MODULE 4

Post Traumatic Stress Disorder

Materials Needed:

- Handout 12: PTSD and Its Impact on the Family
- Handout 13: What We’d Like Our Families to Know about Living with PTSD
- Brochures on local treatment options for service members/veterans with symptoms of PTSD

Check-In from Previous Week & Introduction:

- Ask any new group members to introduce themselves and review the group guidelines and confidentiality.
- Ask if any group members have questions from the previous week.
- Check-in regarding if anyone used hot thoughts/cool thoughts or the time-out procedure and how it went.
- Explain to group that today’s session will focus on PTSD. Emphasize that while most people who return from Iraq and Afghanistan do not develop PTSD, it is not uncommon to experience some symptoms of the disorder following a deployment and that early treatment can make a huge difference in the course of the disorder.

A. **Review of the Diagnosis of PTSD**

A. The diagnosis of PTSD (Post Traumatic Stress Disorder) is only made when very specific criteria are met. One person who has been diagnosed with PTSD may look very different from another person with the same disorder. The specific traumatic experience and the impact on the person and his/her loved ones are unique to each family. The diagnosis can only be made by a trained mental health professional (preferably one with experience in working with PTSD).

B. PTSD is an anxiety disorder. Not every symptom will be discussed here, but each type of symptom will be reviewed.

C. First, the person experienced or witnessed an event that involved actual or threatened death or serious injury, and the person felt very afraid or helpless. Traumatic events can include a wide variety of different experiences, including (but not limited to):

1. military troops involved in combat
2. victims and rescue workers involved in natural disasters (e.g., earthquakes, floods, hurricanes)
3. victims and rescue workers involved in man-made disasters (e.g., the terrorist attacks of 9/11)
4. sexual assault or other violent crimes
5. domestic violence
6. physical and/or sexual abuse
7. immigrants fleeing violence in their homeland
8. torture

D. People may RE-EXPERIENCE the event in a variety of ways:
   1. May have distressing dreams or nightmares of the event
   2. May feel very uncomfortable when confronted with a reminder of the event (e.g., watching a war movie)
   3. May have mental images or thoughts about the trauma that barge in on them even when they don’t want to think about it

E. People may experience INCREASED AROUSAL:
   1. May be irritable and/or have angry outbursts
   2. May experience insomnia (problems falling or staying asleep)
   3. May be overly aware of their surroundings (e.g., the veteran may sit with his back to the wall in public places so as to be able to see all that is occurring around him)
   4. May startle easily

F. People may AVOID certain triggers or reminders of the trauma (e.g., conversations, places, and thoughts associated with the event). For example, many service members/veterans have strong reactions to the sound of helicopters, fireworks displays, thunderstorms, humid weather, and sand.

G. People may report feeling NUMB:
   1. May feel emotionally distant from other people
   2. May engage in previously enjoyed activities less often

II. Background Information on PTSD

A. Community-based research has revealed that approximately 8% of Americans will develop PTSD at some point in their lives.

B. Although not formally labeled PTSD until recently, the symptoms have been recorded throughout history:
   1. Civil War: phenomenon was called soldier's heart
   2. WWI: phenomenon was called shell shock
   3. WWII: symptoms were called combat neurosis or battle fatigue
4. The formal diagnosis of PTSD first emerged in 1980 in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III)

C. Most people who are exposed to a traumatic event experience some PTSD symptoms following the event... but the symptoms generally decrease over time and eventually disappear. Approximately 8% of men and 20% of women go on to develop PTSD. For both men and women, rape is the most common trigger of PTSD. (National Center for PTSD)

a. Although symptoms of PTSD usually emerge within 3 months of the trauma (DSM-IV), some individuals do not develop difficulties until later. Some individuals avoid facing the painful emotions from the trauma for many years, often using substance abuse or other addictive behaviors to distract themselves from the feelings.

b. 35.5% of returning service members and veterans have symptoms of anxiety disorders or depression (MHAT V, 2008). Of those troops, between 5 and 15% meet criteria for PTSD (Tanielian & Jaycox, 2008).

D. PTSD symptoms can vary over time and between people. Some symptoms may diminish rapidly, while others may fluctuate in intensity throughout the individual's life. Approximately 30% of those who have PTSD develop a chronic form that persists throughout their lifetime (National Center for PTSD).

E. Who develops chronic PTSD? Several factors can be considered, including:
   1. severity of the trauma
   2. duration of exposure
   3. level of involvement
   4. functioning before the trauma
   5. extent of social support
   6. presence of healthy coping skills

F. If someone has PTSD, he/she is at greater risk for having another mental illness or substance abuse problems. In fact, 84% of people with PTSD have also experienced another mental disorder during the course of PTSD (Kessler et al., 1995). For people diagnosed with PTSD, the lifetime prevalence rates of other disorders include:

   Major Depressive Disorder 48%
   Alcohol Abuse/Dependence 40%
   Drug Abuse/Dependence 31%
   Generalized Anxiety Disorder 16%
   Social Phobia 28%
III. Effects of Combat Veterans’ PTSD on Relationships and Families

Provider Note: The specific consequences of traumatic experiences will be addressed in this section, with an emphasis on the consequences of military combat. The potentially disruptive effects of these symptoms on relationships will also be reviewed. Use the following questions to gauge and improve the group’s awareness of the effects of PTSD on relationships:

Discussion Questions:
- What are the toughest issues for you and your family in living with PTSD?
- How do you cope? What techniques have worked? What hasn’t worked?

Provider Note: The purpose of this section is to develop a greater understanding of some of the relational and social impacts of PTSD. The aim is both to increase understanding about the disorder and its impact, and to explore strategies for more effectively managing some of the symptoms. Lead the group in a discussion about the impact of these various issues, being sure to mention or include the points mentioned below each question.

Discussion Question:
- How has social anxiety affected your family life?
  1. Family may become isolated due to the social anxiety many people living with PTSD experience. As veterans often feel very uncomfortable in large groups and crowds, the family may be quite limited in their activities.
  2. The service member/veteran with PTSD may pressure the family members (directly and/or indirectly) to stay home with him/her, thereby narrowing the family’s social contacts and limiting the ability to obtain support. Family members often feel guilty for pursuing independent activities.

- How have you coped with these changes?
  1. Spending time with other people who can be more supportive.
  2. Going places in separate cars.
  3. Developing a plan ahead of time for how to manage places/situations that may create anxiety.

Discussion Questions:
- For family members: How emotionally connected to your family member with PTSD do you feel?
- For veterans/service members: Do you feel less emotionally connected since the deployment?
1. Emotional withdrawal and emotional numbing are ways that people with PTSD try to protect themselves from overwhelming emotion.

2. Service members/veterans with PTSD may be emotionally unavailable due to preoccupation with managing mental stress. The emotional distance in the relationship may also stem from the higher levels of fear of intimacy experienced by both veterans with PTSD and their partners (in comparison to family in which the veteran does not have PTSD) (Riggs, Byrne, Weathers, & Litz, 1998).

3. The service members/veterans may be reluctant or unwilling to share feelings with their spouses and children (Matsakis, 1989). Consequently, family members may feel rejected and lonely, and they may blame themselves for their loved one’s emotional distance.

4. The individual may struggle with experiencing and expressing positive emotions. He or she may be unavailable to his children and unable to meet their emotional needs (Curran, 1997).

- How do you cope with emotional numbing and distance as a family?
  1. Getting lots of social support from other people and places.
  2. Reminding ourselves that this is a symptom of PTSD, and trying not to take it personally.
  3. Working on projects or doing active things together as a way to connect.

Discussion Question:

- For the veteran/service member: Have you had any significant changes in your sleep patterns since the deployment? How have those impacted you?
- For the family member: Have you noticed a change in your veteran/service member’s sleep? How have those changes impacted you?

1. Given the difficulties many service members/veterans with PTSD have with sleep (including insomnia, frequent wakings, nightmares, etc.), many couples choose to sleep in separate beds (and rooms). This physical separation can parallel the emotional distance experienced in the relationship. Physical intimacy can also be adversely affected by this sleeping arrangement.

2. In addition, the service member/veteran’s behavior during a nightmare can be very frightening for the family. In the midst of a nightmare or flashback, some individuals become physically aggressive, thinking that their partners are the enemy in a combat situation. Wives often report extreme terror and confusion about these experiences, as they do not understand the out-of-control behavior.
How have you coped with sleep problems?

1. Getting a consultation from a psychiatrist for sleep medications can be a very helpful step.

2. Practicing good sleep hygiene (going to bed and waking up at same time each day, and avoiding caffeine or alcohol close to bed, using bed only for sleep and sex, etc.)

3. It may be necessary to set up another place to sleep if nightmares or sleep disturbances become so severe that the partner cannot sleep in the same bed. While this is not a good long-term solution, it may be helpful in the short-term.

Discussion Question:

What challenges have you faced in negotiating family roles and responsibilities?

1. The roles that each spouse assumed before the deployment may change. For example, husbands whose wives were deployed and are now experiencing PTSD symptoms may need to assume additional parenting and childrearing responsibilities. In families where the service member/veteran was the primary breadwinner, the other spouse may now need to assume those responsibilities as well as additional tasks in managing the household. Spouses may feel overwhelmed by all of the demands in their lives and may resent the veteran’s withdrawal from family responsibilities.

2. If the spouse at home has taken over many of the service member/veteran’s tasks, he or she may be unable to pursue his/her own goals, which can breed resentment (Matsakis, 1989).

What has helped you navigate these changes effectively?

1. Openly communicating about goals and expectations.

2. Using this transition time to make positive changes.

3. Discussing and keeping schedules so that everyone knows what to expect.

4. Asking for and accepting outside support and help when it's needed.

IV. Treatment Options for PTSD

Provider Note: PTSD can be a debilitating illness, but there is also reason for hope and optimism. With treatment, many people with PTSD recover completely. For those who do not recovery completely, they still can achieve significant reduction in the severity and frequency of their symptoms and in the impact those symptoms have on their lives. A range of treatments are supported by research and proven to make a significant difference in the lives of people living with PTSD. PTSD does not have to be a debilitating disorder, and it does not have to be permanent!
A. Participating in treatment for PTSD can be challenging, as clients are invited to directly face memories and feelings that they may have avoided for many years. Clients are much more likely to succeed in treatment if the client:

1. Is not abusing alcohol or using any street drugs. As stated earlier, substance abuse is often an issue for people with PTSD. Clients need to learn skills to cope with strong emotions so that they can directly face the traumatic memories without numbing themselves with substances.

2. Has adequate coping skills (individual is not suicidal or homicidal).

3. Has sufficient social support.

4. Has a safe living situation (not homeless or in an abusive environment).

B. Although each person and his/her treatment plan are unique, the following goals are often important aspects of therapy:

1. Examine and learn how to deal with strong feelings (such as anger, shame, depression, fear or guilt).

2. Learn how to cope with memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy, but become less frequent and less upsetting.

3. Discover ways to relax (possibly including physical exercise).

4. Increase the frequency of doing previously enjoyed.

5. Re-invest energy in positive relationships with family and/or friends.

6. Enhance sense of personal power and control in his/her environment.

C. Components of treatment for PTSD

Most treatment programs involve a comprehensive approach, including several modalities:

- Psychiatric medications
- Education for client and family
- Group therapy
- Cognitive behavioral therapy
- Writing exercises
1. Psychiatric Medications
   a. Choice of medication(s) depends on the individual’s specific symptoms and any other mental health difficulties (e.g., depression, panic attacks)
   b. In general, medications can decrease the severity of the depression, anxiety and insomnia.
   c. Medications may be prescribed by the client’s primary care provider or psychiatrist.

2. Education for client and family about PTSD
   a. Education is very important, both for the client and the family. It typically addresses the nature of PTSD (e.g., symptoms, course, triggers), communication skills, problem-solving skills, and anger management.
   b. The education may occur in a variety of different ways, such as couples/family therapy, psychoeducational programs (including REACH and the SAFE Program), support groups, etc.

3. Group Therapy
   a. In general, groups “counter the profound sense of isolation, social withdrawal, mistrust, and loss of control. The acknowledgment by victims that they are not alone, can support others, and can safely share their traumatic experiences within a responsive social context provides an opportunity for healing.” (Hadar Lubin, MD, 1996).
   b. Groups have a variety of formats, including: process oriented, trauma oriented (e.g., telling one’s story), present-day focused (e.g., coping skills), and/or psychoeducational (e.g., anger management)

4. Cognitive/behavioral therapy
   a. Cognitive therapy involves inviting clients to examine their thinking processes and replace irrational (unhelpful) thoughts with more realistic (helpful) thoughts. This form of therapy has received strong research support.
   b. Behavioral therapy involves inviting clients to change their behaviors, which results in a shift in their mood/mental state. Behavioral interventions may include teaching relaxation techniques, imagery, and breathing techniques.
   c. Anger management training may involve both cognitive and behavioral skills.
   d. Exposure based therapy (e.g., prolonged exposure; cognitive processing therapy) involves helping the person to repeatedly “re-tell” the traumatic experience in great detail, such that the memory becomes less upsetting. Researchers have found this approach to be very effective in decreasing symptoms of PTSD. [Pass around CPT and PE flyers noting availability at VAMC].
   e. Writing about the traumatic event and subsequent thoughts/feelings can be an important component of treatment.
Provider Note: Discuss treatment options available at your facility and in your community.

Review local treatment options:

Example: Oklahoma City VA Medical Center

A. Outpatient PTS Recovery Treatment Program
B. OEF/OIF Program
C. Women of Courage/Men of Courage - Veterans with PTSD related to MST (military sexual trauma), other sexual assault, or childhood sexual abuse
D. Outpatient mental health clinic psychoeducational classes:
   - Sleep Management Class (4 week class)
   - Anger Management Class (6 week class)
   - Anxiety/Stress Management Class (8 week class)
   - Depression Management Class (8 week class)
E. Biofeedback
F. Support Group for Women:
G. Outpatient Substance Abuse Treatment Center (SATC).
H. Family Services:
   - Couples/Marital/Family Therapy
   - REACH Program:
     A 9 month psychoeducational program for veterans with PTSD and their family members. This program focuses on learning tools for dealing with symptoms and enhancing relationship.
   - SAFE Program (Support and Family Education).
     A 90-minute monthly educational/support class for family members ONLY.

2. Vet Centers

Oklahoma City (1024 NW 47th Street, Suite B, Oklahoma City, OK, 405-456-5184)
Lawton (501 Southeast Flower Mound Road, Lawton, OK, 580-351-6511)
Tulsa (1408 South Harvard Avenue, Tulsa, OK 74112; 918-748-5105)

3. Other regional treatment options:

Some other VA facilities (including Little Rock, AR; Topeka, KS) offer time-limited inpatient programs for veterans with combat-related PTSD. Some also offer time-limited inpatient programs for veterans with sexual-assault related PTSD.

V. Tips for Family Members and Friends on Being in a Relationship with Someone Who Has PTSD

Provider Note: Distribute Handout 12: “PTSD and Its Impact on the Family” and discuss resources related to OEF/OIF soldiers & their families. Encourage family members to consider the following guidelines for interacting with their loved ones:
A. Do not push or force your loved one to talk about the details of his/her upsetting memories. Try to avoid feeling jealous if your loved one shares more with other survivors of similar traumas or his/her therapist than to you. Rather, be pleased for them that they have a confidant with whom they feel comfortable.

B. Do not pressure your loved one to talk about what he/she is working on in therapy. Also, avoid trying to be his/her therapist.

C. Attempt to identify with your loved one and anticipate some of his/her triggers (e.g., helicopters, war movies, thunderstorms, violence). Learn and anticipate some of his/her anniversary dates (e.g., especially painful events).

D. Recognize that the social and/or emotional withdrawal you experience may be due to your family member’s own issues and have nothing to do with you or your relationship.

E. Do not tolerate abuse of any kind – financial, emotional, physical, or sexual. Individuals with PTSD sometimes try to justify their behavior (e.g., angry outbursts, destroying property, lying) and “blame” their wrongdoing on having this psychiatric disorder. Service members/veterans may try to rationalize their behavior by stating that they were “not themselves” or “not in control” or “in another world.” However, veterans/service members should always be held responsible for their behavior.

F. Pay attention to your own needs.

G. Take any comments that your loved one makes about suicide very seriously and seek professional help immediately.

H. Do not tell your loved one to just “forget about the past” or just “get over it.” Explore the available treatment options in your community, and encourage your loved one to seek professional help. However, respect that they know if/when they are ready to take this courageous step, and do not pressure them excessively.

I. Educate yourself about PTSD through reading, lectures, talking to others in similar situations, etc. See the OEF/OIF Resource Guide (Handout B) for more resources and information.

J. As time allows, discuss Handout 13, “What We’d Like Our Family Members and Friends to Know about Living with PTSD,” soliciting reactions to the sentiments shared by other family members.

VI. Wrap-Up

- Ask if group members have any questions about the communication or issues discussed in today’s class. Discuss questions.
- Ask participants to share one thing they learned today and/or one new skill they are going to try.
• Review the value of an assessment and treatment if service members/veterans are concerned about PTSD symptoms. Focus on instilling hope that PTSD is a treatable condition.
• Have group members complete the evaluation and knowledge forms (Handouts D & E)
• Remind the group of the next group date and time, and pass out reminder cards.
PTSD and Its Impact on the Family

A. The diagnosis of PTSD is only made when very specific criteria are met. The specific traumatic experience and the impact on the person and his/her loved ones are unique to each family. The diagnosis can only be made by a trained mental health professional.

B. First, the person experienced or witnessed an event that involved actual or threatened death or serious injury, and the service member/veteran felt very afraid or helpless.

C. People may RE-EXPERIENCE the event in a variety of ways (e.g., distressing dreams).

D. People may experience INCREASED AROUSAL (e.g., anger, sleep problems).

E. People may AVOID certain reminders of the event.

F. People may report feeling NUMB.

Treatment Options for PTSD

A. Overall goals of therapy
   1. Examine and learn how to deal with strong feelings (such as anger, shame, depression, fear or guilt).
   2. Learn how to cope with memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb.
   3. Trauma memories usually do not go away entirely as a result of therapy, but become less frequent and less intense.
   4. Discover ways to relax (possibly including exercise).
   5. Increase in pleasant activities.
   6. Re-invest energy in positive relationships with family and/or friends.
   7. Enhance sense of personal power and control in his/her environment.

B. Components of treatment
   1. psychiatric medications
   2. education for client and family about PTSD
   3. group therapy
   4. cognitive/behavioral therapy
   5. writing exercises
Tips for Family Members and Friends on Relationships with Someone Who Has PTSD

A. Do not push or force your loved one to talk about the details of his/her upsetting memories. Try to avoid feeling jealous if your loved one shares more with other survivors of similar traumas or his/her therapist than to you. Rather, work to be pleased for them that they have a confidant with whom they feel comfortable.

B. Do not pressure your loved one to talk about what he/she is working on in therapy. Also, avoid trying to be his/her therapist.

C. Attempt to identify (with your loved one) and anticipate some of his/her triggers (e.g., helicopters, war movies, thunderstorms, violence). Learn and anticipate some of his or her anniversary dates (e.g., especially painful events).

D. Recognize that social and/or emotional withdrawal may be due to his or her own issues, and be unrelated to you or your relationship.

E. Do not tolerate abuse of any kind – financial, emotional, physical, or sexual. Individuals with PTSD sometimes try to justify their behavior (e.g. angry outbursts, destroying property, lying) and “blame” their wrongdoing on having this psychiatric disorder. Veterans/service members may try to rationalize their behavior by stating that they were “not themselves” or “not in control” or “in another world.” However, veterans/service members should always be held responsible for their behavior.

F. Pay attention to your own needs.

G. Take any comments that your loved one makes about suicide very seriously and seek professional help immediately.

H. Do not tell your loved one to just “forget about the past” or just “get over it.”

I. Learn as much as you can about PTSD. See the OEF/OIF Resource List (Handout B).

J. Explore the available treatment options in your community, and encourage your loved one to seek professional help. However, respect that they know if/when they are ready to take this courageous step, and do not pressure them excessively.

Local treatment options:

Example: Oklahoma City VA Medical Center

A. Outpatient PTS Recovery Treatment Program
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• Depression Management Class (8 week class)
E. Biofeedback
F. Support Group for Women:
G. Outpatient Substance Abuse Treatment Center (SATC)
H. Gambling Treatment
I. Stop Smoking Program.
J. Additional Family Services
   • Couples/Marital/Family Therapy
   • SAFE Program (Support and Family Education).
      A 90-minute monthly educational/support class for family members ONLY

3. Vet Centers

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3. Other regional treatment options:

   Some other VA facilities (including Little Rock, AR; Topeka, KS) offer time-limited inpatient programs for veterans with combat-related PTSD. Some also offer time-limited inpatient programs for veterans with sexual-assault related PTSD.

What We’d Like Our Family Members and Friends to Know about Living with PTSD

The following are suggestions from veterans who were involved in combat in the Vietnam War – Oklahoma City VA Medical Center Spring, 2000 (printed and shared with permission of the veterans in these groups):

1. GIVE ME SPACE when I need to be alone – don’t overwhelm me with questions. I’ll come and talk to you when I’m ready.

2. Get away from me if I am out of control, threatening, or violent.

3. Be patient with me, especially when I’m irritable.

4. Don’t personalize my behavior when I explode or get quiet.

5. Learn and rehearse a time-out process.

6. Don’t patronize me or tell me what to do. Treat me with respect and include me in conversations and decision-making.

7. Don’t pity me.

8. Don’t say “I understand,” when there are some things that you cannot understand.

9. Realize that I have unpredictable highs and lows – good and bad days.

10. Anticipate my anniversary dates – recognize that these could be tough times.

11. I’d like to share my traumatic experiences with you, but I fear overwhelming you and losing you.

12. I want to be close to you and share my feelings, but I’m afraid to… and sometimes I don’t know how to express my emotions.

13. I also fear your judgment.

14. Know that I still love and care about you, even if I act like a jerk sometimes.

15. Don’t ask me to go to crowded or noisy places, because I’m uncomfortable in those settings.