening inside your body. Internal Family Systems may help you understand conflicts you have carried for years. Faith and spirituality may reconnect you with meaning that trauma nearly extinguished.

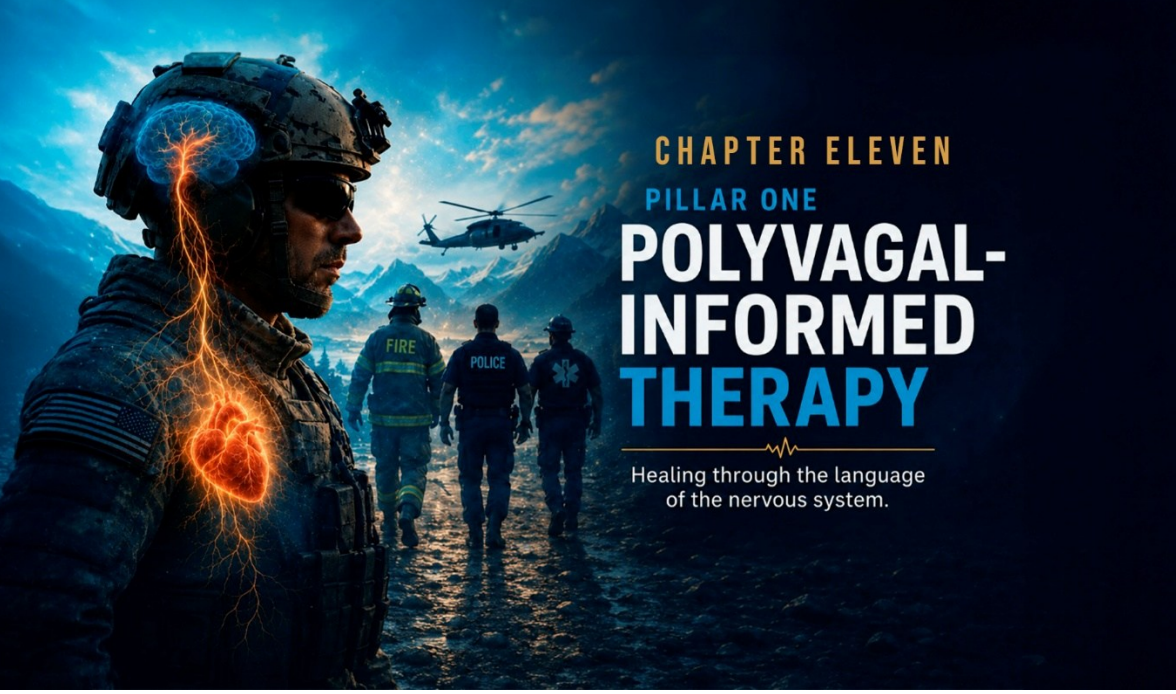
There is no wrong doorway. Begin where something within you recognizes hope.

The chapters ahead will take you more deeply into each pillar. We will respect the strength that carried you this far while helping you develop new ways of living now that the mission has changed.

Symptom relief matters. Stability matters. Functioning matters. But the hope of healing reaches further. It is the hope that you can become more present within your own life, more connected to the people you love, more at peace within your body, and more grounded in meaning and purpose.

The goal is not to return you to the person you were before trauma. It is to help you move forward as a more integrated, grounded, and fully alive version of the person you are still becoming.

Welcome to the Four Pillars of NeuroFaith®. This is where the deeper work of restoration begins.



Pillar One Polyvagal-Informed Therapy

You may know, logically, that you are home. You may know the door is locked, the street is quiet, the restaurant is safe, and the person beside you loves you. Yet your shoulders remain tight. Your eyes keep tracking the exits. A slammed door sends a jolt through your chest. Sleep comes lightly, if it comes at all. Or perhaps your body goes in the other direction: you become heavy, numb, exhausted, disconnected, and unable to care about things that once mattered.

This is one of trauma's most frustrating realities: the mind may understand that the danger has passed while the body continues to live as though it has not (Porges & Porges, 2023).

To summarize what we established earlier, the autonomic nervous system continually evaluates safety and danger through neuroception. The sympathetic system mobilizes you to fight or flee, the dorsal vagal system can contribute to collapse or shutdown when danger feels inescapable, and the ventral vagal system supports safety, connection, flexible thinking, and recovery. We will not repeat all of that science

here. Chapter 10 has a different purpose: learning to use that map (Porges, 2011, 2017).

Polyvagal-Informed Therapy begins with a practical truth: trauma is not only a memory of something that happened. Trauma is also a dynamic pattern held in the brain and body. It can live in breathing, muscle tension, heart rhythm, posture, digestion, sleep, startle responses, pain, emotional numbing, and the impulse to scan, withdraw, attack, control, or escape. This is why insight alone is often not enough. You cannot always reason a nervous system out of an alarm state. Sometimes you must first help the body experience enough safety to stand down (Porges & Porges, 2023).

That does not mean we ignore thoughts, beliefs, memory, meaning, faith, grief, or moral injury. It means we approach them in the right order. When the nervous system is highly activated or shut down, the parts of the brain needed for reflection, perspective, language, and choice are less available. As the body becomes more regulated, you gain greater access to the mind. Then trauma-focused therapies can help you work with memories and beliefs such as I should have prevented it, I failed my people, I am permanently damaged, I cannot trust anyone, or I am not safe anywhere.

> Body first does not mean body only. Regulation creates the conditions in which reflection, trauma processing, new learning, and restored connection become possible.

The Nervous System You Brought Home

Military service and emergency work train the nervous system to do extraordinary things. You learn to notice what others miss, make decisions with incomplete information, override fear, endure discomfort, suppress emotion long enough to complete the task, and

move toward danger while others move away. Those abilities are not pathology. They are disciplined forms of survival.

The difficulty comes when an operational setting becomes the body's default setting. The same vigilance that protected a patrol may become constant scanning at the grocery store. The rapid mobilization that got you through an ambush, structure fire, violent arrest, code, or mass-casualty call may appear at home as irritability, impatience, road rage, insomnia, or an explosive reaction to a minor interruption. The emotional compartmentalization that allowed you to function at the scene may later become numbness with your spouse, children, friends, or faith community.

At other times, the system runs out of mobilizing energy. You may feel drained, detached, ashamed, hopeless, or unable to move. You may spend hours in a chair, avoid calls, cancel plans, or feel as if you are watching life from a distance. This shutdown is not laziness. It may be the nervous system's protective attempt to conserve energy and reduce unbearable sensation.

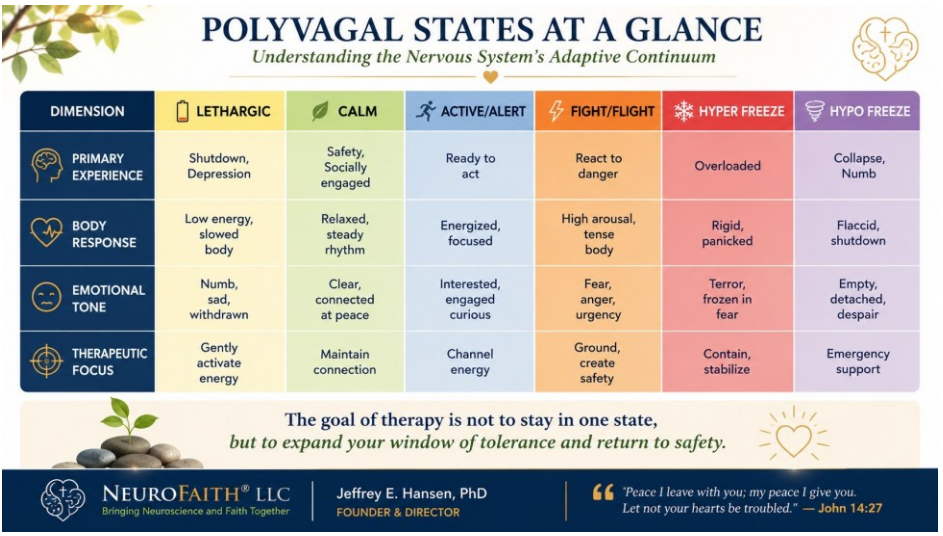
A regulated nervous system is not one that remains calm all the time. Health is flexibility: moving into action when action is required, remaining connected under manageable stress, and returning toward recovery when the danger has passed. The goal is not to turn a warrior into someone passive or unprepared. It is to restore range and choice (Porges, 2011, 2017).

A Field Map: Green, Orange, Red, and Yellow

The accompanying Emotion Regulation Chart summarizes the states discussed earlier and turns them into a practical field map. Its colors provide plain, nonjudgmental language for noticing your state. They are not diagnoses or measures of character. A map does not shame you for

where you are; it helps you decide what direction to move next (Dana, 2018, 2020).

Emotion Regulation Chart



POLYVAGAL STATES AT A GLANCE

Understanding the Nervous System's Adaptive Continuum

DIMENSION	LETHARGIC	CALM	ACTIVE/ALERT	FIGHT/FLIGHT	HYPER FREEZE	HYPO FREEZE
PRIMARY EXPERIENCE	Shutdown, Depression	Safety, Socially engaged	Ready to act	React to danger	Overloaded	Collapse, Numb
BODY RESPONSE	Low energy, slowed body	Relaxed, steady rhythm	Energized, focused	High arousal, tense body	Rigid, panicked	Flaccid, shutdown
EMOTIONAL TONE	Numb, sad, withdrawn	Clear, connected at peace	Interested, engaged curious	Fear, anger, urgency	Terror, frozen in fear	Empty, detached, despair
THERAPEUTIC FOCUS	Gently activate energy	Maintain connection	Channel energy	Ground, create safety	Contain, stabilize	Emergency support

The goal of therapy is not to stay in one state,
but to expand your window of tolerance and return to safety.

NEUROFAITH® LLC
Bringing Neuroscience and Faith Together

Jeffrey E. Hansen, PhD
FOUNDER & DIRECTOR

"Peace I leave with you; my peace I give you. Let not your hearts be troubled." — John 14:27

Green: regulated and connected

Your breathing is fuller, your heart rhythm is steadier, your attention can widen, and you can take in the whole situation rather than only the threat. You can listen, think, use humor, receive care, and feel appropriately alert without being consumed by urgency. Green does not mean defenseless. It means present, flexible, and able to choose.

Orange Mobilized

Your body is preparing for action. Muscles tighten, breathing speeds up, attention narrows, and energy rises. You may become restless, guarded, impatient, controlling, or unable to sit still. Orange can be useful when you need to perform. It becomes costly when it persists after the task has ended.

Red: overwhelmed alarm

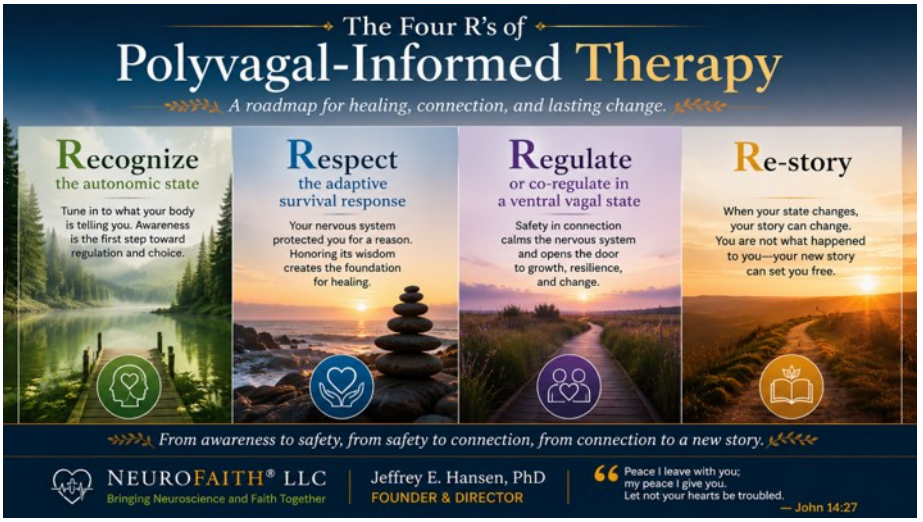
Mobilization has intensified. You may experience rage, panic, terror, tunnel vision, an urge to flee, or the feeling that you must act immediately. Reasoning with yourself may be difficult because survival circuitry has taken priority. Red is not the time for a major relationship conversation or a detailed analysis of the past. It is the time to reduce danger, create space, and regulate.

Yellow: shutdown or collapse

Energy drops. You may feel heavy, foggy, numb, ashamed, depressed, disconnected, or unable to initiate action. You may withdraw, sleep excessively, stare at a screen, or lose track of time. Yellow is not simply a quieter version of green. It is a protective state that often requires gentle energy, movement, warmth, light, rhythm, and safe connection rather than further slowing.

Some people move quickly from orange or red into yellow. Others live in a blended state: physically exhausted but internally vigilant, numb but unable to sleep, depressed yet constantly scanning. These are not rigid boxes; the map simply helps you notice the direction your system is moving.

The Four R's: A Practical Path Back Toward Regulation



Polyvagal clinician Deb Dana describes four useful movements: Recognize, Respect, Regulate, and Re-story (Dana, 2018, 2020). The first three work primarily from the bottom up, using sensation, movement, breath, environment, and relationship to influence the brain. The fourth works more from the top down, using language, perspective, meaning, and new beliefs. For trauma survivors, this order matters.

Recognize the autonomic state

Operational competence often depends on ignoring your own body. You finish the mission, treat the patient, secure the scene, complete the report, check on everyone else, and deal with yourself later. The problem is that later may never come. Recognition begins by reversing that habit for a few moments. You learn to read your own internal instruments.

Do not begin with Why am I acting this way? Begin with What is my body doing right now? The first question can quickly become an accusation. The second is observation.

- Breathing: Is it rapid, shallow, held, or full?
- Heart and chest: Is there pounding, pressure, fluttering, or unusual slowing?
- Muscles: Are your jaw, hands, shoulders, abdomen, or back braced?

- Attention: Are you seeing the whole room, or only possible threats?
- Energy: Are you charged, restless, and ready to move, or heavy, foggy, and collapsed?
- Connection: Do people feel accessible, irritating, unsafe, or impossibly far away?
- Impulse: Do you want to fight, flee, freeze, hide, use a substance, control the situation, or disappear?

> A 30-second check-in: Pause and name five things without trying to fix them: my breathing is..., my muscles are..., my heart is..., my energy is..., and my impulse is.... Then name the zone that best fits: green, orange, red, or yellow. End with: This is a state, not my identity. States can change.

Recognition creates a small amount of distance between you and the reaction. Instead of I am out of control, you can say, My system is moving into red. Instead of I am worthless and lazy, you can say, My system is in yellow and trying to conserve. This language reduces shame and opens the door to choice.

Respect the adaptive survival response

Respect does not mean liking the response or allowing it to harm you or someone else. It means understanding that the response developed for protection. Your nervous system was not trying to ruin your marriage, isolate you from your children, destroy your sleep, or make civilian life miserable. It was trying to keep you alive using rules learned under extreme conditions.

Perhaps anger created enough force to get you through. Perhaps emotional numbness allowed you to handle bodies, injuries, loss, or repeated exposure to human cruelty. Perhaps never fully relaxing kept you ready. Perhaps alcohol, opioids, pornography, gambling, work, or relentless exercise temporarily changed an unbearable internal state. Recognizing the protective function does not excuse destructive behavior, but it helps us treat the cause rather than merely condemn the symptom.

This distinction is especially important for freeze, collapse, and dissociation. People often judge themselves for what they did not do during a traumatic event. They ask why they did not fight harder, move faster, speak, or save everyone. Under overwhelming or inescapable threat, the nervous system may inhibit action, narrow awareness, alter pain perception, or disconnect a person from experience. These are involuntary survival responses, not moral verdicts (Porges, 2017).

Responsibility remains part of healing. If protective reactions frighten your family, fuel substance misuse, or isolate you from people who love you, those consequences must be faced. But responsibility works better without contempt: This response makes sense, and it is costing me. It protected me then, and I need a different response now.

> Replace What is wrong with me? with What is my nervous system trying to protect me from right now? Then add: Thank you for trying to protect me. I am going to check whether this response is still needed.

Regulate or co-regulate in a ventral vagal state

Once you recognize and respect the state, choose an intervention that fits it. Regulation is not forcing yourself to feel peaceful; it is helping the nervous system move one step toward safety, connection, and flexibility. Even a five-percent shift matters because the aim is enough steadiness to recover choice (Dana, 2018, 2020).

When You Are in Orange or Red

A highly activated system usually needs less stimulation, more space, slower rhythm, and a clear signal that immediate action is not required. If there is actual danger, address safety first. Polyvagal practices are not substitutes for leaving an unsafe setting, calling for help, or obtaining emergency care.

Orient to the present. Slowly turn your head and let your eyes scan the room. Name the date, your location, and three signs that the current setting is different from the traumatic setting.

Lengthen the exhale. Breathe gently through the nose if comfortable. Let the out-breath become slightly longer than the

in-breath without forcing a deep breath. Try four seconds in and six seconds out for several cycles, adjusting if lightheaded.

Release one point of bracing. Unclench the jaw, lower the shoulders, open the hands, or let the tongue rest. Do not demand that the entire body relax at once.

Use grounded pressure. Feel both feet against the floor, your back against a chair, or your hands pressing against a wall. Firm, controlled muscular effort can give mobilized energy somewhere safe to go.

Reduce input. Step away from the argument, crowd, news, traffic, bright light, or noise. Say clearly that you need time to regulate and will return at a specific time.

Move rhythmically. Walk at a steady pace, ride a stationary bike, stretch, or perform slow controlled repetitions. The purpose is not punishment or exhaustion; it is organized completion of mobilizing energy.

Use a familiar cue of safety. A trusted voice, prayer, music, a service dog, time outdoors, or a familiar object can remind the body that this moment is not the past.

> The tactical pause: Stop. Create physical space. Feel your feet. Look for three present-day safety cues. Exhale longer than you inhale five times. Decide on only the next safe action. Do not solve the marriage, the career, or the past while your system is in red.

When You Are in Yellow

Shutdown often needs a different approach. More stillness and slower breathing may deepen collapse. Begin with small amounts of safe activation.

- Bring in light and orientation. Open the curtains, step outside, and name what you see and hear.

- Use small movement. Sit upright, press your feet into the floor, stretch your arms, walk to the mailbox, or complete one simple task.
- Add rhythm and temperature. Use music with a steady beat, a warm shower, a cool cloth on the face, or a warm drink, depending on what helps you feel more present.
- Invite low-demand connection. Sit near someone safe, call a trusted peer, attend a familiar group, or spend time with a calm animal. You do not need to explain everything.
- Choose one act of agency. Drink water, eat something nourishing, take prescribed medication as directed, or make the appointment. Small action tells the system that movement is possible.

> The return-from-shutdown sequence: Light. Upright posture. Feet on the floor. Ten slow steps. Water. One safe person. One manageable task. Stop before effort becomes overwhelm, and repeat later.

Co-regulation: We Do Not Heal Alone

Self-regulation matters, but human nervous systems were built to regulate in relationship. Co-regulation occurs when the steady presence of another person helps your body move toward safety. Long before we can explain what we feel, we read faces, voices, posture, movement, proximity, and rhythm. We continue doing this throughout life (Porges, 2011, 2017) (Porges, 2011, 2017).

Active duty service members, veterans, and first responders often understand co-regulation better than they realize. A trusted team member's voice can lower chaos. A competent leader can steady an

entire group. People who served together may communicate safety with a glance, a tone, or a few words. The challenge is learning that connection can remain useful after the team disperses and the uniform comes off.

Isolation may feel safer because nobody can surprise, disappoint, question, or misunderstand you. In the short term, withdrawal may reduce demand. Over time, however, prolonged isolation deprives the nervous system of corrective experiences. Healing often requires carefully chosen people, not every person. One trustworthy relationship is more valuable than a room full of unsafe ones (Dana, 2018; Porges, 2017).

Signals of Safety You Can Offer

The same cues that help you feel safe can help your spouse, children, peers, patients, or colleagues regulate. These behaviors must be genuine rather than performed as tricks.

- Use kind, attentive eyes without staring or demanding eye contact.
- Let your voice carry warmth and natural variation. A flat, clipped command voice may be useful operationally but can signal danger at home.
- Keep your face and words congruent. A forced smile paired with anger or contempt will not feel safe.
- Respect personal space. Do not move in quickly, block an exit, tower over someone, or insist on physical contact.
- Slow the pace. Fewer words, a lower volume, and pauses between sentences give both nervous systems time to settle.
- Listen before fixing. Being understood can regulate more effectively than receiving immediate advice.

For family members, one of the most regulating statements can be: I can see that your system is overloaded. I am here. We do not have to solve this in this moment. What would help you feel a little safer right now?

Build a Personal Regulation Plan Before You Need It

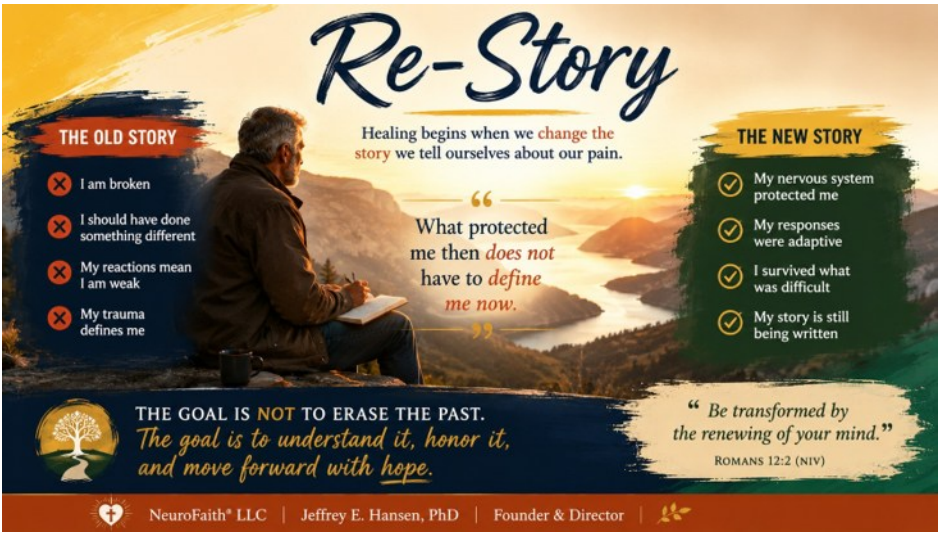
When you are in red or deep yellow, creativity and recall are reduced. Build your plan while you are relatively regulated. Keep it brief enough to use.

My early orange signs are...
My red signs are...
My yellow signs are...

Three practices that reliably help me move one step toward green are...
Two people who can help me co-regulate are...
The words I want them to use are...
The behaviors that make things worse are...
If I become unsafe or unable to function, I will contact...

Practice the plan when you do not desperately need it. Like any trained response, regulation skills become more available under stress through repetition.

Re-story



Once your body is more regulated, you can begin working with the story your mind created around the trauma. The story often formed while you were terrified, helpless, enraged, grieving, exhausted, or responsible for impossible decisions. It may contain fragments of truth, but it may also contain conclusions shaped by survival (Dana, 2018, 2020; Kain & Terrell, 2018).

Common trauma beliefs active duty service members, veterans, and first responders include: I failed. I should have known. I should have saved them. I am weak because this affects me. If I relax, something terrible will happen. Nobody outside the job can understand. I am dangerous. I am permanently broken. God abandoned me. I do not deserve to come home when others did not.

Trying to argue with these beliefs while the body is in full alarm often fails. The body interprets the intensity of the state as evidence that the belief must be true. Regulation does not automatically erase the belief, but it creates enough space to examine it rather than obey it.

Questions for Re-storying

- What did I know at the time, not what do I know now?
- What control did I actually have in that situation?
- What standard am I using for myself that I would never use for another person who served beside me?
- What did my nervous system do to help me survive or continue functioning?
- What part of the story belongs to grief, and what part belongs to guilt?
- Is this belief completely true, or is it a survival conclusion that has never been reexamined?
- What would a more accurate and compassionate statement sound like?

Re-storying is not positive thinking and it is not pretending that terrible things were acceptable. It is the disciplined work of building a narrative that includes the whole truth: what happened, what it cost, what was outside your control, what you did to survive, what you regret, what you value, and who you are becoming (Kain & Terrell, 2018).

> Old story: If I stop scanning, I will fail to protect my family.
>
> More complete story: Vigilance protected people in dangerous settings. At home I can use reasonable precautions, notice present safety, and allow my family to experience me as present rather than permanently on patrol.
>
> Old story: I froze, so I am a coward.
>
> More complete story: My nervous system entered an involuntary survival state under overwhelming threat. I can grieve what

> happened without converting physiology into a verdict on my character.
>
> Old story: I should be over this by now.
>
> More complete story: My body learned survival through repeated experience. It will learn safety through repeated experience as well. Progress may be incremental, but incremental does not mean insignificant.

Regulation Makes Trauma Therapy More Reachable

Polyvagal-informed work is not necessarily a complete trauma treatment by itself. It is a foundation that can make other effective treatments more tolerable and productive. Once you can notice activation, remain within a workable range, and return toward regulation, you may be better able to engage therapies that directly address traumatic memories, avoidance, guilt, shame, and negative core beliefs (Dana, 2018, 2020).

Depending on your needs and the training of your clinician, treatment may include Cognitive Processing Therapy, Prolonged Exposure, Eye Movement Desensitization and Reprocessing, trauma-focused cognitive behavioral approaches, Acceptance and Commitment Therapy, Internal Family Systems, or other evidence-informed and emerging approaches. These treatments differ, but many require enough nervous-system stability to approach painful material without becoming completely overwhelmed or shut down.

The purpose of regulation is not to avoid the trauma forever. If calming techniques become a way to escape every difficult feeling or memory, they can unintentionally reinforce avoidance. The purpose is to help you approach the work with greater capacity. A good therapist will help you find the difference between flooding and productive discomfort,

between forced disclosure and courageous engagement, and between temporary relief and lasting change.

Incremental progress deserves respect. Perhaps you notice activation ten minutes earlier, recover from an argument in an hour rather than a day, sit with a memory briefly without leaving the present, or tell your spouse that you are moving into red instead of slamming the door. These are meaningful signs that the nervous system is learning flexibility.

Do Not Turn Regulation Into Another Performance Test

Warriors and first responders can turn any assignment into a standard to meet. Nervous-system regulation may become one more arena for self-judgment: I should control this. I am doing the breathing wrong. I failed because I still had a nightmare.

That mindset recreates threat. Regulation is a relationship with the body, not domination of it. A practice that helps one day may not help another, and a technique that calms one person may activate someone else. Closing the eyes may feel peaceful to one veteran and unsafe to another. Deep breathing can help, but forced breathing may provoke dizziness or panic. Choice, pacing, and curiosity matter.

Ask not, Did I make the feeling disappear? Ask, Did I become slightly more present, more able to choose, or less alone? Healing develops through repeated experiences in which the body expects danger and encounters enough safety instead.

When Self-Regulation Is Not Enough

There are moments when skills are not enough and immediate support is required. Seek urgent help if you are at risk of harming yourself or someone else, cannot care for basic needs, are experiencing severe

withdrawal, have gone for an extended period without sleep and are becoming unstable, or are losing contact with reality. Contact emergency services, the Veterans Crisis Line, a local crisis service, or a trusted professional according to your location and circumstances. Reaching for support is not a failure of regulation. It is an act of protection.

Medical evaluation is also important when symptoms such as chest pain, fainting, severe breathing difficulty, sudden neurological changes, or other concerning physical symptoms occur. Trauma can affect the body, but not every physical symptom should be assumed to be trauma.

A Daily Five-Minute Practice

The nervous system changes through repetition. The following brief practice can help you build familiarity without waiting for a crisis.

1. **Orient.** Look around slowly. Let your eyes land on three neutral or pleasant details. Remind yourself where you are and what day it is.
2. **Notice.** Name your breath, muscle tension, energy, impulse, and current color zone.
3. **Choose.** If activated, lengthen the exhale and release one point of bracing. If shut down, sit upright, bring in light, and add gentle movement.
4. **Connect.** Bring to mind a trustworthy person, animal, place, prayer, or memory of safety. When possible, make actual contact with someone safe.
5. **Re-story.** Complete one sentence: My body is trying to protect me from..., and in this present moment I know....

6. End before the exercise becomes another demand. Consistency matters more than intensity.

To Summarize: The Body Can Learn a New Ending

To summarize, Polyvagal Theory offers a compassionate explanation for why you can be home and still not feel home, surrounded by people and still feel alone, exhausted and still unable to rest. Your nervous system may simply be continuing strategies that once helped you survive (Porges & Porges, 2023).

Those responses were not evidence that you lacked courage. But survival is not the final destination. Through repeated experiences of safety, movement, connection, truth, faith, and skilled treatment, the nervous system can learn new patterns (Porges, 2017).

As your body settles, the mind becomes more available. You can examine negative core beliefs without being swallowed by them, approach traumatic memories without confusing past danger with present danger, repair relationships, receive comfort, grieve losses, and reclaim purpose (Kain & Terrell, 2018).

The mission now is not to erase the warrior, the officer, the firefighter, the paramedic, the dispatcher, the corrections officer, or the medic within you. It is to help every part of you recognize that constant battle is no longer required.

Your body learned how to survive. With patience, practice, safe relationships, and appropriate treatment, it can also learn how to live.

Transition to Pillar Two

Polyvagal-Informed Therapy teaches us to recognize the body's alarm and help the nervous system recover flexibility. The next pillar builds on that foundation by turning to the dynamic conversation between the

heart and the brain. Through HeartMath® and neurocardiology, we will explore how breathing, heart rhythm, attention, and emotion can be brought into greater coherence, strengthening resilience and expanding the body's capacity for safety and connection.

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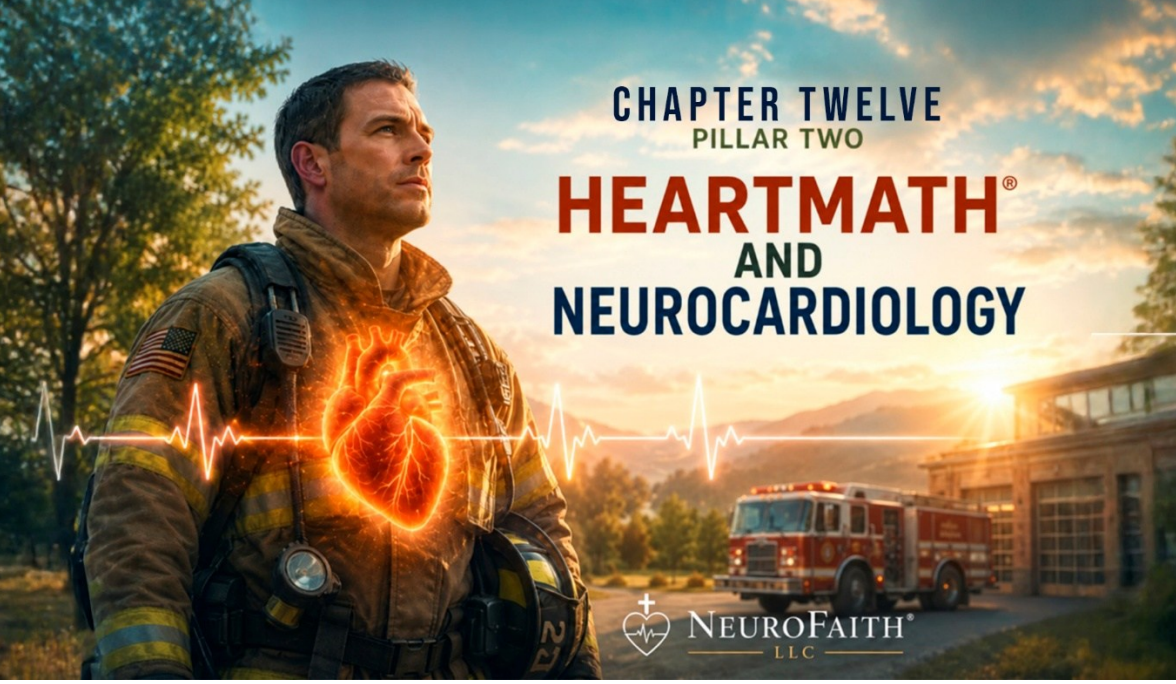


Pillar Two HeartMath®

In *The Wisdom of the Heart and the Pathway Home*

In the previous chapter, we learned to recognize when the nervous system moves into mobilization, shutdown, or connection. We also learned an essential sequence: help the body become regulated enough that the mind can engage the deeper work of trauma. HeartMath® and neurocardiology now give us another practical doorway into that same process.

Your heart is not simply a pump operating in isolation. It is in constant conversation with the brain. Through nerve pathways, breathing, blood pressure, hormones, and the changing rhythm between heartbeats, the heart continuously sends information upward. The brain uses that information as part of its ongoing assessment of safety, demand, and readiness. When the body is under threat, the heart changes. When the heart's pattern becomes steadier, the information reaching the brain also changes (McCraty, 2023).

That matters to active duty service members, veterans, and first responders because trauma often disrupts rhythm. You may be sitting in a quiet room while your heart pounds as if action is required. You may become activated during conflict before you know what you are feeling. You may lie down exhausted while your body refuses to release the day. Heart-focused regulation gives you something concrete to do in those moments. By changing breathing, attention, and emotional focus, you can begin influencing the signals traveling between the heart, brain, and autonomic nervous system.

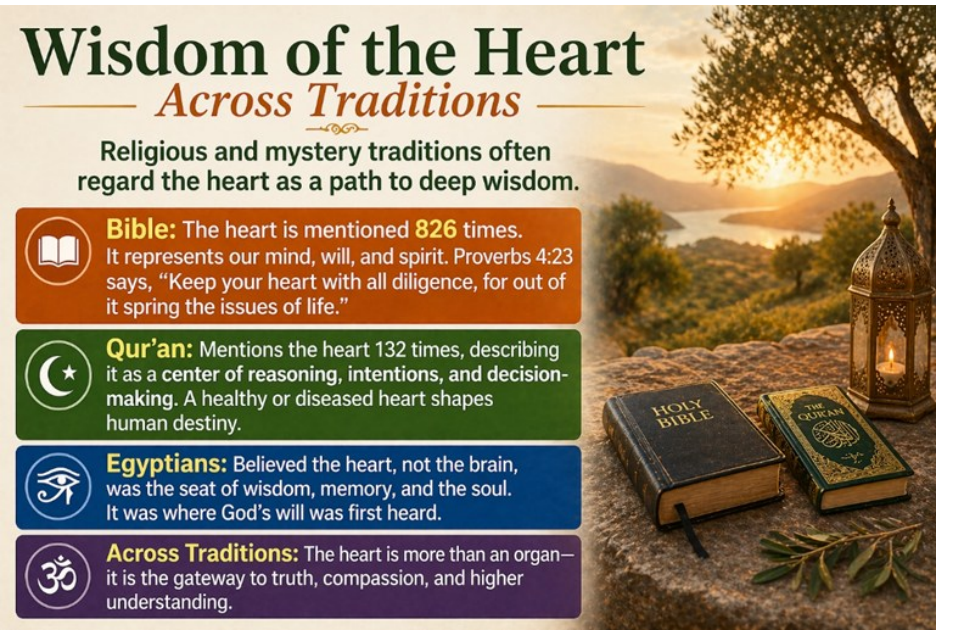
This is not mystical control over every symptom, and it is not a demand to feel positive when something painful has happened. It is a trainable skill that may help you create a more orderly physiological pattern, recover perspective, and respond with greater choice.

Polyvagal work helps you recognize the state you are in. HeartMath® gives you a practical way to influence the rhythm within that state.

The Ancient Wisdom of the Heart

Long before anyone could measure heart rate variability, map the vagus nerve, or watch the brain respond to changes in bodily state, human beings understood that the heart mattered. Across centuries and cultures, the heart became the language of courage, sorrow, loyalty, love, conviction, and spiritual life. We speak of losing heart, taking heart, knowing something by heart, having a change of heart, or acting from the heart. We do not use that language because the heart is merely sentimental. We use it because human beings have always sensed that the heart stands near the center of what it means to be alive.

Scripture gives the heart an equally central place: "Above all else, guard your heart, for everything you do flows from it" (Proverbs 4:23, NIV). The ancient writer was not presenting a lesson in cardiovascular physiology. He was pointing toward something deeper: our inner life shapes how we see, choose, relate, endure, and become. The heart symbolizes the place where thought, emotion, conscience, desire, faith, and identity meet.

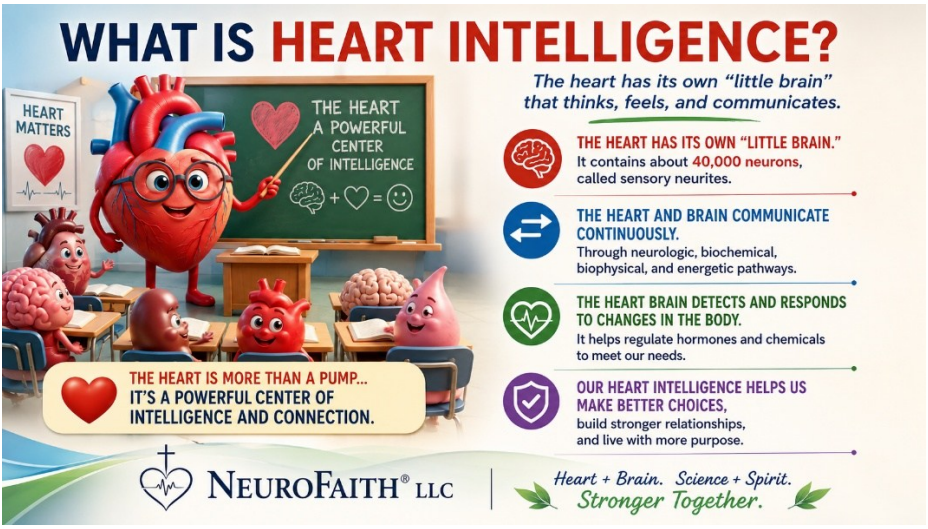


For a long period, modern science had little room for such language. The heart was treated primarily as a mechanical pump, magnificent in its construction but subordinate to the brain. That view gave medicine extraordinary knowledge, yet it also narrowed our imagination. Neurocardiology has begun to widen it again. The heart remains a pump, but it is not only a pump. It contains an intrinsic nervous system, communicates continuously with the brain, responds exquisitely to emotion and stress, and participates in the regulation of the entire organism (McCraty, 2023).

Science does not diminish the mystery of the heart. At its best, science allows us to approach that mystery with greater humility and wonder. What the ancients intuited in poetry, prayer, courage, and grief, we are now learning to observe through physiology. The languages are different, but they may be pointing toward the same profound truth: the human person is not a mind carried around by a body. We are an integrated whole, and the heart belongs within the story of healing.

The heart is not competing with the brain. Healing emerges from the conversation among heart, brain, body, relationships, meaning, and spirit.

positive autonomic state, we can access it much more easily.



Braden (2020) notes that the heart has over 40,000 cells called sensory neurites, very similar to the cells in the brain, and there is evidence that the heart has a certain capacity for some types of memory as well as a gut level wisdom that guides us (Dispenza & Braden, 2019).

The Heart of a Warrior

Active duty service members, veterans, and first responders know something about the heart that cannot be learned in a laboratory. They know the heart of the soldier who returns for a wounded friend, the firefighter who enters the building again, the officer who places a body between danger and a stranger, the medic whose hands remain steady while someone else's life is slipping away. They know the heart of the spouse who waits, the family that carries uncertainty, and the survivor who wakes the next morning and somehow chooses to continue.

The heart can also become guarded. Repeated exposure to loss, betrayal, horror, and responsibility can teach a person that feeling deeply is dangerous. You may still function brilliantly while closing the door to grief, tenderness, dependence, or joy. The mission may have required you to compartmentalize, but the compartment does not always reopen

when you come home. The very heart that carried courage into danger may later struggle to receive love in safety.

This is why HeartMath® belongs in a trauma model. It is not simply a breathing technique attached to a machine. At its best, it is an invitation to come back into relationship with the heart: to notice its rhythm, influence its pattern, listen to what the body is communicating, and rediscover emotional states that survival may have pushed aside. Coherence is physiological, but it can also become deeply personal. It can be the experience of no longer fighting yourself.

Gregg Braden: Where Science and Wonder Meet

One of my heroes in the effort to bring science and spirituality back into conversation is Gregg Braden. Braden began his career in the earth sciences and aerospace and defense industries, then became widely known as an author and speaker exploring resilience, human potential, prayer, emotion, and the relationship between the heart and brain. He did not found the HeartMath Institute, but he has become one of its most passionate and gifted interpreters.

What I appreciate about Braden is not simply the information he presents. It is his sense of wonder. He speaks as someone who believes that scientific discovery should enlarge the human spirit rather than flatten it. His presentations invite us to consider that calm, coherent states may give us greater access to intuition, resilience, compassion, and wise action (Braden, 2015a, 2015b, 2020). He has an unusual ability to make research feel alive.

One presentation I particularly enjoy is Practice This Technique to Relieve Daily Stress: Three Keys to Heart-Brain-Earth Harmony. I encourage you to find it and listen for yourself. Braden's style is warm, expansive, and unapologetically hopeful. You do not have to accept every

interpretation he offers to appreciate the invitation at the center of his work: slow down, move out of chronic threat, bring heart and brain into greater harmony, and discover what becomes possible when we are no longer ruled by survival.

Braden has also drawn attention to the network of approximately forty thousand specialized neurons, sometimes called sensory neurites, within the heart's intrinsic nervous system. This does not mean that the heart thinks exactly as the brain thinks or stores autobiographical memory in the same way. It does mean that the heart possesses a far more complex neural organization than the old image of a simple pump would suggest, and that the flow of information between heart and brain deserves our attention (Braden, 2020; Dispenza & Braden, 2019).

Stories of the Heart: When Memory Seems to Travel

At the edge of this discussion are stories that are difficult to explain and nearly impossible to forget. They should not be presented as settled scientific proof, yet neither should they be stripped of their power merely because they invite questions science has not fully answered. Two such accounts have circulated widely in discussions about the heart, memory, and human identity.

The first is the story of Claire Sylvia, a professional dancer who received the heart and lungs of an eighteen-year-old young man named Tim following his death in a motorcycle accident. After the transplant, Sylvia reported unfamiliar cravings and changes in preference, including a desire for foods such as chicken nuggets and green peppers. When she later met Tim's family, she learned that some of these preferences had belonged to him. Sylvia described the experience in her memoir, A Change of Heart (Sylvia & Novak, 1997).

The second account was reported by neuropsychologist Paul Pearsall. He described an eight-year-old girl who received the heart of a ten-year-old girl who had been murdered. According to the account, the recipient later experienced vivid nightmares containing details that appeared connected to the donor's death and were reportedly shared with authorities (Pearsall, 1998). It is a haunting story, and it has understandably attracted both fascination and skepticism.

These reports are anecdotal. They do not establish that personal memories are stored in the heart or transferred through transplantation. Medication effects, suggestion, family narratives, coincidence, stress, and the profound psychological meaning of receiving another person's organ all deserve consideration. Science requires caution, replication, and plausible mechanisms.

But caution does not require cynicism. These stories leave us with a beautiful and unsettling question: Is the heart only a pump, or does it participate in memory, emotion, relationship, and identity in ways we have not yet fully understood? We can remain open to wonder without claiming more than the evidence allows. Sometimes the honest scientific answer is not yes or no, but we do not yet know. That answer leaves room for humility, curiosity, and awe.

Why the Heart Matters After Trauma

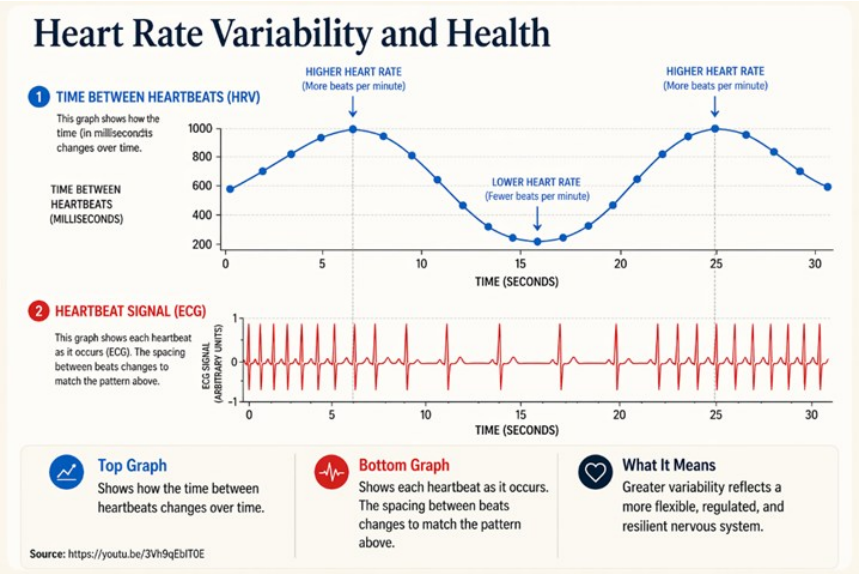
People in military and emergency professions learn to trust rapid bodily information. You may have sensed that a room, vehicle, patient, fire, or person was dangerous before you could explain why. That experience is sometimes called intuition, but it does not require us to treat the heart as a second thinking brain. The body detects patterns, and the brain receives continuous information from the body. Heart rate, breathing, muscle tension, and internal sensation can shape attention and decision-making before conscious reasoning catches up.

This system is invaluable during danger. A faster heart rate and stronger mobilization can deliver oxygen, energy, and readiness. The difficulty arises when the emergency ends but the internal rhythm remains disordered. The heart may continue sending the brain a pattern associated with strain, urgency, or instability. The brain, in turn, may interpret bodily activation as further evidence that something is wrong. A feedback loop develops: threat changes the heart and breath; those changes reinforce the perception of threat; and the body mobilizes again.

Heart-focused practices can interrupt that loop. They do not erase memory or solve moral injury. They help create a physiological platform from which you can think more clearly, remain connected, and approach rather than automatically avoid what hurts.

Heart Rate Variability: The Space Between the Beats

Your heart does not beat with metronomic sameness. Even when your pulse averages sixty beats per minute, the time between individual beats changes from moment to moment. This beat-to-beat variation is called heart rate variability, or HRV. It reflects the heart's ongoing adjustment to breathing, posture, movement, emotion, illness, recovery, and demands from the autonomic nervous system (McCraty, 2023).



A healthy heart is not a perfectly regular heart. It is a responsive heart. Greater variability is often associated with physiological flexibility, but a single HRV number does not tell the whole story. HRV differs across people and changes with age, fitness, sleep, medication, alcohol, illness, hydration, breathing, and time of day. It should not become another score by which you judge yourself.

HeartMath® pays particular attention not only to how much variability is present but also to its pattern. During frustration, anxiety, or anger, the rhythm may appear more irregular. During slow, steady breathing combined with a renewing emotional focus, the pattern may become smoother and more wave-like. HeartMath® calls this state physiological coherence (McCraty, 2023).

Think of coherence as coordinated readiness. The system is not asleep or defenseless. The heart, breathing, attention, and emotion are working together with less internal friction.

Coherence Is Not the Same as Calm

Calm can sound unrealistic to someone who has spent years prepared for the next call. Coherence is a better target. You can be coherent while alert. You can be steady while making a difficult decision. You can feel grief without becoming completely disorganized. You can experience anger without surrendering your behavior to it.

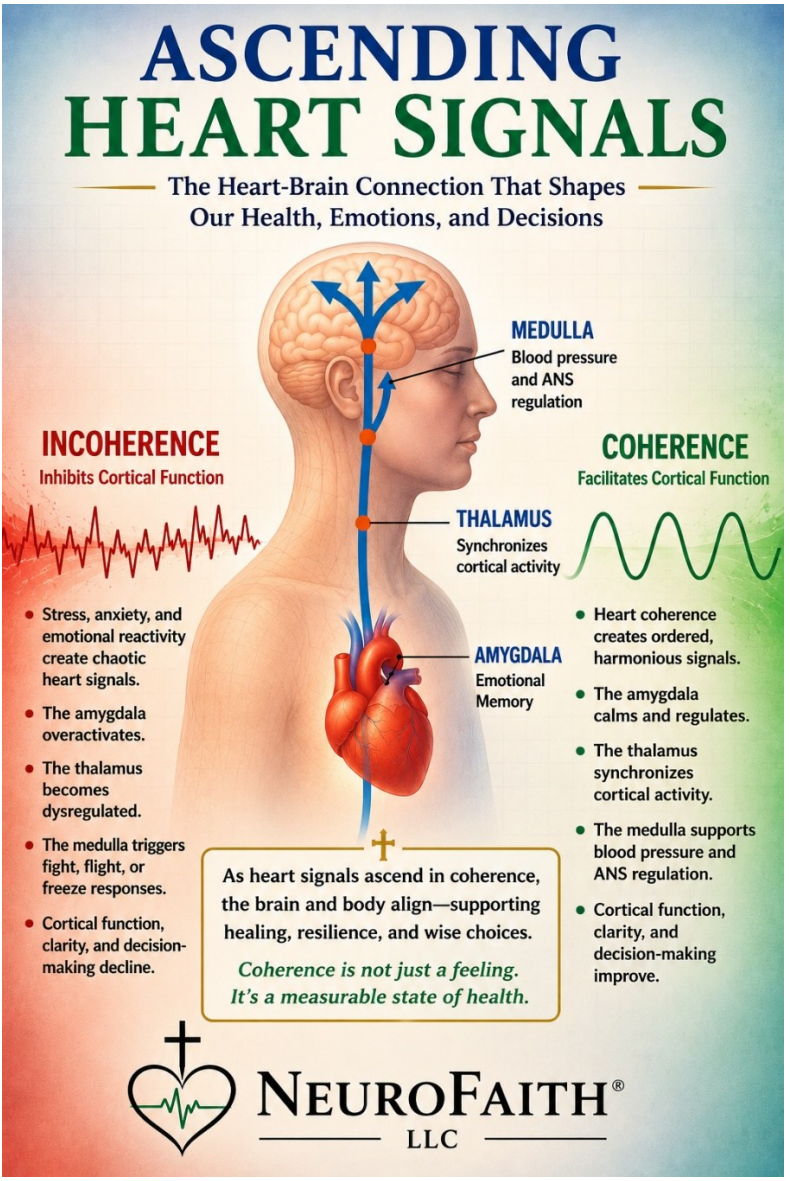
Coherence also does not require you to manufacture happiness. If you have just remembered a friend who died, received terrible news, or confronted an injustice, forcing gratitude may feel false. Begin with something quieter: sincerity, steadiness, appreciation for a loyal dog, respect for a person who stood beside you, love for your family, commitment to your values, or the simple intention to remain present.

The goal is not emotional denial. The goal is to create enough order in the body that the emotion can move through you without taking command of the entire system.

The Heart–Brain Conversation in Plain Language

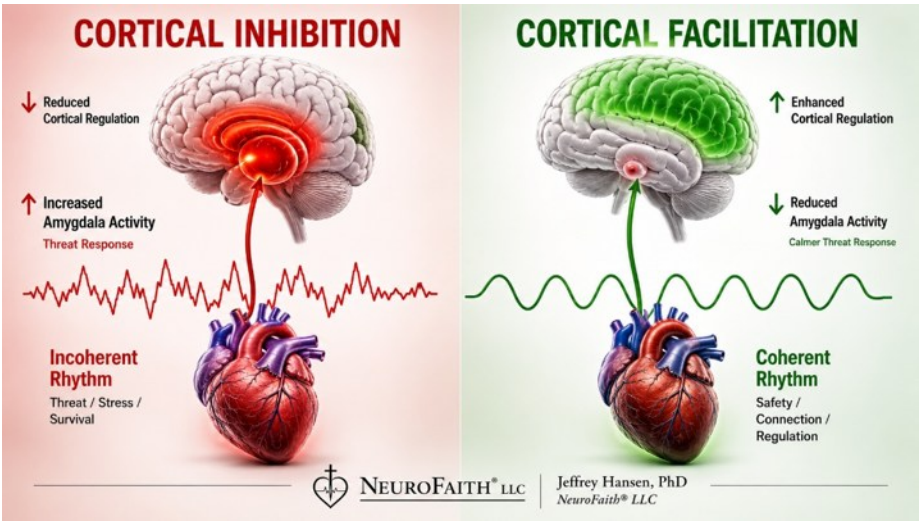
The heart and brain communicate through several interacting pathways. You do not need to memorize them, but understanding the basic routes makes the practice less mysterious (McCraty, 2023).

- Neural communication. The heart and brain exchange information through the autonomic nervous system, including vagal pathways.
- Breathing and pressure changes. Each breath influences heart rhythm, and changes in circulation and blood pressure are continually reported to the brain.
- Chemical communication. Stress hormones and other chemical messengers influence both cardiovascular function and brain activity.
- Rhythmic information. The pattern of heartbeats provides ongoing sensory information that can influence attention, emotion, and regulation.



When threat is high, survival networks take priority and flexible thinking becomes harder. When breathing and heart rhythm become more ordered, the brain may have better access to attention, inhibition, perspective, and choice. We should not reduce this to the heart switching the amygdala off or turning the prefrontal cortex on like a

light. The biology is more complex. The practical truth, however, remains: the state of the body influences the quality of our thinking.



A Practical Coherence Exercise

The following practice draws on HeartMath® principles and can be used without equipment. Do not force the breath. If breath-focused exercises make you dizzy, panicky, or more activated, return to ordinary breathing, keep your eyes open, orient to the room, and work with a trained clinician.

Step 1: Establish the Present

Place both feet on the floor if possible. Look around slowly and identify three signs that tell you where you are now. Let your shoulders drop only as much as feels safe. You are not ordering the body to relax; you are giving it current information.

Step 2: Heart-Focused Breathing

Bring your attention to the center of your chest or the area around your heart. If that feels uncomfortable, rest your attention on the breath at the nose or abdomen. Imagine the breath moving gently in and out

through the heart area. Breathe a little more slowly and evenly than usual, perhaps five seconds in and five seconds out, without strain.

Step 3: Activate a Renewing Feeling

Bring to mind a person, animal, place, moment, prayer, or value that evokes genuine appreciation, care, courage, or steadiness. Do not merely think about it. See whether you can experience even a trace of the feeling in your body. A two-percent shift is enough.

Step 4: Sustain the Pattern

Continue the steady breathing and renewing focus for one to three minutes. If your attention wanders, return without criticism. Notice whether your jaw, hands, chest, or field of vision changes. You are gathering information, not grading performance.

Step 5: Ask for the Next Wise Action

Once you feel even slightly steadier, ask: What is the next useful thing to do? Not, How do I solve my entire life? The answer may be to speak more slowly, postpone a difficult conversation, drink water, contact a trusted person, write down what happened, pray, walk, or obtain professional help.

The one-minute version: Feel your feet. Focus near the heart. Breathe evenly. Recall one genuine source of appreciation or courage. Ask for the next wise action.

Using Coherence in the Moments That Matter

Before a Difficult Conversation

Take one or two minutes before entering the room or making the call. The purpose is not to suppress what needs to be said. It is to prevent an old threat response from choosing your tone, volume, and timing. Decide what outcome matters most and what kind of person you want to be during the conversation.

After a Trigger

First use the color-zone map from Chapter 10. If you are in red, create safety and space before attempting a detailed coherence exercise. When you are able, use steady breathing and a familiar source of appreciation. Then separate what is happening now from what your body remembers.

After a Shift, Call, or Mission

The body needs a transition between operational readiness and home. Before entering the house, sit for two minutes, feel the support beneath you, breathe steadily, and intentionally remember who and what you are returning to. This is a small ritual of standing down. It tells the body that one environment has ended and another has begun.

During Sleeplessness

Coherent breathing may help reduce activation, but do not turn sleep into another mission. If counting breaths makes you work harder, release the count and attend to a comfortable rhythm. If you remain awake and frustrated, step out of bed briefly, use low light, and return when sleepiness increases. Persistent sleep problems deserve clinical evaluation.

Before Trauma-Focused Therapy

Use a brief coherence practice before approaching difficult material, then check your state again during and after the session. The objective is not to avoid emotion but to remain present enough to process it. Your therapist can help you recognize when you are productively engaged and when you are becoming flooded or shut down.

When You Are Shut Down

Heart-focused breathing is often taught as a calming practice, but a person in dorsal shutdown may not need further slowing. If you feel heavy, numb, foggy, or collapsed, begin with the Chapter 10 return-from-shutdown sequence: light, upright posture, small movement,

water, and low-demand connection. Then add heart-focused breathing while sitting or walking rather than lying down. Choose an energizing feeling such as courage, loyalty, purpose, or determination instead of trying to become deeply peaceful.

This distinction matters. The same technique should not be applied mechanically to every state. Regulation is responsive, not formulaic.

Biofeedback: Making the Invisible Visible

HeartMath® devices and other HRV biofeedback tools can display heart-rhythm patterns in real time. For active duty service members, veterans, and first responders, this is especially appealing. Instead of being told to relax, you can see whether a change in breathing and attention alters the pattern on the screen.

The feedback can strengthen learning, but the device is a training aid rather than a verdict. A low score does not mean you are failing, damaged, or unsafe. Chasing a perfect score can itself create frustration and incoherence. The real-world question is whether practice helps you recover more efficiently, think more clearly, sleep more consistently, and remain more connected to the people and purposes that matter.

You also do not need equipment to benefit. The central skills are attention, breathing, emotional focus, practice, and awareness of what changes inside you.

Coherence Between People

The earlier polyvagal chapter described co-regulation: one nervous system can influence another through voice, facial expression, posture, timing, and relationship. HeartMath® extends this discussion by emphasizing that your internal state affects what you bring into a room.

The most clinically useful point is straightforward: people read one another, and steadiness can spread just as activation can.

Anyone who has served on a team has witnessed this. One frantic leader can amplify chaos. One grounded leader can help a group organize under pressure. At home, a regulated parent can help a frightened child settle. A spouse who lowers the pace and softens the voice can reduce escalation. A clinician who remains present can lend steadiness to a person approaching a painful memory.

Some HeartMath® writings go further, discussing electromagnetic fields, energetic communication, and entrainment between people. These are interesting areas of exploration, but we should distinguish measurable cardiac electrical and magnetic activity from stronger claims about one person's heart directly synchronizing another's at a distance. The evidence for those broader interpretations remains debated. We do not need to overstate the science to appreciate the observable power of co-regulation, emotional contagion, attunement, and calm leadership.

The practical question is not whether your heart field reaches a particular number of feet. It is what happens to the people you love and lead when you enter the room.

A Heart Lock-In® Practice for Connection

The Heart Lock-In® Technique was developed by the HeartMath® Institute to sustain coherence and intentionally extend care toward yourself and others. The practice follows three movements: center in your heart, activate a regenerative feeling, and allow that feeling to move inward and outward (HeartMath Institute, 2020).

1. Center and Breathe

Shift your attention to your heart area and imagine your breath flowing in and out through your heart or chest. Breathe slowly from your abdomen. Keep your inhale slightly shorter and your exhale slightly longer, allowing your body to settle. You might quietly think, "Breathe in life. Breathe out peace."

2. Focus on a Regenerative Feeling

Recall a sincere feeling of gratitude, appreciation, love, care, compassion, or courage. Hold your attention there and allow the feeling to become as real in your body as it can be without forcing it.

3. Receive and Radiate

With each inhale, receive that regenerative feeling. With each exhale, radiate it toward yourself, another person, your family, your team, your community, or a situation needing steadiness and care. Continue receiving on the inhale and radiating on the exhale for several minutes.

For some readers, prayer will fit naturally here. You may breathe in the life and peace of God, bring another person before Him, and release what you cannot control. Others may use the language of compassion, values, or service. The physiological practice does not require a particular faith tradition, but faith can deepen its meaning.

For some readers, prayer will fit naturally here. You may bring another person before God, release what you cannot control, and ask to become a steadier instrument of courage, wisdom, mercy, or peace. Others may use language of compassion, values, or service. The physiological practice does not require a particular faith tradition, but faith can deepen its meaning.

The
Heart Lock-In®
TECHNIQUE
A Simple 3-Step Practice to
Activate Coherence,
Cultivate Positive Emotions,
and Radiate Love
1
Step 1: Center and Breathe
Focus your attention on your heart area
Imagine your breath flowing in and out through your heart or chest
Breathe slowly and deeply from the abdomen, letting your belly rise with each inhale
Keep the in-breath shorter, drawing in energy and life. Some find it meaningful to imagine they are breathing in the breath of God
Let the out-breath be longer than the in-breath. This engages the parasympathetic nervous system and fosters relaxation, calm, and peace
Breathe in
Life
Breathe out
Peace
2
Step 2: Focus on Regenerative Feelings
While maintaining this rhythm, shift your attention to feelings of gratitude, appreciation, love, care, or compassion
Hold your focus there
Allow yourself to fully experience these emotions as they grow stronger and more stable in your heart
Gratitude
Appreciation
Love
Care
Compassion
3
Step 3: Radiate and Receive
With each in-breath, take in those renewing feelings. Allow yourself to be filled with love, compassion, and appreciation
With each out-breath, send those feelings outward, radiating care, compassion, and love to yourself and to others
Continue this cycle of receiving on the inhale and radiating on the exhale
Sustain the flow of coherence for several minutes
Heart Coherence Changes Everything.
NeuroFaith®
HeartMath®
NeuroFaith® | Jeffrey E. Hansen, PhD | Adapted from HeartMath®

What HeartMath® Can and Cannot Do

- HeartMath® is a valuable part of an integrated approach, but it should not carry promises it cannot bear.
- It can help you practice influencing breathing, attention, heart rhythm, and emotional state.
- It may improve your ability to notice activation earlier and recover more efficiently.
- It can support preparation for sleep, difficult conversations, trauma therapy, and reconnection at home.
- It does not erase traumatic memories or automatically resolve grief, shame, moral injury, addiction, or relationship wounds.
- It does not replace medical assessment, psychotherapy, medication when appropriate, crisis intervention, or practical changes to an unsafe environment.
- It should never become another reason to blame yourself when symptoms persist.

The strongest use of HeartMath® is neither grandiose nor trivial. It gives you a repeatable way to influence part of your physiology, build confidence through direct experience, and create better conditions for the other work of healing.

Do Not Turn Coherence Into Another Performance Test

Active duty service members, veterans, and first responders are practiced at meeting standards. It is easy to turn coherence into one more test: I should get into green immediately. My HRV should be higher. I should be able to control my heart. That pressure defeats the purpose.

Some days you may notice a clear shift. Other days the change will be modest. Medication, pain, illness, dehydration, caffeine, alcohol, fatigue, hormonal changes, and recent exertion can all affect heart rhythm and HRV. Progress is better measured across time than in a single session.

Ask whether you became a little more present, a little less reactive, or a little more capable of choosing the next wise action. That is enough for the nervous system to begin learning.

When Symptoms Require More Than Practice

Heart-focused exercises are not a substitute for medical care. New or severe chest pain, fainting, marked shortness of breath, an irregular heartbeat, or sudden neurological symptoms require appropriate medical evaluation. Likewise, seek urgent help if you are at risk of harming yourself or someone else, are unable to care for basic needs, or are losing contact with reality. Using support is not failure. It is sound judgment.

From the Heart Toward Home

Chapter 10 taught us to recognize the language of the autonomic nervous system. This chapter has invited us more deeply into the heart-brain conversation. Through steady breathing, focused attention, sincere emotion, prayer, appreciation, and connection, the body can begin moving from automatic survival toward a more coherent rhythm.

For the warrior, police officer, firefighter, paramedic, dispatcher, corrections officer, and veteran, this is not about becoming soft or unprepared. It is about recovering something survival may have hidden. The heart that learned courage in danger can also learn presence in safety. The person who carried others can learn to receive care. The leader who steadied a team can learn to offer that same steadiness at home.

HeartMath® reminds us that healing is not simply about quieting the mind. It is about restoring relationship among the heart, brain, body, and soul. As coherence grows, we may become less reactive and more reflective. We may listen before defending, pause before striking back, remain present when grief rises, and choose according to our deepest values rather than our fastest alarm.

Perhaps one of the most beautiful truths in this work is that healing rarely stops with the individual. A steadier heart changes the atmosphere around it. Parents influence children. Spouses influence one another. Leaders influence teams. Firefighters influence the crew. Officers influence their partners. Clinicians influence their patients. Calm can spread, courage can spread, and hope can spread. One regulated person may become a place of refuge for many others.

And still, coherence is not the end of the journey. A more regulated body does not automatically release every burden. Some fears, vows, griefs, and protective roles continue living within us. One part remains on guard. Another carries the names of those who did not come home. Another refuses to feel because feeling once threatened the mission. Another believes it must never fail again.

Who is the angry part still standing watch? Who is the rescuer who cannot stop carrying everyone? Who is the frightened part that never felt protected? Who is the perfectionist convinced that one mistake will cost another life? These are not signs that you are broken. They are parts of you that developed for reasons worthy of understanding.

That is where we turn next. Internal Family Systems will help us approach these protective and wounded parts with curiosity, compassion, courage, and grace. Healing does not come by silencing them or ordering them off the field. It comes by listening to what they have carried, honoring why they came, and inviting them home.

Pillar Three Internal Family Systems (IFS)

There are few discoveries in modern psychology as breathtaking as Internal Family Systems, commonly known as IFS and developed by Richard C. Schwartz, Ph.D. It is as though someone has been given a glimpse into the architecture of the inner world, revealing that what once felt like chaos within us may actually be an intricate and purposeful system.

For those who have carried the weight of combat, responded to horrific calls, worn a badge, climbed into burning buildings, worked desperately to save a life, battled addiction, or quietly lived beneath the burden of unresolved trauma, this understanding can feel revolutionary. More than that, it can feel profoundly redemptive.

Perhaps what has felt broken within you has not been broken at all.

Perhaps it has been protecting you.

Perhaps it has simply been waiting to be understood.

Throughout this book, we have explored how trauma is not merely something you remember. It is something you carry. Trauma can become embedded within the autonomic nervous system, pulling you away from safety and into recurring states of fight, flight, freeze, or collapse.

For many active duty service members, veterans, and first responders, this becomes a way of life. Hypervigilance begins to feel normal. Emotional numbing becomes familiar. Sleep becomes difficult. Trust becomes complicated. Relationships become harder to navigate. The deployment ends, the call is cleared, the fire is extinguished, or the uniform is hung in the closet, but the nervous system does not always receive the message that the danger has passed.

We have also explored the remarkable role of the heart. Through neurocardiology and HeartMath®, we have learned that the heart is far more than a pump. It participates in emotional regulation, coherence, connection, and our experience of safety. As the heart moves toward coherence, something quiet but powerful begins to happen. The nervous system settles. The body becomes more receptive to healing. We become increasingly able to experience connection, meaning, and peace.

Yet trauma affects more than the body and heart. It also shapes the inner world.

When pain overwhelms our capacity to cope, the mind does not simply fail. It does something extraordinary. It organizes. It adapts. It develops an internal system designed to help us survive what once seemed unbearable.

Anyone who has served in the military or emergency services understands this intuitively. Different situations call forth different sides of us. One part remains calm under pressure. Another constantly scans for danger. Another pushes emotion aside so the mission can continue. Another takes command when everyone else is overwhelmed. Still another quietly carries the grief of those we could not save.

You may recognize the part of you that can move toward danger without hesitation but feels uncomfortable sitting quietly with someone you love. You may know the part that performed flawlessly during the emergency and then fell apart hours later when no one was watching. You may have a part that can carry an injured stranger from a wrecked vehicle but does not know how to ask for help when you are the one who is hurting.

These parts are not signs of weakness. They are remarkable adaptations born out of necessity.

Some parts carry wounds so deep and tender that they withdraw from awareness, waiting for the day when it may finally be safe enough for them to be seen. Other parts step forward to manage life, anticipate danger, maintain control, and carry responsibilities far beyond what they were ever designed to bear. When pain breaks through despite those efforts, still other parts rush in to provide immediate relief through anger, emotional numbing, distraction, compulsive behavior, substance use, or anything else that promises even a moment of escape.

Even the inner critic, perhaps the most misunderstood of all our parts, may have developed as a protector. Beneath its harshness may stand a vigilant guard that believes criticism will keep us sharp, disciplined, prepared, and beyond reproach. It may believe that if it can prevent

every mistake, it can protect us from failure, humiliation, rejection, shame, or loss.

This is where Internal Family Systems offers something truly remarkable. It gives us more than another collection of psychological terms. It offers a compassionate way of understanding what is happening inside us.

IFS invites us to recognize that we are not merely fragmented collections of thoughts, impulses, and emotions. We possess an organized internal system filled with parts that have been faithfully, though sometimes imperfectly, attempting to protect what is most precious.

These parts are not enemies to defeat. They are protectors waiting to be understood.

Beneath the protectors, burdens, and wounds lies something trauma cannot completely destroy. IFS calls this the Self, the calm, curious, compassionate, and courageous center capable of leading the internal system.

Trauma may obscure our access to the Self, but it does not eliminate it.

As safety increases and Self-leadership begins to emerge, healing becomes possible. Exiled pain is no longer abandoned but approached with compassion. Protective parts discover that they no longer need to work with such exhausting intensity. The nervous system begins to soften. The heart begins to open. Addiction can loosen its grip. Trauma no longer has to dictate the present, and hope, often buried beneath years of service and survival, can begin to rise again.

Our inner world is not random. It possesses an order, a pattern, and an internal ecology in which every part developed for a reason. With understanding and healing, those parts can become allies rather than adversaries.

Meeting the Parts Within Us

Rather than hearing only one voice inside ourselves, IFS helps us recognize the rich inner community that has always been there. Each part carries its own story, fears, memories, responsibilities, and ways of protecting us.

The word "parts" may initially sound strange. It does not mean that you possess multiple personalities or that something is fundamentally wrong with you. We all speak the language of parts without realizing it.

A part of me wants to go, but another part wants to stay.

A part of me knows I need help, but another part does not trust anyone.

A part of me wants to stop drinking, but another part cannot imagine getting through the night without it.

A part of me loves my family, but another part wants everyone to leave me alone.

A part of me knows the war is over, but another part is still waiting for the next attack.

IFS takes these familiar experiences seriously. Instead of dismissing them as inconsistency or weakness, it helps us understand the protective system operating beneath them.

The primary members of this internal system include:

- **Exiles:** The vulnerable and wounded parts that carry deep pain, fear, shame, grief, loneliness, or traumatic memories.
- **Managers:** Protective parts that attempt to prevent pain through control, preparation, performance, perfectionism, emotional restraint, or avoidance.
- **Firefighters:** Protective parts that react when pain breaks through, seeking immediate relief through anger, numbing, distraction, impulsivity, or addiction.
- **The Inner Critic:** A part that evaluates, judges, corrects, or shames, often believing that relentless criticism will keep us safe.
- **Self:** The calm, curious, compassionate, confident, and courageous center capable of leading the internal system toward healing.

Each part has a story. Each carries a burden. Each, in its own way, has been trying to help.

Healing does not begin by declaring war on these parts. It begins by turning toward them with curiosity, understanding, and compassion. As we come to know them, we begin to recognize that what felt like internal chaos is often a system working desperately to protect something deeply valuable.

Exiles: The Parts That Carry the Pain

Exiles are the vulnerable and wounded parts that carry intense emotional pain. They may hold fear, shame, grief, abandonment, helplessness, betrayal, loneliness, or traumatic memories that were too overwhelming to process when they occurred.

Because their pain is so intense, exiles are frequently pushed outside conscious awareness. This does not mean the pain disappears. It remains within the system, often waiting beneath the surface.

A veteran may carry an exiled part burdened by the death of a friend. A firefighter may carry the face of a child who could not be saved. A police officer may carry the helplessness of arriving moments too late. A paramedic may carry the memory of performing every lifesaving measure correctly and still losing the patient. A dispatcher may carry the final words of a terrified caller whose voice still returns in the quiet of the night.

There may have been no opportunity to grieve at the time. The mission continued. Another call came in. Someone else needed help. The pain was pushed aside because it had to be.

That is what exiling means. The painful experience is placed somewhere deep inside so the rest of the person can continue functioning.

The exile may carry more than memory. It may carry the beliefs formed in the moment of trauma:

> "I failed."
> "I should have saved them."
> "It was my fault."
> "I am helpless."
> "I am not safe."
> "I cannot trust anyone."
> "If I let myself feel this, I will never recover."

These beliefs may remain frozen in time, even when the adult mind understands that they are not entirely accurate. A seasoned firefighter may intellectually know that no one could have survived the fire, while an exiled part still carries the agony of not bringing everyone home. A veteran may understand that the ambush was unavoidable, while a younger part remains convinced that greater vigilance could have saved a brother.

When an exile becomes activated, the nervous system can flood with distress. A sound, smell, anniversary, argument, news report, crowded room, or seemingly harmless moment may open a door to pain that has been contained for years.

Suddenly, the reaction feels far larger than the present situation. That does not mean you are overreacting or losing your mind. It may mean that the present moment has touched an older wound.

Other parts then work tirelessly to push that pain back down. Managers tighten control. Firefighters search for immediate relief. In addiction and depression, exiles often carry the very suffering the rest of the system is desperately trying to escape.

The exile is not trying to ruin your life. It is carrying something that has never been fully witnessed, understood, or healed.

Managers: The Parts That Keep Everything Under Control

Managers are proactive protective parts responsible for maintaining order, control, stability, and predictability. Their job is to prevent exiled pain from reaching the surface.

Managers are often the parts that get us through training, deployments, long shifts, academy demands, difficult calls, family

responsibilities, and years of public service. They organize, prepare, anticipate, and perform.

Managers may operate through perfectionism, overachievement, people-pleasing, emotional restraint, rigidity, intellectualization, avoidance, or spiritual performance. They are deeply invested in appearing competent, dependable, disciplined, and composed.

Many managers are highly functional and socially rewarded. They can make excellent soldiers, clinicians, leaders, teachers, employees, parents, spouses, and ministry workers. They get things done. They anticipate problems. They carry responsibility. They rarely allow themselves to fall apart.

Yet beneath all that competence is often fear.

A manager may quietly believe:

> "If I stay in control, nothing bad will happen."
> "If I remain useful, no one will leave me."
> "If I never make a mistake, no one can shame me."
> "If I keep moving, I will not have to feel."
> "If I take care of everyone else, I will never have to admit that I need care too."

Managers are often all about performance. They push us to become the best student, soldier, officer, clinician, leader, employee, spouse, parent, or person of faith. They may believe safety can be earned through excellence.

This strategy can work remarkably well for a long time. A person may build an impressive career, receive promotions, earn medals, raise a

family, and become the one everyone depends upon. From the outside, life appears stable and successful.

Inside, however, the manager may be exhausted.

It has been standing watch for years, sometimes decades, convinced that everything will collapse if it ever lowers its guard.

For people who have worked in professions where mistakes can cost lives, this makes complete sense. Vigilance, control, emotional restraint, and precision are necessary on the battlefield or at an emergency scene. The problem begins when the manager does not know how to stand down after the danger has passed.

The same part that helped you survive combat may continue scanning the restaurant for exits. The part that kept a chaotic scene under control may try to control every detail at home. The part that suppressed emotion during the call may keep suppressing it when your spouse asks what is wrong.

A manager can remain on duty long after the shift is over.

Firefighters: The Parts That Rush In to Stop the Pain

Firefighters are reactive protective parts that emerge when exiled pain breaks through despite the managers' efforts. Their mission is immediate relief.

Managers plan. Firefighters react.

The name is fitting. When a firefighter part senses emotional fire, it does not stop to debate long-term consequences. It grabs whatever appears capable of extinguishing the flames.

When distress becomes intolerable, firefighters may turn to anger, dissociation, binge eating, gambling, pornography, alcohol, drugs, compulsive sexual behavior, reckless activity, excessive work, isolation, or other forms of escape.

Some firefighter strategies look dramatic. Others are socially acceptable and difficult to recognize. Working sixteen hours a day can function as emotional avoidance. Spending every free moment at the

gym can become a way of outrunning grief. Constantly scrolling a phone can keep silence away. Sleeping excessively can provide escape from a world that feels unbearable.

A firefighter is not thinking about next month. It is trying to get you through the next five minutes.

This is essential to understanding addiction. An addictive behavior is not always chosen because someone does not care about the consequences. It is often chosen because, in that moment, it works. It changes the internal state. It dulls grief, quiets memories, reduces anxiety, softens shame, or creates temporary distance from unbearable pain.

In extreme circumstances, firefighter activity may include self-injury or suicidal behavior. Although its methods can become dangerous or destructive, its underlying intention remains protective. It is trying to stop suffering using whatever method it has learned.

Understanding that intention does not excuse harmful behavior. It does not eliminate responsibility or erase consequences. It gives us a more accurate place from which to begin healing.

A firefighter part is not evil. It is desperate.

If we attack it with shame, it may become even more desperate. If we approach it with curiosity, we may begin to understand what pain it has been trying to extinguish.

The Inner Critic: The Protector With a Harsh Voice

The inner critic is a powerful and frequently misunderstood part of the internal system. It often develops in environments where mistakes, vulnerability, rejection, or failure felt dangerous.

At its healthiest, the critic can provide feedback, encourage accountability, and help us bring our behavior into alignment with our values. When driven by fear, however, it becomes harsh, condemning, and relentless.

It may say:

> "You should have known better."
> "You are weak."
> "You failed your team."
> "You should have done more."
> "You do not deserve forgiveness."
> "If people really knew you, they would reject you."

For active duty service members, veterans, and first responders, the critic can become especially brutal. It may replay decisions made in

seconds under impossible circumstances and judge them with the comfort of hindsight. It may hold us responsible for outcomes no human being could have controlled. It may insist that because we survived when someone else did not, we have forfeited the right to peace.

The critic may believe that if it punishes you first, no one else can hurt you. It may believe that relentless self-judgment will prevent future mistakes. It may even believe that continuing to suffer is a way of honoring those who were lost.

From a spiritual perspective, the difference between useful correction and crushing condemnation is essential. Healthy conviction can guide us toward truth, accountability, repair, and restoration. Condemnation declares that we are permanently defined by our worst moment and beyond the reach of mercy.

The critic does not need to be destroyed. It needs to be understood and relieved of a job it was never meant to hold.

When it no longer has to serve as judge, prosecutor, and executioner, it can assume a healthier role. It can offer measured feedback without humiliating us. It can support responsibility without demanding endless punishment.

Understanding Addiction Through the Lens of Parts

For individuals struggling with addiction, IFS can bring profound clarity and relief. Many have spent years believing that they lack willpower, discipline, character, or moral strength. Internal Family Systems offers another way to understand what has been happening.

Long before substances or compulsive behaviors entered the picture, the internal system was already working tirelessly to manage pain.

Managers often take the lead early in life. They attempt to create safety by being responsible, dutiful, successful, prepared, or indispensable. They may push you to become the perfect student, reliable employee, strong provider, compliant child, courageous soldier, dependable officer, or spiritually disciplined person.

Their message is often, "If we do everything right, the pain will remain buried."

For a time, this strategy may appear successful. Life can look functional and even admirable from the outside. Yet the pain carried by exiled parts does not disappear. It waits.

As stress increases, loss occurs, trauma resurfaces, or emotional demands overwhelm the managing system, the buried pain begins to break through. Control falters. The system becomes overwhelmed. That is when firefighters rush in.

Firefighters are not concerned with insight or long-term consequences. Their sole task is immediate relief. Alcohol, drugs, pornography, rage, gambling, isolation, or other compulsive behaviors can become powerful firefighter strategies.

From the outside, addiction may look irrational and self-destructive. From inside the person's nervous system, it can feel like survival.

This is one reason shame is such an ineffective treatment for addiction. The person already possesses parts that are terrified, wounded, exhausted, and condemning. Adding more humiliation does not heal

those parts. It usually drives them deeper into hiding and increases the need for escape.

As you begin to understand this dynamic, shame can soften. You may start recognizing that your behavior has functioned as a desperate defensive response rather than proof of a defective identity.

This understanding does not excuse harmful behavior. It does not eliminate responsibility or minimize the damage addiction can cause. Instead, it changes the question.

Rather than asking, "What is wrong with me?" you can begin asking, "What has my system been trying to protect me from?"

That question opens a door.

As shame decreases, agency begins to return. You become better able to notice when managers are tightening their grip or when firefighters are preparing to act. Awareness creates space between pain and reaction. Within that space, a different response becomes possible.

Perhaps you begin to notice that the urge to drink grows stronger after conflict with your spouse. Maybe the urge to isolate appears after a difficult anniversary. Perhaps anger erupts whenever someone expresses concern because a manager interprets concern as criticism or loss of control.

These patterns are not random. They are communications from the internal system.

Rather than fighting your defenses or attempting to eliminate them, you can begin engaging them. You can listen to what they fear, understand what they protect, and help them discover healthier roles.

Knowledge becomes power, but not power used against yourself. It becomes the power to understand yourself, lead yourself, and participate actively in your healing.

From a NeuroFaith® perspective, this restoration of agency is deeply important. As understanding replaces judgment and curiosity replaces condemnation, the heart begins to feel safer. When the heart feels safer, change becomes possible. Defenses no longer need to dominate. They can finally begin to rest.

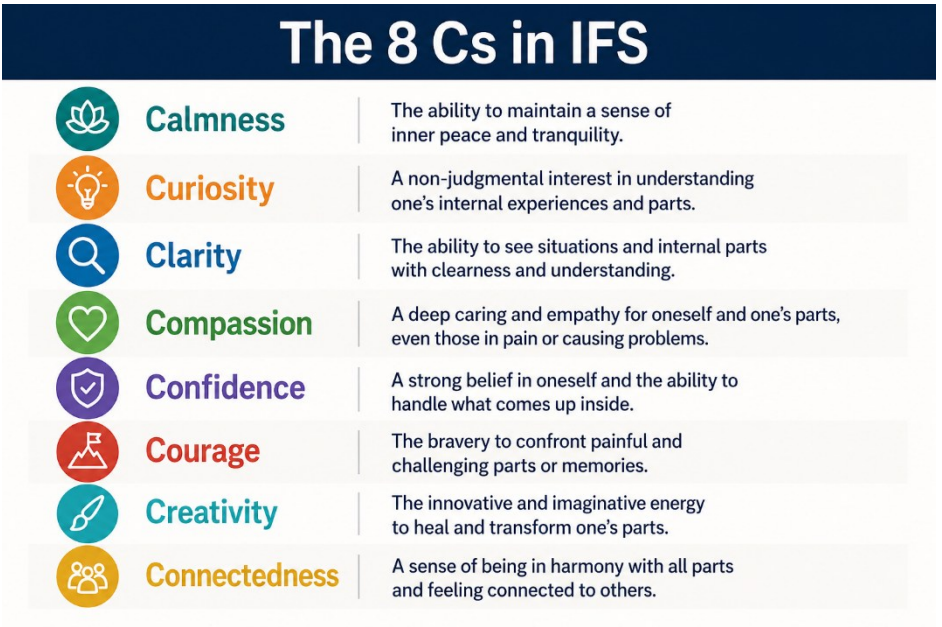
Self: The Center of Who We Are

The Self is not another part fighting to take control. It is the centered presence capable of relating to every part with patience, wisdom, strength, and compassion.

IFS identifies this centered presence through qualities commonly known as the Eight Cs:

- **Calm:** The ability to remain grounded even when difficult emotions are present.
- **Curiosity:** A genuine desire to understand rather than judge what is happening inside.
- **Clarity:** The ability to see a situation without being completely controlled by fear, shame, anger, or confusion.
- **Compassion:** A caring response toward suffering, including our own suffering.
- **Confidence:** A quiet trust that we can face what is within us without being destroyed by it.

- **Courage:** The willingness to approach painful experiences rather than continually running from them.
- **Creativity:** The ability to imagine new responses and possibilities beyond the strategies we have always used.
- **Connectedness:** The capacity to experience meaningful relationship with ourselves, other people, the natural world, and whatever we hold sacred.



When Self is present, the internal conversation changes.

Instead of saying, "I hate the part of me that drinks," Self may ask, "What pain is this part trying to relieve?"

Instead of saying, "I need to get rid of my anger," Self may ask, "What is my anger protecting?"

Instead of saying, "I am weak because I cannot stop thinking about that call," Self may ask, "What part of me is still carrying that experience alone?"

This does not make us passive. Compassion is not the absence of accountability. Self-leadership may require firm boundaries, difficult decisions, treatment, sobriety, confession, repair, or significant life changes. The difference is that these actions no longer arise from hatred of ourselves. They emerge from clarity, courage, and care.

Many active duty service members, veterans, and first responders are natural leaders in the external world. They know how to assess a situation, establish priorities, protect vulnerable people, and bring order to chaos. IFS invites them to bring those same leadership abilities into the internal world.

The goal is not to force every part into submission. Good leaders do not merely silence their people. They listen, understand the mission, recognize what each person carries, and provide clear direction.

Self-leadership is internal leadership at its best.

A Broader Spiritual Understanding of Self

IFS often describes Self in psychological terms as the calm and compassionate center that remains beneath our defensive layers. NeuroFaith® values this understanding while also recognizing that many people experience Self through a larger spiritual framework.

For some, Self is understood through relationship with God. For others, it is connected with a higher power, sacred meaning, moral purpose, the human spirit, or a deep sense that life belongs to something larger than the individual.

We do not all use the same language for this experience. Veterans, service members, and first responders come from many religious traditions, spiritual backgrounds, and worldviews. Some possess a strong and established faith. Some have had faith wounded by trauma, betrayal, moral injury, or loss. Others remain uncertain about what they believe.

NeuroFaith® does not require every person to describe the sacred in the same way. It recognizes, however, that healing frequently involves more than reducing symptoms. Human beings long for meaning, belonging, identity, connection, forgiveness, purpose, and hope.

Trauma can disrupt every one of these.

A veteran may not only ask, "Why am I having nightmares?" but also, "Who am I now that I am no longer in uniform?"

A firefighter may not only ask, "How do I stop replaying the call?" but also, "How can a world with this much suffering still possess meaning?"

A survivor may not only ask, "How do I calm my nervous system?" but also, "Can I ever trust life, other people, or God again?"

These are not merely psychological questions. They are spiritual questions, even when the person asking them does not belong to a particular religious tradition.

From a NeuroFaith® perspective, the Self is not an isolated island of personal strength. It becomes most fully alive through connection. Healing occurs as we reconnect with our bodies, hearts, relationships, values, communities, sense of purpose, and understanding of the sacred.

Therapy can help remove obstacles to this connection. It can help frightened parts feel safer, burdened parts release pain, and protective parts step back from extreme roles. Faith can provide a larger horizon in which suffering, courage, mercy, sacrifice, hope, and restoration acquire meaning.

The two do not need to compete.

How the Parts Work Together

In a traumatized system, exiles carry pain, managers attempt to prevent pain, and firefighters attempt to escape pain.

The system is not simply broken. It is overworked.

Imagine a fire station that has been responding to emergencies continuously for years. The alarms never stop. Equipment is wearing down. Everyone is exhausted, but no one trusts that it is safe to rest. Some members attempt to control every possible risk. Others react immediately to anything resembling danger. Somewhere in the back of the station, grief from previous calls remains unspoken because there has never been time to process it.

That is what many traumatized internal systems feel like.

Managers remain on constant alert because they do not trust firefighters to make good decisions. Firefighters become more extreme because they do not believe managers can contain the pain. Exiles become increasingly desperate because no one is listening to them. The inner critic attacks everyone, believing that greater discipline will restore control.

Every part works harder, yet the system becomes less stable.

As Self-leadership increases, protectors no longer need to remain trapped in extreme roles. Managers can release some of their exhausting need for control. Firefighters can discover safer ways to respond to distress. Exiles can be approached with compassion rather than being abandoned in isolation. The inner critic can offer guidance without condemnation.

Internal conflict gradually gives way to cooperation.

This shift does not occur through force. You cannot bully frightened parts into trusting you. It occurs through safety, patience, curiosity, consistency, and relationship.

The Six Fs: Approaching the Internal System

In order to reach the pain pushed outside awareness, we must first build relationships with the protective parts guarding it. Those protectors have important reasons for keeping us away from painful memories and emotions.

IFS offers a practical pathway through six steps commonly called the Six Fs: Find, Focus, Flesh Out, Feel, Befriend, and Fear.

These steps are not a rigid procedure. They are a compassionate way of approaching the inner world. You do not have to perform them perfectly, and you should never force yourself into traumatic material before adequate safety and support have been established.

1. Find

Begin by identifying the part that is active in the present moment.

You may notice an emotion, physical sensation, image, impulse, memory, or internal voice. Perhaps your chest tightens, your jaw clenches, your stomach drops, or you suddenly feel the urge to withdraw, lash out, drink, numb yourself, or regain control.

The goal is not to analyze or change the experience. The goal is simply to notice it.

You might say quietly, "Something in me is becoming angry," or "A part of me wants to get out of this room."

That small act of noticing begins to create space.

2. Focus

Once you recognize the part, gently direct your attention toward it.

Remain grounded enough to observe the part rather than becoming completely consumed by it. Instead of saying, "I am furious," you might begin to say, "A part of me is furious."

Instead of saying, "I am a failure," you might say, "A part of me believes I failed."

This is not wordplay. It reminds you that the feeling is real, but it is not the entirety of who you are.

If a firefighter arrives at a chaotic scene, that firefighter does not become the fire. The firefighter observes it, assesses it, and responds to it. In the same way, focusing allows Self to remain present with an emotion without being completely overtaken by it.

3. Flesh Out

Approach the part with curiosity.

Where do you notice it in your body? How old does it seem? When did it first begin doing this job? What does it fear? What is it trying to prevent? What does it believe would happen if it stopped?

You may discover that anger is protecting grief. Perfectionism may be protecting shame. Withdrawal may be protecting fear of rejection.

Addiction may be protecting a wounded part that does not believe it can survive another moment of emotional pain.

One veteran may discover that the part constantly scanning for danger still believes he is responsible for bringing everyone home. A police officer may realize that her emotional numbness began as the only way she could keep answering calls. A paramedic may recognize that relentless self-criticism developed after one terrible outcome that no amount of training could have prevented.

Understanding begins to replace judgment, and internal trust begins to grow.

4. Feel

Allow the emotions carried by the part to be experienced gradually and safely.

This does not mean opening the floodgates, forcing yourself to relive trauma, or becoming overwhelmed. It means learning, preferably with appropriate support, to remain present with emotion without immediately fleeing from it.

A veteran who has spent years avoiding grief may begin by tolerating it for only a few moments. A firefighter may allow herself to acknowledge that one particular call still hurts. A police officer may finally name the fear beneath the anger.

The nervous system must learn that feeling emotion in the present is not the same as reliving the original danger.

Healing unfolds at the pace of safety. Trauma cannot be rushed, and restoration cannot be forced.

5. Befriend

Approach the part with compassion and appreciation for what it has attempted to do.

You do not have to approve of its methods to recognize its protective intention. You can acknowledge that it stepped forward when you had few other resources available.

You might say:

> "I understand why you learned to stay alert."
> "I see that you were trying to keep me from feeling that pain."
> "You helped me survive a time when I did not know what else to do."
> "I do not want to get rid of you. I want to help you find a safer job."

Internal hostility begins to soften. Cooperation starts replacing conflict.

For many people, this is a radical change. They have spent years hating the parts that drink, rage, withdraw, panic, or criticize. Befriending does not mean surrendering control to those parts. It means creating enough trust that they no longer need to seize control.

6. Fear

Ask what the part fears would happen if it released control or changed its role.

A manager may fear that everything will collapse. A firefighter may fear that unbearable pain will return. An inner critic may fear that without constant punishment, you will become careless, weak, or unacceptable.

A hypervigilant part may say, "If I stop scanning, someone will die."

An emotionally numb part may say, "If I let you feel this, you will never recover."

An addicted part may say, "Without this, we will have no relief."

These fears deserve to be heard. Protective parts cannot be ordered to stand down while they still believe the war is raging.

When those fears are named and addressed, parts can begin to recognize that the present is different from the past. They can learn that Self is available, support exists, and they are no longer responsible for carrying the entire system alone.

A Simple Way to Begin

You do not need to master the entire IFS model before using it. You can begin with a single moment of awareness.

The next time you notice a strong reaction, pause before condemning yourself. Take a breath and ask:

> "What part of me is here right now?"
> "What is this part trying to do for me?"
> "What is it afraid would happen if it did not react this way?"
> "What does it need from me in this moment?"

You may not receive an immediate answer. That is all right. The act of asking with curiosity rather than hostility already changes the relationship.

If the reaction is intense, focus first on safety and regulation. Feel your feet against the floor. Look around the room. Slow your breathing. Place a hand over your heart if that feels comfortable. Remind your nervous system where you are and that the danger is not occurring in this moment.

Then return to the part when you are ready.

This work is often most effective with a therapist trained in IFS and trauma care, particularly when the parts carry severe trauma, self-harm, suicidal thoughts, dissociation, or addiction. Courage does not mean doing everything alone.

Engaging Emotions Rather Than Avoiding Them

One of the most valuable lessons of IFS is that emotions are not enemies to eliminate. They are meaningful signals that deserve attention.

Jenna Riemersma's *Altogether You* offers an accessible introduction to IFS for people of faith. She challenges our tendency to welcome emotions such as happiness and joy while suppressing sadness, fear, grief, anger, or anxiety.

Difficult emotions are sometimes dismissed, condemned, or spiritualized before they have been understood. A person may be told to remain positive, have greater faith, be grateful, move forward, or simply stop dwelling on the past.

Although these responses may be well intended, they can communicate that certain parts of us are unacceptable. The hurting part then learns to go underground, taking its pain with it.

Emotions are messengers. They may alert us to unmet needs, violated boundaries, unresolved grief, moral injury, loneliness, betrayal, or danger. Like a canary in a coal mine, they can warn us that something needs attention before the entire system collapses.

Words may be the language of the thinking mind, while emotions often serve as the language of the body and heart. When emotional signals are ignored, the body continues communicating through tension,

sleeplessness, irritability, panic, physical symptoms, compulsive behavior, or relational conflict.

Moving toward pain does not mean allowing it to overwhelm us. It means approaching it with safety, support, curiosity, and compassion.

When pain is acknowledged rather than resisted, its intensity often begins to decrease. The nervous system settles, protective parts soften, and emotional awareness becomes a doorway to healing instead of something to fear.

Pain is not always proof that something is wrong with you. Sometimes pain is feedback from a part that has been waiting a very long time to be heard.

A Necessary Spiritual Clarification

IFS provides a powerful psychological description of Self as the calm, compassionate, and courageous center beneath our layers of protection. NeuroFaith® honors this insight while placing it within a broader understanding of human identity and spiritual life.

Human beings are more than collections of symptoms, reactions, or neural pathways. We are relational beings who search for meaning, purpose, belonging, truth, forgiveness, and connection with what we consider sacred.

Trauma affects these spiritual dimensions as deeply as it affects the brain and body.

Trauma may leave a person questioning who they are, what they believe, whether the world is trustworthy, or whether life still possesses meaning. Moral injury may create a painful conflict between what

someone witnessed, what they were ordered to do, what they could not prevent, and the values they once held.

Some people emerge from trauma with faith strengthened. Others feel abandoned, angry, doubtful, or spiritually disoriented. These reactions should not be shamed. Spiritual struggle can be an honest response to experiences that shattered a person's understanding of the world.

NeuroFaith® does not insist that every person use the same spiritual language. One person may understand healing through a relationship with God. Another may speak of a higher power, sacred purpose, connection with creation, moral truth, or the enduring strength of the human spirit.

What matters is that healing includes room for the deepest questions of identity, purpose, relationship, and hope.

IFS helps us understand the internal system. Faith can help us locate that system within a larger story.

It can remind us that our lives are more than what happened to us. It can offer meaning when suffering appears meaningless, belonging when trauma creates isolation, and hope when the future feels closed.

From this perspective, Self-leadership is not merely self-sufficiency. It is leadership grounded in humility, compassion, moral clarity, meaningful connection, and openness to something larger than ourselves.

Integration Rather Than Opposition

NeuroFaith® does not place psychology, neuroscience, and faith in competition. They illuminate different but deeply connected dimensions of the same human experience.

Psychology helps explain how wounds form and how relationships can help heal them.

Neuroscience reveals how the brain and body respond to danger and safety.

Polyvagal Theory helps us understand why the nervous system remains mobilized, guarded, or shut down long after the threat has passed.

Neurocardiology and HeartMath® show how coherence can support regulation, connection, and emotional stability.

IFS provides language for the inner system and the parts that learned to protect us.

Faith helps us explore meaning, identity, belonging, hope, and relationship with what we hold sacred.

When these domains are integrated, healing becomes both compassionate and anchored. As the nervous system stabilizes and internal conflict softens, people often become more capable of trust, vulnerability, connection, and spiritual openness.

Therapy does not need to replace faith, and faith should not be used to bypass pain. At their best, they can work together. Therapy can help prepare the soil in which meaning, connection, and spiritual restoration take root.

Conclusion: From Survival to Restoration

For the veteran, active duty service member, police officer, firefighter, paramedic, dispatcher, or corrections officer, who has spent years protecting others, Internal Family Systems offers a profoundly liberating message.

What feels like internal conflict is not necessarily evidence that you are weak, defective, or broken beyond repair. It may be evidence that different parts of you have been working tirelessly to help you survive.

One part learned to remain constantly alert. Another learned to suppress emotion so the mission could continue. Another carried grief, fear, guilt, or shame because there was no time or safe place to process it. Another discovered a quick way to numb the pain when it became unbearable.

Those parts developed for reasons that once made sense.

The manager that constantly strives for perfection, the firefighter that desperately seeks relief, the exile carrying years of hidden pain, and even the relentless inner critic may all be trying to protect you. Their methods may no longer serve you well, but their original purpose was not to destroy you.

They were trying to keep you alive.

As healing unfolds, these parts no longer have to carry impossible burdens alone. Managers can gradually release their exhausting need to control every outcome. Firefighters can discover healthier ways to respond to pain. Exiles can come out of hiding and be welcomed with compassion. Even the inner critic can exchange relentless accusation for thoughtful and measured guidance.

The goal is not to eliminate parts of yourself. It is to help them recognize that the emergency is over, the mission has changed, and they no longer have to perform the same desperate jobs.

> You are not the worst thing that happened to you.
> You are not your trauma.

> You are not your addiction.
> You are not your anxiety, anger, grief, guilt, or shame.
> You are a human being created for connection, purpose, courage, truth, love, meaning, and peace.

For those who have served, the movement from survival toward restoration may feel unfamiliar. Survival taught you to armor up, stay alert, suppress pain, complete the mission, and protect everyone else. Healing asks something different. It asks you to turn inward, listen carefully, and bring compassion to the very places you may have spent years avoiding.

That is not weakness. It is another form of courage.

It is the courage to approach the wounded parts rather than abandoning them. It is the courage to listen to protectors rather than fighting them. It is the courage to accept help, rebuild trust, and believe that life can become more than an endless response to danger.

Internal Family Systems gives us language for this journey. It shows us that the inner world is not a battlefield that must be conquered. It is a community that needs wise and compassionate leadership.

As Self begins to lead, the system no longer has to remain at war with itself. The heart becomes safer. The nervous system softens. Protectors begin to rest. Buried pain is no longer carried alone. What once felt fragmented can begin moving toward harmony.

This is the profound promise of IFS. The parts that helped you survive do not have to disappear. They can heal, change, and become valuable members of the life you are now building.

The mission is no longer merely survival.

The mission is restoration.

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Pillar Four Spirituality and Faith

Transformational Healing Through Faith, Neuroscience, and the Rewriting of the Soul

Of all the pillars within the NeuroFaith® Model, this one stands apart. Not because it is less grounded in science, but because it reaches into a dimension of human experience that science alone cannot fully explain.

Polyvagal-Informed Therapy, neurocardiology, and Internal Family Systems have given us remarkable tools for calming the nervous system, restoring physiological balance, and understanding the inner architecture of our emotional lives. They help explain why the body reacts as it does, why the heart longs for coherence, and why our inner world organizes itself around protection.

For the combat veteran, active duty service member, and first responder, these discoveries are profoundly hopeful. They help explain

why the mission continues long after the uniform comes off, why hypervigilance lingers, why relationships become difficult, and why peace can feel so elusive.

Yet even these remarkable discoveries eventually bring us face to face with questions that neuroscience alone cannot answer.

- What restores an identity shattered by trauma?
- What heals the deepest wounds of shame?
- What gives meaning to suffering once the nervous system finally becomes quiet?
- How do you forgive yourself for the life you could not save, the partner you lost, the child you could not revive, or the split-second decision you have replayed a thousand times?
- How do you rediscover purpose when the mission that organized your life has ended?

These questions lead us into territory that science can illuminate but cannot fully occupy. They lead us into the realm of spirituality and faith.

Within the NeuroFaith® Model, spirituality is not treated as a vague abstraction, an escape from reality, or a sentimental addition to therapy. It is understood as a foundational dimension of healing that interacts with the brain, body, heart, relationships, and inner emotional world.

Authentic faith does not have to compete with neuroscience. It can provide the larger framework within which neuroscience finds meaning.

We are not merely biological organisms, psychological beings, or social creatures. We are meaning-seeking beings. We ask why we are here, what we owe one another, what makes a life honorable, whether

suffering can be redeemed, and whether love remains real when the world has shown us its darkest face.

The traditional biopsychosocial model helped clinicians recognize that health is shaped by biology, psychology, and relationships. Yet the deeper we travel into trauma and recovery, the clearer it becomes that another dimension must be acknowledged.

Human beings long not only for safety, coherence, and inner harmony. We long for purpose. We long for forgiveness. We long for hope. We long for a set of values that can point us toward true north when our lives feel morally and emotionally disoriented. We long to know that our lives matter and that our suffering has not been meaningless.

We also long for an identity deeper than our job, rank, diagnosis, trauma, failures, or worst day.

That longing points us toward the soul.

Healing therefore moves beyond the biopsychosocial model into what many now recognize as a **biopsychosocial-spiritual** understanding of the person. Restoration is not simply about reducing symptoms or feeling better. It is about recovering a coherent sense of who we are, what we value, where we belong, and how we want to live.

Spirituality is not an escape from science. It is another part of the human story science has increasingly learned to take seriously.

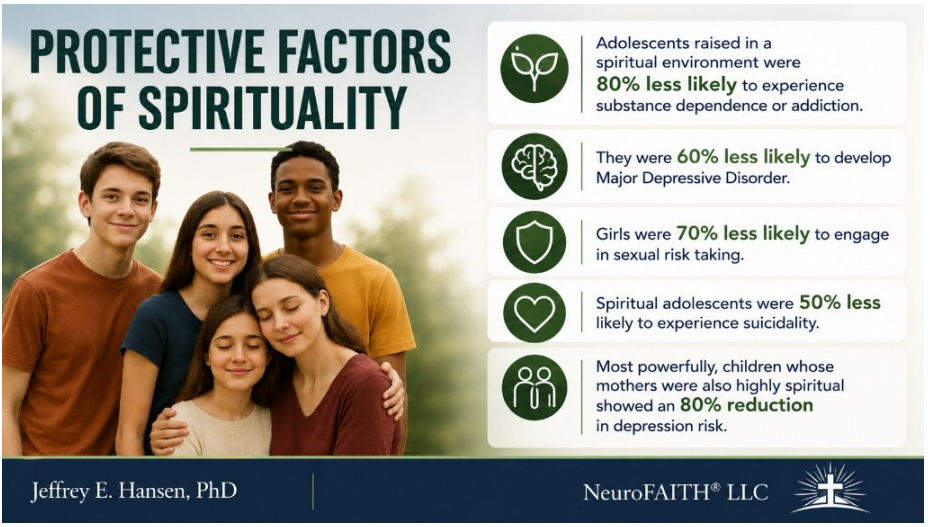
Lisa Miller's Research: A New Science of Spirituality

Dr. Lisa Miller, a clinical psychologist at Columbia University, has become one of the most respected voices bridging spirituality and neuroscience. In her groundbreaking book *The Awakened Brain* (2021),

Miller presents evidence suggesting that personal spirituality can serve as a significant source of resilience and protection.

Her findings, drawn from more than two decades of research, including longitudinal and twin studies, include striking associations:

- Adolescents raised in a spiritual environment were **80 percent less likely** to experience substance dependence or addiction.
- They were **60 percent less likely** to develop Major Depressive Disorder.
- Girls were **70 percent less likely** to engage in sexual risk-taking.
- Spiritually engaged adolescents were **50 percent less likely** to experience suicidality.
- Children whose mothers were also highly spiritual showed an **80 percent reduction in depression risk**.



These numbers are astonishing. They suggest that spirituality is not merely a private preference or comforting idea. It may function as an

important source of resilience, identity, relationship, and emotional protection.

Research summarized by Miller in *The Awakened Brain* (2021) also suggests that people who report a strong personal spirituality show increased cortical thickness in regions involved in self-reflection, meaning-making, and emotional regulation. These same regions are often thinner in people with depression and significant trauma histories. Greater cortical thickness in these areas may help buffer against depressive symptoms and strengthen resilience, particularly among those already at elevated risk.

The older biopsychosocial model, valuable as it remains, does not capture the whole person. The soul is not a detached abstraction floating somewhere outside the body. Spiritual experience is woven into the ways people understand themselves, interpret suffering, form relationships, make moral decisions, and imagine the future.

The biopsychosocial-spiritual model is not an attempt to force religion into clinical care. It is a recognition of human wholeness.

In *The Effect of Spirituality on Health and Healing*, Brian Udermann (2000) concluded from an extensive literature review that spiritual involvement was positively associated with reduced incidence of stroke, cardiovascular disease, cancer, suicide, substance abuse, and general mortality. These outcomes remained significant even after controlling for variables such as socioeconomic status and physical health behaviors.

Udermann writes: *"Strong scientific evidence suggests that individuals who regularly participate in spiritual worship services or related activities and who feel strongly that spirituality or the presence of a higher being or*

power are sources of strength and comfort to them are healthier and possess greater healing capabilities" (p. 194).

When spirituality is integrated thoughtfully with clinical wisdom, it may support neuroplasticity, strengthen emotional regulation, restore identity, deepen community, and reshape the story through which people understand their lives.

The NeuroFaith® Model therefore approaches spirituality with both reverence and scientific curiosity. It recognizes that spiritual experience can affect the brain, heart, nervous system, behavior, and relationships. At the same time, it acknowledges that the deepest dimensions of healing involve more than physiological regulation or psychological insight.

They involve the restoration of meaning, identity, belonging, and soul.

Yet before we can understand how spirituality contributes to healing, we must confront one of the forces that most profoundly wounds the human interior world.

That force is **shame**.

Developmental trauma can write shame into the narrative code of the soul. Unlike guilt, which says, "I did something wrong," shame says, "I am wrong."

Guilt focuses on behavior and may lead to accountability, repair, and growth. Shame attacks identity itself. It is totalizing, isolating, and destructive. It creates an existential rupture that is often resistant to reason and remarkably difficult to overcome through willpower alone.

Dr. David Hawkins (2014, 2020), though controversial, offered a framework for understanding emotional energy states. Using

kinesiology, Hawkins placed shame at the lowest level of his proposed scale of consciousness, assigning it a level of 20 on a scale from 0 to 1,000. He argued that shame produces demoralization, physiological deterioration, and despair.

Hawkins' methodology has been criticized, and his scale should not be treated as settled science. Even so, many clinicians, recovery professionals, and spiritual leaders have found his description of shame experientially recognizable.

Shame constricts. It drives hiding, isolation, addictive behavior, relational sabotage, and hopelessness. It tells the wounded person that connection is dangerous because being truly seen will inevitably lead to rejection.

In this sense, shame is profoundly anti-life.

The Neurobiology of Shame

If shame were merely an inaccurate belief, it might be easier to overcome. Unfortunately, shame becomes embedded far deeper than conscious thought. It can become encoded within the body, nervous

system, heart, relationships, and physiological systems governing survival.

A person may intellectually understand that the traumatic event was not their fault while continuing to experience a powerful bodily conviction that they are defective, responsible, unsafe, or unworthy.

The thinking brain may say, "I know better."

The nervous system answers, "I still do not feel safe."

The Polyvagal System

The body is often the first place shame is experienced. Before the conscious mind has time to interpret what is happening, the nervous system reacts as though a threat has appeared.

The hypothalamic-pituitary-adrenal axis, the body's primary stress-response system, activates rapidly. As previously discussed, the hypothalamus signals the pituitary gland, which stimulates the adrenal glands to release cortisol and other stress hormones into the bloodstream (Porges & Porges, 2023).

This response is designed to protect life during genuine danger. In situations involving trauma, humiliation, rejection, or chronic emotional threat, however, the system may become repeatedly activated. Over time, the body begins anticipating interpersonal rejection in much the same way it anticipates physical harm.

For active duty service members, veterans, and first responders, this may be especially confusing. You may have stood steady in situations that would terrify most people, only to feel your entire body react when someone expresses disappointment, questions your judgment, or moves emotionally close to you.

The threat is no longer an explosion, weapon, fire, violent suspect, or crashing vehicle. It is the possibility of being exposed, judged, rejected, or found inadequate.

When we carry toxic shame, the body may remain in a persistent state of tension. Muscles tighten. Breathing becomes shallow. Sleep is disrupted. The heart races in response to relatively minor interpersonal stress. We may scan facial expressions and changes in tone for evidence that rejection is coming.

These responses are not evidence of weakness or poor character. They are physiological echoes of repeated emotional injury.

Polyvagal Theory offers a particularly helpful framework for understanding these responses. In review, the autonomic nervous system contains pathways that continuously scan the environment for cues of safety and danger.

When safety is detected, the ventral vagal pathway supports calmness, connection, facial expression, vocal warmth, curiosity, and social engagement. When danger is perceived, the nervous system shifts toward sympathetic mobilization or dorsal shutdown (Porges & Porges, 2023).

Shame profoundly disrupts this system because shame is usually experienced within relationships. The nervous system begins associating social exposure with danger. Eye contact becomes difficult. The voice becomes restricted. Facial expression loses animation. We withdraw emotionally because hiding feels safer than being known.

In sympathetic activation, we may become anxious, restless, perfectionistic, irritable, defensive, or driven. We work harder, speak

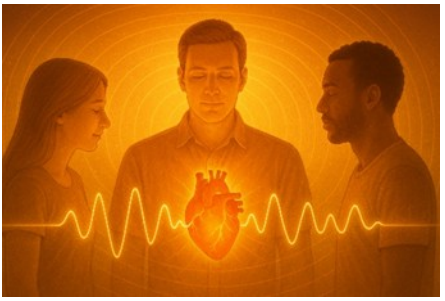
faster, and attempt to control our surroundings so rejection cannot catch us by surprise.

In dorsal shutdown, the opposite pattern appears. We become numb, exhausted, disconnected, hopeless, and emotionally withdrawn. We may stop returning calls, isolate from family, sleep excessively, or feel as though we have disappeared from our own lives.

These patterns look different, but they arise from the same underlying problem. The nervous system has lost its sense of relational safety.

Healing therefore requires more than intellectual understanding. The nervous system itself must gradually learn that connection is no longer dangerous.

The Heart Dimension



The storm of shame does not stop at the nervous system. It also affects the heart.

As previously discussed, research in neurocardiology suggests that the heart is far more than a mechanical pump. It communicates continuously with the brain and the rest of the body. Emotional states influence heart rhythms, and those rhythms influence neurological and physiological regulation (McCraty, 2023).

When we experience emotional coherence, heart rhythms become smoother and more organized. This state is associated with improved emotional regulation, clearer thinking, greater flexibility, and increased resilience.

When we experience fear, anger, or shame, however, heart rhythms may become more chaotic and irregular. We feel exposed and unsafe. Emotional tension increases. Heart-rate variability may decrease, and communication between the heart and brain becomes strained.

Yet the heart also participates in healing. Practices that cultivate gratitude, compassion, reverence, connection, and love can help restore coherence. As the heart becomes more regulated, the brain receives stronger signals of safety and calmness.

For many people, spiritual practices provide a powerful pathway toward this coherence. Prayer, meditation, worship, reflection, time in nature, meaningful ritual, service to others, gratitude, and participation in a faith community may help calm the nervous system and restore harmony between the heart and brain (McCraty, 2023).

This does not mean that a person can pray away trauma or that spiritual practice should replace competent treatment. It means spirituality does not exist apart from physiology. It participates in how the body experiences safety, connection, and hope.

The heart, quite literally, begins to remember peace.

Psychology can name shame, reveal its origins, and reduce its power. Neuroscience can help us understand how it becomes embodied. Relationships can create experiences of safety that were previously absent.

Faith offers something further. It gives us a larger source of meaning and a new ground for identity. It tells us that our worth does not have to be decided by trauma, performance, failure, rank, reputation, or the worst moment of our lives.

The Eye of the Storm

Shame is often misunderstood as a simple emotion. In reality, it behaves more like a storm moving through the entire human system. It affects the nervous system, body, heart, relationships, inner emotional world, and the story we tell about ourselves.

It does not merely produce discomfort. It reshapes identity.

Shame whispers a devastating lie. It says the problem is not simply something we have done or something that happened to us. The problem is who we are.

For the veteran carrying moral injury, shame may say, "You should have prevented it."

For the firefighter who could not save a child, it may say, "Someone better would have found a way."

For the police officer involved in a fatal incident, it may say, "You can never allow anyone to know what this did to you."

For the paramedic who has grown numb after years of death and suffering, it may say, "You have lost your humanity."

For the person struggling with addiction, it may say, "If people knew how bad it has become, they would leave."

Shame convinces us that we are fundamentally defective, unworthy of love, and unsafe to reveal. It drives the wounded self into secrecy because secrecy appears safer than exposure.

Faith traditions have wrestled with shame, hiding, moral failure, mercy, restoration, and belonging for thousands of years. Although they do not all describe the human condition in the same way, many share a conviction that a person's deepest identity cannot be reduced to failure or suffering.

At their best, faith traditions call people out of hiding and back into relationship. They provide practices of confession, forgiveness, reconciliation, compassion, community, service, and renewed purpose. They offer a sacred context in which the wounded person may be fully known without being discarded.

To understand how deeply shame shapes identity, it is helpful to consider several voices that have influenced modern psychology and trauma recovery: John Bradshaw, Tim Fletcher, and Curt Thompson.

Each approaches shame from a different perspective. Together, they reveal a shared truth. Shame is not merely an emotional state.

It is an identity wound.

John Bradshaw: The Wounded Healer and the Language of Shame

John Bradshaw's life reflected the struggle he would later help thousands of other people understand. Born in Houston in 1933, Bradshaw grew up in a family shaped by alcoholism and emotional instability. His father's absence left a profound wound of abandonment that followed him into adulthood.

Bradshaw initially pursued the priesthood, studying philosophy and theology at the University of Toronto. Like many people drawn toward spiritual vocation, he hoped intellectual and theological understanding might quiet the deeper ache within his heart. Beneath those studies,

however, remained a persistent sense that something was fundamentally wrong with him.

After leaving the priesthood, Bradshaw battled alcoholism and despair before eventually entering recovery. Through that process, he discovered the insight that would define his life's work.

The deepest pain carried by many people was not guilt over their actions. It was shame concerning their identity.

In his influential book *Healing the Shame That Binds You*, Bradshaw distinguished between healthy shame and toxic shame. Healthy shame reminds us of our limitations. It encourages humility, responsibility, and our need for other people. Toxic shame operates very differently. It convinces us that we ourselves are defective. Shame is transformed from a temporary feeling into an identity (Bradshaw, 2005).

Bradshaw referred to this condition as **soul murder**.

When toxic shame takes root, authenticity begins to disappear. We learn to hide not only our mistakes but also our needs, emotions, longings, and vulnerabilities. We become disconnected from our true selves and begin performing roles designed to gain approval or prevent rejection.

This can be especially powerful within military and first-responder cultures. Competence, strength, decisiveness, endurance, and loyalty are essential qualities. They save lives. Yet when they become the only acceptable parts of us, we may begin believing that vulnerability, grief, uncertainty, or asking for help represents failure.

The role slowly replaces the person.

Bradshaw also recognized that shame is often transmitted across generations. In families where love is conditional, affection is withheld, addiction dominates, or perfection is demanded, children quickly learn that their worth depends upon performance.

Over time, they internalize the belief that their needs and deepest longings are wrong. The spontaneity, joy, imagination, and curiosity of childhood gradually give way to caution and self-protection (Bradshaw, 2005).

Yet Bradshaw's work also pointed toward hope. He recognized that healing shame requires more than intellectual insight. It requires honesty, community, acceptance, and grace.

Through being known and still accepted, people can begin rediscovering the truth that their worth was never erased. Bradshaw helped us understand shame as an identity wound rather than merely a moral failure.

Tim Fletcher: Shame and the Narrative of the Mind

Tim Fletcher extends Bradshaw's insights by exploring how shame becomes embedded within the nervous system and the narrative structure of the brain. Fletcher is a Canadian counselor and founder of RE/ACT Recovery Education for Addictions and Complex Trauma. His work focuses upon the relationship between developmental trauma, addiction, shame, and negative core beliefs.

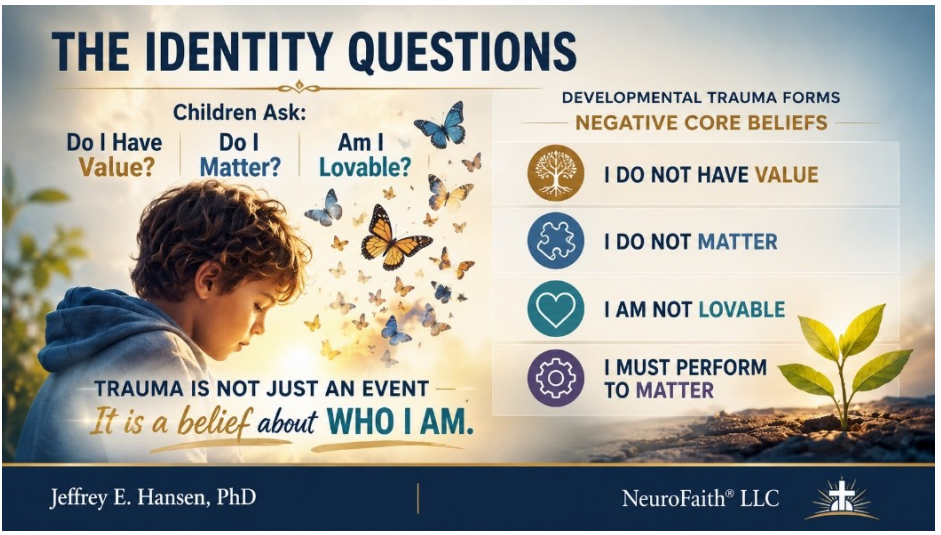
Fletcher explains that trauma creates more than painful memories. It reshapes the beliefs people hold about themselves.

When children grow up in environments where their emotional needs are repeatedly ignored, criticized, punished, or invalidated, they eventually arrive at a devastating conclusion:

"The problem must be me."

From that conclusion emerges a set of core beliefs that become the operating system of the wounded mind. Fletcher frequently identifies four beliefs common among people who have experienced developmental trauma:

> "I am not lovable."
> "I am not safe."
> "I do not matter."
> "I am bad."



These beliefs can become deeply embedded in the brain's Default Mode Network, the neural system involved in self-referential thinking and

autobiographical identity. Over time, they become the lens through which relationships and experiences are interpreted (Fletcher, 2022; Fletcher, 2023; Fletcher, 2025).

When trauma occurs repeatedly during development, the Default Mode Network may become organized around negative beliefs about the self. These beliefs then shape the continuing narrative of identity (Thompson, 2023).

This is one reason shame feels so permanent. It is not simply an emotion that visits occasionally. It becomes part of the mind's background activity.

Positive events are minimized. Criticism is magnified. Ambiguous interactions are interpreted as rejection. The mind quietly rehearses the same painful narrative again and again.

Even genuine love may have difficulty penetrating this internal story. Compliments feel suspicious. Acceptance feels temporary. Trust feels dangerous. Love feels as though it must eventually be withdrawn.

Addiction may emerge as an attempt to escape the relentless pressure of this narrative. Alcohol, drugs, pornography, gambling, work, anger, isolation, or other compulsive behaviors provide temporary relief from a mind that never stops repeating, "You are not enough."

Fletcher's work highlights an important truth for trauma treatment. Recovery cannot stop with behavioral change alone. A person may become sober and still feel worthless. Someone may learn coping strategies while continuing to believe they are fundamentally unlovable.

Until the underlying identity narrative is addressed, the deepest wound of shame remains.

Healing therefore requires more than willpower or self-improvement. It requires a transformation in the story the mind tells about the Self.

Curt Thompson: Being Seen and Known

Psychiatrist Curt Thompson brings another important dimension to this conversation by integrating neuroscience, attachment theory, relational healing, and Christian spirituality.

In *The Soul of Shame*, Thompson explains that shame disrupts the neural pathways allowing human beings to experience belonging (Thompson & Seybeth, 2018).

Human beings are made for connection. The brain develops within relationships that shape its ability to regulate emotion, experience safety, and interpret social cues.

When we experience consistent love, presence, responsiveness, and safety, the nervous system learns that relationships can be trusted. When those experiences are absent or distorted, the mind adapts by preparing for rejection.

Shame is therefore a relational injury. It teaches us that being seen is dangerous.

Thompson describes how shame disrupts integration within the brain. The prefrontal cortex, responsible for reflection and self-regulation, becomes less coordinated with emotional and relational circuits within the limbic system. The Default Mode Network reinforces narratives of defectiveness and isolation (Thompson, 2023).

Thompson also emphasizes that healing occurs through relational presence. When we are seen, heard, understood, and accepted without condemnation, the brain begins to reorganize. Neural pathways associated with safety and connection grow stronger.

Although Thompson writes from a specifically Christian perspective, this relational truth reaches beyond any single tradition. Healing occurs through love. It occurs when another person sees what we feared would make us unacceptable and does not turn away.

The Christian tradition expresses this beautifully in the words, *"Perfect love drives out fear"* (1 John 4:18, NIV).

This is one of Christianity's important contributions to the healing of core wounds: identity is not earned through flawless performance. It is received through relationship with a God understood as loving, knowing, and merciful.

Other faith traditions express sacred belonging and compassionate connection in their own distinctive ways. The language differs, but the healing movement is often similar. Fear gives way to trust. Isolation gives way to belonging. Condemnation gives way to compassion. Meaning begins replacing despair.

Thompson's work reminds us that grace is not merely a theological idea. When love replaces condemnation and isolation gives way to safe relationship, the brain itself can begin to change (Thompson, 2025).

The Internal World: Fragmentation and the Inner Family

Shame does not affect only the body and heart. It also quietly reorganizes the internal emotional world.

For many combat veterans and first responders, this process begins long before they recognize it. The accumulated weight of trauma, loss, moral injury, and the relentless pressure to remain strong gradually reshapes how they relate to themselves.

The mission may be over and the emergency may have ended, but the inner battle continues. Shame becomes more than an emotion. It becomes an organizing force within the personality.

As we discussed in the previous chapter, Internal Family Systems offers a remarkably compassionate framework for understanding this process. According to IFS, the human psyche contains multiple internal parts that interact with one another. These include Exiles, Managers, and Firefighters, each developing in response to painful experiences and each attempting, in its own way, to protect us from further suffering (Schwartz, 2023).

For the warrior or first responder, these parts may become especially active.

Exiles carry the deepest wounds. They may include the child who never felt good enough, the Marine haunted by the friend who never came home, the police officer replaying the call that ended in tragedy, the firefighter remembering the child who could not be saved, or the paramedic quietly carrying faces that have never been forgotten.

These parts hold grief, fear, guilt, rejection, humiliation, grief, and abandonment beneath the surface.

Managers devote themselves to preventing those wounds from ever being touched again. They push us toward perfectionism, hyper-responsibility, emotional control, relentless competence, and the conviction that we must always remain strong.

For many first responders, these managers become respected on the job. They make us dependable, disciplined, precise, and composed under pressure. When they become extreme, however, they also make it difficult to rest, trust, ask for help, or allow anyone close enough to know us.

When the emotional burden becomes too great, Firefighters rush in. Their mission is immediate relief. They seek to extinguish pain through whatever promises temporary escape: alcohol, drugs, pornography, compulsive work, anger, emotional withdrawal, gambling, risk-taking, overeating, or countless other behaviors.

These strategies may create further suffering, but they were not originally intended to destroy us. They were desperate attempts to soothe pain that felt unbearable.

Shame intensifies each protective role. Exiles become convinced they are defective rather than wounded. Managers work harder to prevent anyone from discovering what they believe must never be seen. Firefighters become more desperate to numb the pain before it overwhelms the system.

Perhaps nowhere is shame more destructive than in the emergence of the Inner Critic.

For many warriors, veterans, and first responders, this voice sounds painfully familiar:

> "You should have done more."
> "You should have seen it coming."
> "You failed them."
> "You are weak."
> "You are broken."
> "You are not the person everyone thinks you are."

Ironically, the Inner Critic usually began as a protector. It may have believed that if it criticized us first, the world could never wound us more deeply. Over time, however, it becomes relentless. Rather than correcting behavior, it attacks identity.

This is how shame gradually eclipses what Richard Schwartz calls the Eight Cs of Self as mentioned earlier in this book: calm, clarity, curiosity, compassion, confidence, courage, creativity, and connectedness (Schwartz, 2023).

Under the weight of trauma and shame, these qualities appear to disappear. We begin living almost entirely through protective parts rather than from the grounded center of who we truly are.

The good news is that these qualities have not been destroyed. They have been hidden beneath layers of protection.

The Self remains.

Healing is therefore not about eliminating our parts or declaring war upon them. It is about helping wounded protectors recognize that the danger has passed. It is allowing compassion to replace condemnation

and gradually restoring the calm, courageous, connected Self that has been waiting to lead us home.

The Science of Spirituality and the Healing of Shame

Shame moves through every dimension of the human person. It affects the nervous system, heart, internal emotional world, relationships, and narrative structures of the mind. It teaches the body to brace, the heart to constrict, and the mind to repeat a painful story about identity.

If healing is to occur, something powerful enough to reach each of these layers must enter the process. Increasingly, research suggests that spirituality may be one of the forces capable of doing precisely that.

Psychology can help us understand shame and reduce its effects, but insight alone may struggle to dismantle the deeper narrative shame creates. Our wounds need more than coping strategies. They need a new verdict about identity.

Faith can offer that verdict.

At their healthiest, faith traditions tell us that our value rests upon something deeper than performance. They locate us within a story larger than trauma. They provide a moral compass, a community, a source of belonging, and a true north when life has become disoriented.

Faith can say:

"You are more than what happened to you."
"You are more than what you did."
"You are not alone."
"Your life retains meaning."
"You remain worthy of love."
"There is still a path forward."
These are not empty affirmations. They are direct challenges to the central claims of shame.
Shame says, "Hide."
Faith says, "You may be known."
Shame says, "You are alone."
Faith says, "You belong."
Shame says, "You are your worst day."
Faith says, "Your story is not finished."
Shame says, "Nothing lies beyond this pain."
Faith says, "There is something larger than you, and hope remains possible."

Faith as True North

Warriors, veterans and first responders understand the importance of orientation. When conditions become chaotic, you need a fixed reference point. You need to know where you are, what the mission is, what values guide the next decision, and in which direction you must move.

Trauma can destroy that orientation.

Moral injury may leave a person uncertain about what is still good. Loss may dismantle the future they expected. Retirement or separation from service may remove the role around which identity was organized.

Addiction may pull behavior farther and farther from deeply held values.

Faith can become true north.

It offers a reference point outside the constantly shifting landscape of emotion, public opinion, professional identity, and personal performance. It gives us values by which to live and a story in which courage, sacrifice, mercy, truth, responsibility, forgiveness, and service possess enduring meaning.

Faith also challenges the illusion that healing must be accomplished alone. It invites us into relationship with God, a higher power, a sacred reality, a faith community, or a source of meaning beyond the isolated self.

This matters because shame thrives in isolation. It loses power when brought into trustworthy relationship.

Faith at its best does not deny suffering or demand superficial positivity. It does not tell the traumatized person to pray harder, stop grieving, or pretend everything happens for an easily understood reason.

Mature faith can sit beside suffering without running from it. It can make room for grief, anger, doubt, lament, confusion, and silence. It can help us remain connected to meaning even when answers remain incomplete.

Christianity as One Pathway Toward Healing Core Wounds

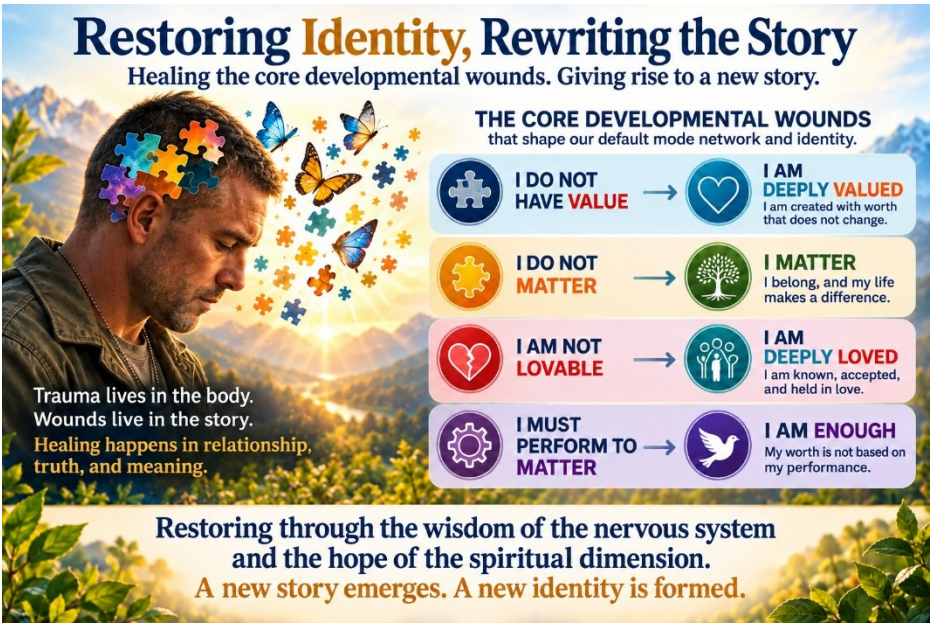
The NeuroFaith® Model is intended for people from many spiritual backgrounds. It does not require a person to adopt one tradition before receiving care or beginning the healing process.

At the same time, Christianity deserves acknowledgment as one faith tradition that speaks directly to the core wounds of shame, abandonment, unworthiness, and fractured identity.

Its central message is that human worth is not earned through strength, flawless behavior, status, or performance. A person is known completely and still loved. Failure does not place someone beyond grace. Suffering does not erase identity. Restoration remains possible.

The Christian Scriptures express this identity in deeply personal language: *"For you created my inmost being; you knit me together in my mother's womb"* (Psalm 139:13, NIV).

For a person whose identity has been rewritten by shame, this offers a radically different story. It suggests that there was an identity before the trauma, before the addiction, before the diagnosis, before the uniform, and before the worst day.



Christianity is not alone in affirming compassion, sacred worth, community, and meaning. Other faith traditions provide their own language, practices, stories, and pathways for reconnecting people with what is sacred.

The task is not to pretend that every tradition teaches exactly the same thing. It is to recognize a common healing movement: away from isolation and toward belonging, away from meaninglessness and toward purpose, away from self-condemnation and toward mercy, and away from despair and toward hope.

A person's faith should be approached with respect, curiosity, and humility. It should never be imposed by a therapist or used to silence pain. It should be invited into treatment when it is meaningful to the person and when it can support healing rather than judgment.

Soul Restoration

Healing from trauma, addiction, and emotional injury is never simply the reduction of symptoms. It is the gradual rediscovery of the person who existed before shame rewrote the story of identity.

Shame tells us that we are the sum of our failures. It insists that belonging must be earned, love is conditional, and anyone who truly knows us will eventually turn away. Over time, these beliefs become embedded within the nervous system, heart, relationships, and stories we tell ourselves. Eventually, they no longer feel like beliefs or interpretations. They simply feel true.

This is one reason trauma recovery can be so difficult. It is not enough to tell a veteran that the loss was not his fault, assure a firefighter that she did everything possible, or remind a paramedic that no one could have changed the outcome. The thinking mind may accept these words

while the wounded heart continues carrying a very different conclusion. Shame does not surrender easily because it has often become part of the person's deepest understanding of who they are.

Yet beneath these layers of pain, something more enduring remains. Beneath trauma and addiction is often a longing for peace. Beneath hypervigilance is a longing for safety. Beneath perfectionism is a longing for acceptance. Beneath anger may be a longing to be understood. Beneath isolation may be a longing to belong. Beneath every wounded protector is the desire to be fully known and still loved.

These longings are not evidence that something is wrong with us. They are evidence of our humanity and of the relational beings we were created to be.

As healing unfolds, the body gradually begins to recognize safety. The nervous system becomes less reactive and more regulated. The heart moves toward coherence. The inner critic begins to lose its unquestioned authority. Protective parts discover that they no longer have to remain on constant duty or carry impossible burdens alone. They can begin trusting the steadier leadership of the Self and the support of safe relationships.

Faith can deepen this process by giving the wounded person an identity that does not rise and fall with performance. It provides a larger story in which suffering is real but does not possess the final word. It offers values that function as true north, a community in which burdens can be shared, and a source of meaning extending beyond the limits of individual strength.

For some people, this restoration is experienced through a personal relationship with God. Others encounter it through prayer, meditation,

sacred community, service, nature, moral commitment, or a growing awareness that they belong to something larger than themselves. The language and practices differ, but the movement is often similar. Isolation begins giving way to connection. Meaninglessness gives way to purpose. Condemnation gives way to compassion. Despair begins making room for hope.

Christianity expresses this sacred identity in deeply personal language: *"For you created my inmost being; you knit me together in my mother's womb"* (Psalm 139:13, NIV). For a person whose identity has been rewritten by trauma and shame, these words offer another way of seeing the self. They suggest that there was an identity before the trauma, before the addiction, before the diagnosis, before the uniform, and before the worst day. That deeper identity was not created by achievement and therefore cannot be erased by failure.

Other faith traditions offer their own language for sacred worth, mercy, belonging, connection, and renewal. NeuroFaith® does not require everyone to describe this mystery in the same way. It does affirm that healing often involves recovering an identity sturdy enough to hold both the beauty and pain of our story.

Recovery is therefore much more than rebuilding a damaged life. It is rediscovering meaning, dignity, belonging, and purpose. It is learning that the qualities required for survival do not have to remain the only qualities available to us. The veteran who learned to remain vigilant can also rediscover rest. The firefighter who learned to suppress emotion can also rediscover tenderness. The police officer who carried everyone else's safety can learn to receive care. The paramedic who became numb enough to continue responding can begin feeling alive again without being overwhelmed.

This does not dishonor the warrior, rescuer, protector, or professional identity. It brings that identity back into relationship with the whole person. Service remains part of the story, but it no longer has to carry the entire weight of identity.

For the warrior, veteran, and first responder, this may be among the most important truths in the entire journey: You are not simply what happened to you. You are not your diagnosis, addiction, or shame. You are not the call you could not save, the deployment you cannot forget, the decision you regret, or the burden you have carried alone for years.

You are a person of inherent worth, capable of love, courage, relationship, purpose, and restoration. You belong to a story larger than your pain.

As this truth begins reaching more than the thinking mind, the storm of shame gradually quiets. The body breathes more freely. The heart finds a steadier rhythm. The mind begins telling a different story, and the soul becomes more willing to step out of hiding.

The voice calling us home is not a voice of condemnation. It is a voice of invitation, reminding us that we are still worthy of connection, still capable of purpose, and still held within a reality larger than everything we have endured.

Healing is the movement from isolation toward connection, from confusion toward true north, from shame toward dignity, and from despair toward hope. It is not the erasure of the past but the transformation of our relationship with it. The wounds remain part of the story, but they are no longer permitted to define the whole story.

This is soul restoration: the recovery of meaning, identity, love, and peace

Innovative Treatments for the Wounds of Trauma

If you have carried the wounds of trauma for months or years, you may already know what it is like to hear, "Let us try one more medication." Perhaps a medication helped you sleep, took the edge off your anxiety, or made the depression a little less crushing. Medication has an important place, and for some people it is lifesaving.

You may also know the other side of that story. You may have tried one medication after another, waited weeks for each one to work, endured side effects, and still awakened carrying the same heaviness. You may be taking several medications and no longer feel certain which one is helping, which one is hurting, or whether any of them are reaching the wound beneath the symptoms.

After enough disappointments, it is easy to begin wondering whether anything can still help you. That question does not mean you are weak or unwilling to recover. It may simply mean that you are tired. You have fought this battle for a long time, and hope itself can become difficult when treatment after treatment has failed to bring meaningful relief.

Trauma does not always become post-traumatic stress disorder. You may carry trauma as depression, anxiety, panic, disrupted sleep, irritability,

emotional numbness, chronic pain, substance use, isolation, or a loss of meaning and hope. You may not fit neatly into a diagnostic box, but your suffering is still real. The treatments discussed in this chapter are therefore not limited to PTSD. Their strongest evidence is often found in depression, including depression and anxiety that have grown out of trauma.

Over the past two decades, treatments have emerged that work differently from traditional daily medications. Transcranial magnetic stimulation, ketamine, and esketamine may offer another path when familiar approaches have not been enough. Psilocybin and other psychedelic-assisted treatments are also being studied, although they remain future directions rather than established answers.

None of these treatments can erase what happened to you. They cannot rebuild a marriage, restore a fallen brother or sister, resolve moral injury, or tell you who you are now that the uniform has come off. What they may do is help a brain that has become stuck begin to move again. Sometimes that small movement is where healing begins.

TMS: Helping a Stuck Brain Begin to Move

The name transcranial magnetic stimulation sounds more intimidating than the treatment usually feels. TMS is noninvasive. Nothing is surgically implanted, and you do not need anesthesia. You remain awake in a chair while an electromagnetic coil rests against your scalp and delivers carefully controlled magnetic pulses. Many people describe the sensation as a tapping against the head.

For depression, those pulses are usually directed toward an area near the front of the brain that helps regulate mood, motivation, attention, and emotional control. That area communicates with deeper regions involved in fear, memory, reward, and the stress response. When depression has settled over your life, those networks may no longer communicate as effectively as they once did. You may feel slowed down, emotionally shut off, unable to experience pleasure, or trapped in the same hopeless thoughts day after day.

TMS does not simply switch happiness back on. The brain is far more complicated than that. Repeated stimulation appears to encourage activity and communication within networks that have become underactive or poorly regulated. Over time, those networks may become more flexible and responsive.

If you have lived through combat, a terrible call, repeated exposure to death, or years of staying ready for the next emergency, depression may not look like sadness. You may still report for duty, care for your family, and complete everything expected of you while feeling almost nothing inside. You may retreat to the garage, the basement, or a dark room because ordinary life has become exhausting. You may feel constantly irritated and ready for a fight without understanding why. TMS may be worth considering when depression has not improved sufficiently with medication or when medication side effects have become too difficult.

Unlike a pill, TMS does not travel through your entire body. It does not ordinarily cause weight gain, sexual side effects, gastrointestinal problems, or emotional blunting. It can cause headaches or scalp discomfort, especially early in treatment. Seizures are possible but rare when appropriate safety procedures are followed. Certain metallic or electronic devices in or near the head may prevent someone from receiving it.

TMS also asks something of you. Traditional treatment may require sessions five days a week for several weeks, although newer accelerated approaches can shorten that schedule. Improvement may be gradual. Not everyone responds, and some people later need maintenance sessions or another course of treatment.

Still, if you have tried several medications and are beginning to believe that nothing will help, TMS offers another path. It works directly with the brain networks involved in depression rather than asking your whole body to carry another daily medication. The strongest evidence is for depression. Research involving PTSD, anxiety, and other trauma-related problems continues to develop (O'Reardon et al., 2007).

The deeper message is one worth holding onto: your brain is not a fixed machine. Even after years of depression, anxiety, and trauma, it may retain the ability to reorganize and change.

Ketamine and Esketamine: Opening a Window for Change

Ketamine is not a new medication. It has been used in medicine for more than fifty years, primarily as an anesthetic. What is newer is the discovery that, at much smaller doses, ketamine can sometimes bring rapid relief to people living with severe depression.

Traditional antidepressants may take several weeks before their benefits become clear. If you have been deeply depressed, you know how long those weeks can feel. Ketamine is different. Some people notice meaningful improvement within hours or days. That does not mean everything is suddenly fixed. It may mean that, for the first time in a long while, change feels possible (Zarate et al., 2006).

Ketamine and esketamine are related, but they are not identical. Ketamine is often given for depression through an intravenous infusion. Its psychiatric use is considered off-label, which means that an approved medication is being used for a purpose other than its original approved indication.

Esketamine is one part of the ketamine molecule. It is given as a nasal spray under the brand name Spravato and is approved for adults with treatment-resistant depression. It must be administered in a certified medical setting so that you can be monitored afterward (Popova et al., 2019).

Why Might Ketamine Help?

The honest answer is that we do not yet understand everything ketamine does. What we do know is that it works differently from most traditional antidepressants. Instead of acting primarily through serotonin, it affects glutamate, a chemical messenger that helps your brain cells communicate, learn, adapt, and form connections.

Depression can make your brain and your life feel painfully rigid. The same thoughts keep traveling the same well-worn roads: Nothing is going to change. My family would be better off without me. I should have done more. I do not deserve to feel better. No one who was not there could ever understand.

When you have repeated those thoughts for long enough, they may no longer feel like thoughts. They feel like facts. Trauma, shame, grief, depression, and isolation can deepen those pathways until it becomes difficult to imagine another way of living.

Ketamine may temporarily loosen some of that rigidity. It appears to encourage communication between brain cells and support neuroplasticity, which is your brain's ability to reorganize itself, form new connections, and learn new ways of responding.

Our co-author and psychiatrist, Kris Peterson, MD, has emphasized the possible role of brain-derived neurotrophic factor, commonly called BDNF. We have described BDNF as something like "Miracle-Gro for the brain." The comparison is imperfect, but the idea is useful. BDNF helps support the growth, survival, and adaptability of neurons. Ketamine and esketamine may activate biological pathways involving BDNF and the formation of new neural connections.

We should not turn an exciting scientific possibility into a promise. Researchers are still learning how these changes translate into lasting improvement. But if you have suffered for years, the possibility matters. Your brain may not be broken beyond repair. It may be stuck in patterns that once helped you survive but now make it difficult to live.

The Open Window

One way to think about ketamine is that it may open a window. Through that window, you may glimpse life without the full weight of depression. You may feel connected to your spouse or children in a way that has been missing. You may recognize that the voice telling you, "You are ruined," is not the whole truth. You may be able to look at a painful memory without being swallowed

by it or finally feel grief that has been buried beneath years of emotional numbness.

But an open window is not the same thing as a healed life. Ketamine cannot do the whole work for you. What it may do is create an opportunity for that work to begin.

This is the idea behind ketamine-assisted psychotherapy. You are prepared before the medication session, supported through the experience, and helped afterward to understand what emerged. You might feel less defended or less trapped inside your usual way of seeing yourself. Memories, emotions, images, or insights may arise. The experience can be peaceful, unsettling, emotionally intense, or some combination of all three.

A powerful experience is not automatically a healing experience. What matters is how you understand it and what you do with it afterward. Integration means bringing the experience back into your ordinary life. What did you notice? What felt different? Which painful belief became less certain? What truth became easier to see? What conversation now needs to happen? What action could make that insight real?

A skilled therapist can help you turn a temporary opening into meaningful movement. If ketamine increases your brain's readiness to change, psychotherapy can help give that change direction.

Ketamine and esketamine are not harmless. They can cause nausea, dizziness, anxiety, sedation, increases in blood pressure, changes in perception, or a disturbing sense of disconnection. Ketamine also carries a risk of misuse, particularly when used repeatedly without careful medical oversight. The setting matters. The provider's training matters. Screening, monitoring, preparation, and follow-up all matter.

You deserve honest informed consent. You deserve to know what is established, what remains uncertain, what safeguards are in place, and how the treatment will fit into a larger plan for recovery. The strongest evidence for ketamine and esketamine is currently in depression, especially depression

that has not responded to conventional treatment. Their usefulness for PTSD, anxiety, and other consequences of trauma is still being studied.

If you have tried medication after medication and have begun to believe that nothing can change, ketamine may offer evidence that your brain is still capable of movement. The pathways of hopelessness may be deeply worn, but they are not the only pathways available.

Future Directions: Psilocybin and Psychedelic-Assisted Therapy

You have probably heard the growing conversation about psilocybin and other psychedelic treatments. Psilocybin is the active compound found in certain mushrooms. It is being studied for depression, anxiety, addiction, and other forms of psychological suffering. Researchers are also asking whether psychedelic-assisted approaches may eventually help people carrying trauma.

The idea is not that you simply take a psychedelic drug and become healed. In responsible clinical research, the medication is only one part of a carefully structured process. You are thoroughly screened, prepared beforehand, closely supported during the experience, and helped to integrate it afterward.

Psilocybin appears to temporarily change communication among brain networks involved in identity, memory, emotion, and the stories you repeatedly tell yourself about who you are. Researchers believe it may soften rigid patterns of thinking and create a period of increased psychological flexibility. If you have become trapped in shame, hopelessness, or the belief that your life has permanently lost its meaning, that temporary flexibility could become important (Goodwin et al., 2022).

The research is promising, but it is not finished. Psilocybin remains investigational rather than an FDA-approved treatment for depression or PTSD. Research specifically involving veterans and PTSD remains limited. Psychedelic experiences can also be frightening, disorienting, or destabilizing and may be dangerous for people with certain medical or psychiatric conditions.

For these reasons, we view psilocybin and related approaches as future directions, not established answers. They deserve careful research, thoughtful regulation, well-trained clinicians, and the same commitment to informed consent that should guide every treatment discussed in this book.

The Story Is Not Over

TMS, ketamine, esketamine, and the emerging study of psychedelic-assisted therapy all point toward a larger truth: your brain remains capable of change.

These treatments cannot erase your past. They cannot replace courage, relationships, skilled therapy, physical care, spiritual grounding, or the difficult work of rebuilding a meaningful life. They are not magic doors through which suffering disappears.

But they may help unlock a door that has seemed permanently closed.

If you are an active duty service member, veteran, police officer, firefighter, paramedic, dispatcher, corrections officer, or another warrior who has repeatedly tried to get better and has begun to lose hope, please remember this: deeply established does not mean permanent. Your nervous system may be exhausted. The pathways of fear, shame, depression, and emotional shutdown may be deeply worn. But your story is not over.

Sometimes healing begins with a dramatic breakthrough. More often, it begins with something quieter: a little less darkness, a little more room to breathe, and the first fragile thought that perhaps life can be different.

If you have made it this far, we want you to pause for a moment and recognize what that means. You have been willing to look honestly at your trauma, your losses, your pain, and the ways your mind and body learned to survive overwhelming experiences. That takes courage.

We are proud of you for taking this step.

We wrote this book specifically for our active duty service members, our veterans, and our first responders. We wrote it for you because you have carried responsibilities, faced dangers, and made sacrifices that most people will never fully understand. You may have survived experiences that changed you, and you may still be carrying wounds that no one else can see.

You may have picked up this book because you are tired of merely getting through the day. You may be searching for a way to sleep, to quiet your mind, to feel close to the people you love, or simply to feel like yourself again. Whatever brought you here, your willingness to look at your pain and consider a path toward healing matters.

Throughout this book, we have explored what happens when the danger has passed but your nervous system continues preparing for battle. We have examined how your trauma can affect your brain, your body, your heart, your relationships, your sleep, your identity, and your ability to feel safe. We have also looked at how your depression, anxiety, anger, addiction, isolation, or shame may have developed as attempts to manage pain that once felt impossible to bear.

These responses are not evidence that you are weak or broken. They are evidence that your brain and body worked remarkably hard to protect you. What helped you survive then, however, may now be keeping you from fully living.

That is where healing begins.

Your healing does not require you to forget what happened, deny what it cost you, or somehow become the person you were before. Some experiences change you permanently. Healing means learning to carry those experiences differently. It means remembering without being overwhelmed, feeling without being consumed, and living without allowing your past to control your present.

The Four Pillars of NeuroFaith® offer an integrated pathway toward your healing. Polyvagal informed therapy can help your nervous system recognize that the danger has passed and rediscover a sense of safety. Neurocardiology and HeartMath® can teach you to work with your heart and body to develop greater coherence and emotional regulation. Internal Family Systems can help you approach the wounded and protective parts within you with curiosity, compassion, and respect. Faith and spirituality can reconnect your healing with meaning, identity, hope, and something greater than yourself.

Each pillar addresses a different part of your healing journey. Together, they remind you that recovery must involve your whole person.

Your brain can change. Your nervous system can recover. Your heart can become coherent once again. Your relationships can be repaired. Your trust can slowly return. You can rediscover meaning. Your shame does not have the final word.

Your recovery will probably not follow a straight road. You will have better days and difficult ones. At times, old reactions may return and leave you wondering whether you have made any progress at all. Those moments do not mean you have failed. They mean you are human.

Your healing may happen quietly. It may begin with a full night of sleep, a conversation that does not end in anger, a moment when your body finally relaxes, or the courage to tell someone that you need help. You may notice it in your first genuine laugh in a long time, the return of tenderness in an important relationship, or a moment of peace you once thought was gone forever.

Do not dismiss those moments. They are signs that something within you is beginning to come home.

If you are tired, discouraged, or wondering whether lasting change is still possible for you, please hear us clearly: it is not too late. You have not traveled too far, suffered too much, or struggled for too long to begin healing. You are still here. You are reading these words. Some part of you is still searching for a better way, and that part of you deserves to be heard.

We are proud of you for stepping forward. We are proud of you for being willing to face what hurts. We are proud of you for considering the possibility that your life can become more than a struggle to survive.

You do not have to make this journey alone. A skilled therapist, a trusted physician, your family, trusted peers, supportive friends, and a healthy faith community can all become part of your road home. Asking for help is not surrender. It is an act of courage. It is a declaration that your life, your relationships, and your future are worth reclaiming.

Perhaps you are reading this as a clinician, physician, chaplain, pastor, peer, or family member who wants to help someone you care about. If so, we hope these pages have helped you see the person beneath the symptoms and understand the courage required to heal. Your willingness to walk beside that person may become an important part of the road home.

You are far more than your diagnosis, your trauma, or your regrets. You are more than what happened to you, and more than the ways you learned to survive it. The wounds you carry are real, but they are not the whole of who you are.

There is still strength within you, even if you cannot feel it today. There is still purpose ahead of you, even if you cannot yet see it. There are relationships worth rebuilding, moments worth experiencing, and parts of yourself that have been waiting patiently for you to return.

Be patient with yourself. Let others walk beside you. Allow yourself to receive the same understanding and compassion you would so readily offer someone else.

Most of all, do not give up.
There is help. There is a pathway forward. There is life beyond survival.
Your wounds matter, but they do not have the final word.
Hope does.
And the road home remains open.

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About the Authors

Jeffrey E. Hansen, Ph.D., Jeffrey E. Hansen, PhD, is a trauma-informed clinical psychologist specializing in trauma, addiction, and resilience. A graduate of UC Berkeley and the University of Arkansas, he spent ten years as an active duty Army psychologist, rising to major. Assignments included Landstuhl and Frankfurt, Germany, Joint Base Lewis-McChord, Washington, and Somalia during Operation Restore Hope.

After the Army, Jeff built an innovative multidisciplinary practice in the Northwest. Over nearly 25 years, it grew to five psychologists and 20 other providers in two buildings, serving children, adolescents, and families.

Jeff later joined the Defense Health Agency at Madigan Army Medical Center as staff pediatric psychologist, Director of Clinical Training for Child and Family Behavioral Health Services, and Graduate Medical Education faculty member.

For three years, he directed clinical training at AnchorPoint and Holdfast, trauma and addiction centers. He developed NeuroFaith®, integrating neuroscience and faith. Jeff maintains a private practice, writes, lectures, and provides NeuroFaith® training and certification nationally and internationally. He has authored or coauthored fourteen books.

Jeff lives in Arizona with his wife and three dogs, finding joy in faith, family, and the freedom of the open road on his BMW R1250RS motorcycle.

Kris A. Peterson, M.D., is a double board certified psychiatrist whose career has been shaped by a deep commitment to serving soldiers, families, and people living with the wounds of trauma. A Tacoma native, he graduated from West Point and the Uniformed Services University before completing his psychiatry training at Walter Reed Army Medical Center.

During his 25 years in the Army, Kris served in South Korea, deployed twice to Iraq, led the Department of Psychiatry at Madigan Army Medical Center, and served as a consultant to the Army Surgeon General. These experiences gave him a firsthand understanding of the courage, sacrifice, and hidden suffering carried by warriors and their families.

After retiring as a colonel in 2012, Kris continued that mission as medical director of Touchstone TMS Centers. There, he helps bring innovative treatments, including TMS and esketamine, to people suffering from treatment resistant depression, anxiety, and PTSD. His work at Touchstone reflects a continuing heart for service and a determination to bring renewed hope to people whose suffering has not yielded to traditional care.

Kris and his wife, Rosemary, a cardiologist, have three children and enjoy traveling together, experiencing new cultures, and sharing the richness of family life

Johnnie Griffitts is a decorated Vietnam veteran, receiving both the Bronze Star and the Purple Heart for his service with B Troop, 7th Squadron, 17th Air Cavalry during the Vietnam War. Like many who returned from combat, he carried both visible and invisible wounds and spent years navigating the challenges of life after military service.

Rather than allowing those experiences to define him, Johnnie dedicated his life to serving fellow veterans. In 2012, he helped found Veterans Honoring Veterans (VHV), a nonprofit organization committed to helping veterans and their families obtain the benefits, resources, and support they have earned through their service. Through VHV, Johnnie has assisted countless veterans with disability claims, housing, education, employment, and connections to vital community resources.

A Certified Peer Specialist through the State of California, Johnnie has devoted thousands of volunteer hours advocating for veterans throughout Southern California and beyond. His leadership and service have been recognized by the United States House of Representatives, the California State Legislature, Riverside County, and the City of Corona. He has also served as an Official Ambassador for the Veterans Burial Program.

Beyond his advocacy, Johnnie is a gifted storyteller, musician, and student of American history. His passion for preserving the stories of those who served reflects his lifelong commitment to ensuring that the sacrifices of America's veterans are never forgotten. He lives by a simple conviction: that honoring those who answered the call is one of the greatest ways to preserve our nation's heritage for generations to come.

Stephanie Bowser, Psy.D. is a Licensed Clinical Psychologist driven by

a commitment to understanding the whole person and advocating for holistic, collaborative care. This dedication shaped her early doctoral research, which focused on improving trauma recovery for military service members. By exploring veterans' personal experiences with PTSD treatment, psychoeducation, and barriers to care, Stephanie's research sought to bridge the gap between official clinical guidelines and the real-world needs of service members, advocating for more compassionate, accessible, and patient-centered trauma care.

Today, this same drive to understand and support the whole person shapes her clinical practice. She provides comprehensive psychological, learning, and neurodevelopmental assessments across the lifespan, helping clients and families understand how they learn, think, and process the world. In her therapy work with adults, Stephanie integrates these insights to provide tailored, holistic support for individuals navigating trauma, neurodivergence, and emotional challenges, helping them find meaningful paths to growth and healing.

In her free time, Stephanie thrives on returning to her culinary roots as a former chef and baker, where she adores cooking and baking as a heartfelt way to connect with others and bring them joy.

Jack Marion is a U.S. Army veteran and Purple Heart recipient whose

life reflects an uncommon depth of courage, loyalty, and service. He first served his country during the Cold War as an 11B infantryman. His military preparation included airborne training, French Commando School, and sniper training.

After more than twenty years away from active duty, Jack had built a career and earned the right to enjoy the peace he had helped preserve. Then came September 11, 2001. Knowing fully what military service demanded and the risks he would face, he chose to answer his nation's call a second time.

Jack returned to war not as a young soldier seeking adventure, but as an experienced soldier committed to protecting the soldiers, medics, and friends entrusted to his care. He was awarded the Purple Heart for wounds received in combat. His body continues to bear the cost of his service through numerous lasting medical conditions, yet he carries no regret. He considers it a profound honor to have served, even at great personal cost.

In *The Wounds We Carry*, Jack brings the indispensable voice of lived experience and a deep concern for others who still carry the visible and invisible injuries of service. Away from his work, he enjoys hiking, fishing, backpacking, and archery.

Salvatore Bitondo, LICSW, known affectionately to many as "Uncle Sal," is a board-certified licensed clinical social worker devoted to those who serve and their families. His civilian work alongside law enforcement and first responders inspired him to become a therapist for those in greatest need. He specializes in trauma care for active-duty service members and their families.

Sal deployed to Iraq and twice to Afghanistan. At Fort Hood, he directed training for the Social Work Internship Program, remains on its faculty, and taught undergraduate and graduate nursing and social work students.

Sal carries wounds of his own. His body bears the ravages of war from a helicopter that, as he puts it, made a "less than genteel landing." He bears those wounds without complaint. After medically retiring, he returned immediately to the Department of War to continue serving military families.

His humanity, steadiness, and exceptional leadership have earned deep respect. Coauthor Jeffrey Hansen considers himself blessed to have worked for Sal, whom he regards as the finest leader he has ever known. Sal never loses sight of the mission or the people entrusted to him, and he profoundly shaped Jeff's growth, both personally and professionally.

Sal intends to remain what the Army calls a force multiplier for as long as his body allows. In *The Wounds We Carry*, he brings hard-earned wisdom, clinical skill, and unwavering commitment to those who carry the wounds of service.