

DEPARTMENT OF VETERANS AFFAIRS

Support And Family Education



Session Three – PTSD and its Impact on the Family

Materials Needed

[Handout F: PTSD and its Impact on the Family](#)

[Handout G: What We'd Like our Family Members and Friends to Know About Living with PTSD](#)

Brochures on local treatment options for people with symptoms of PTSD

I. Review of the diagnosis of PTSD

- A. The diagnosis of post-traumatic stress disorder (PTSD) is made only when very specific criteria are met. One person who has been diagnosed with PTSD may look very different from another with the same disorder. The specific traumatic experience and the resultant impact on the individual and his/her loved ones are unique to each family. The diagnosis can be made only by a trained mental health professional (preferably one experienced in working with trauma survivors).
- B. In psychiatry's classification system, PTSD is termed an anxiety disorder – much like panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder. Rather than outlining all the specific criteria for PTSD, we will review the major clusters of symptoms (*DSM-IV*, 1994).

- C. First, the person experienced or witnessed an event that involved actual or threatened death or serious injury, and he/she felt very afraid or helpless. Traumatic events can include a wide variety of different experiences, including (but not limited to):
- Military combat
 - Natural disasters (e.g., earthquakes, floods, hurricanes) for both victims and rescue workers
 - Man-made disasters (e.g., 9/11/01, the Oklahoma City Bombing) for victims and rescue workers
 - Sexual assault or other violent crimes
 - Domestic violence
 - School shootings
 - Physical and/or sexual abuse
 - Fleeing violence in one's homeland (for immigrants)
 - 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., war movie).
- E. People may avoid certain triggers or reminders of the trauma (e.g., conversations, places, and thoughts associated with the event).
1. For example, many veterans have strong reactions to the sound of helicopters, firework displays, thunderstorms, humid weather, and sand.
 2. Veterans from the Global War on Terrorism often have difficulty driving on American soil, fearing the presence of improvised explosive devices (IEDs) or roadside bombs or the enemy nearby.
- F. People often feel numb:
1. May feel emotionally distant from other people.
 2. May engage in previously enjoyed activities less often.
- G. 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 hypervigilant (e.g., the veteran may sit with his/her back to the wall in public places to be aware of all that is occurring around him/her)
 4. May startle easily

II. Background information on PTSD

- A. Community-based research has revealed a lifetime prevalence of PTSD in the United States today to be approximately 7-8%; it affects about 7.7 million American adults (Kessler, Chiu, Demler & Walters, 2005).
- B. Although not formally labeled PTSD until recently, the symptoms have been recorded throughout history:
1. Biblical accounts describe PTSD symptoms in Job, Joseph and David.
 2. Egyptian, Greek and Roman mythology refer to similar symptoms.
 3. Shakespeare describes nightmares and intrusive thoughts in *Henry IV*.
 4. In WWI the phenomenon was called "shell shock" or "soldier's heart."
 5. In WWII symptoms were called "combat neurosis" or "operational fatigue."
 6. 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. Research with service members returning from the Global War on Terrorism indicates that 15-17% meet criteria for major depression, PTSD, or generalized anxiety disorder shortly after homecoming (Hoge et al., 2004).
1. A prospective study of troops deployed to Iraq and Afghanistan found a three-fold increase in new-onset PTSD among military personnel who had been deployed and who had been exposed to combat, highlighting the importance of the actual exposure to combat (rather than simply deployment itself) in affecting subsequent mental health (Smith et al., 2008).
 2. A related study found that rates of PTSD symptoms, depression, and anger problems were two to five times higher 4 months after returning home (Bliese, Wright, Adler, Thomas & Hoge, 2007). Future research will examine the course of emotional problems among these service members over time. It is hoped that early identification and intervention may prevent the development of long-term problems for many of these men and women.
- D. In general, 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).

- E. Although symptoms of PTSD usually emerge within 3 months of the trauma (*DSM-IV*), some individuals have a delayed onset. Some avoid facing the painful emotional residue from the trauma for many years, often using substance abuse or other addictive behaviors to distract themselves from the feelings. When the individual begins to exhibit symptoms of PTSD many years after the event, families may feel confused.
- F. The course of PTSD is quite variable, as 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).
- G. Several variables affect the likelihood that a trauma survivor will develop chronic PTSD, including (Brewin et al., 2000; Ozer, Best, Lipsey & Weiss, 2003)
1. Severity of the trauma
 2. Duration of exposure
 3. Extent of being actively involved (rather than a witness)
 4. Dissociation at time of the trauma
 5. Premorbid psychiatric functioning (including exposure to prior trauma)
 6. Extent of social support
- H. The Veterans Health Administration was the first institution to develop treatment programs for PTSD. Much-needed treatment programs began to emerge in the mid-1970s in response to the clinical need seen among Vietnam veterans.
- I. The rates of comorbidity of PTSD and other psychiatric diagnoses are strikingly high (Brown, Campbell, Lehman, Grisham & Mancill, 2001; Kessler et al., 2005). If a person has PTSD, he/she is at greater risk for also having another diagnosis. In one large study of individuals with PTSD, 92% met criteria for another Axis I disorder (Brown et al., 2001); more specifically, the following disorders were also present at the following rates:
1. Major depression 77%
 2. Generalized anxiety disorder 38%
 3. Alcohol abuse/dependence 31%

Research specifically with veterans with PTSD has also documented quite high comorbidity rates (e.g., Orsillo et al., 1996). Regarding the Global War on Terrorism, one large study reported that 24-35% of soldiers admitted to using more alcohol than they meant to (Hoge et al., 2004).

III. Effects of combat veterans' PTSD on relationships and families

- PTSD can result from a variety of different traumatic events; the intensity and duration of people's reactions differ depending on many factors (e.g., nature of the trauma, extent of social support, level of premorbid functioning, participation in treatment, repertoire of coping skills).
- We will address the specific consequences of traumatic experiences in this section, with an emphasis on the sequelae of military combat. We will also review the potentially disruptive effects of these symptoms on relationships.

FACILITATOR NOTE: Veterans who have recently returned home from a war zone may experience an acute stress disorder or full-blown PTSD. Regardless of whether or not a mental health diagnosis is present, however, dealing with reintegration into one's family, community, workplace, and civilian role can be challenging. Some specific challenges faced during this reintegration process – as well as ways mental health professionals can support families during this time – are outlined in Bowling & Sherman (in press) and may be useful supplementary material for this session if working with Global War on Terrorism veterans/families.

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Discussion Questions:

- What is the toughest issue for you and your family in living with a veteran with PTSD?
- How do you cope?

A. Social anxiety

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Discussion Question: How has the veteran's social anxiety affected your family life?

1. Families may become isolated due to the social anxiety many veterans experience. As veterans often feel very uncomfortable in large groups and crowds, the family may be quite limited in its activities.
2. The veteran may pressure family members (directly and/or indirectly) to stay home with him/her, thereby narrowing family members' social contacts and limiting their ability to obtain support. Family members often feel guilty for pursuing independent activities.

B. Angry outbursts

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Discussion Questions:

- How have your loved one's anger-management problems affected your relationship?
 - Your family?
 - Any concerns for the children?
1. Anger is often a “weapon” in the veteran’s arsenal of protection against painful feelings, memories, and thoughts. Anger can function as a barrier and further isolate him/her, as other people often pull away from the frightening hostility and rage.
 2. Due to the veteran’s difficulty in managing his anger, the family may live in an atmosphere of constant chaos. This lack of emotional and sometimes physical safety can be damaging to the mental health and development of all family members.
 3. Family members may be at greater risk for being exposed to verbal abuse (e.g., yelling, name calling) and physical abuse (e.g., throwing things, aggression). Both veterans with PTSD and their spouses/partners engage in higher levels of physical violence than do comparable family members when the veteran does not have PTSD (Jordan et al., 1992; Sherman et al., 2006). These repeated negative interactions damage the trust and cohesion within the family.
 4. Children may acquire maladaptive patterns for the expression of anger. Although little research has been done on the children of trauma survivors, one survey revealed that the children of Vietnam veterans with PTSD are more apt to have behavioral problems than children of Vietnam veterans who do not have this disorder. Further, these veterans with PTSD report more parenting problems and poorer family adjustment than veterans without PTSD (Jordan et al., 1992).
 5. Recent research has found that the strongest predictor of parent-child relationship problems was the parent’s emotional numbing. Hence, detachment, numbing and avoidance may directly affect the veteran’s ability to parent by decreasing his/her ability to engage the child in everyday activities (Ruscio, Weathers, King & King, 2002).

6. Spouses/partners are often torn between caring for the acting-out veteran and protecting the children from his angry outbursts.
7. Rage exhibited publicly may further alienate the family from its social network.

C. Emotional unavailability

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Discussion Questions:

- How does it feel to live with a spouse/significant other with whom you do not feel connected?
 - Or to have an emotionally distant relationship?
 - How else do you get your needs for emotional intimacy met?
1. People with PTSD may be emotionally unavailable because they are preoccupied with managing mental stress. The emotional distance in the relationship may also stem from higher levels of fear of intimacy experienced by both veterans with PTSD and their partners (in comparison with couples in which the veteran does not have PTSD) (Riggs, Byrne, Weathers, & Litz, 1998).
 2. Veterans are often reluctant or unwilling to share feelings with their spouses/partners and children. In fact, research has found that veterans with PTSD have difficulty with self-disclosure, emotional expression (Carroll, Rueger, Foy & Donahoe, 1985), and creating intimacy, likely in part due to the emotional numbing common to PTSD (Cook et al., 2004). Consequently, family members may feel rejected and lonely, and they may blame themselves for their loved one's emotional distance.
 3. The individual may struggle with experiencing and expressing positive emotions. He/she may be unavailable to his/her children and unable to meet their emotional needs.

D. Sleep disturbance

1. Given the difficulties many 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 veteran's behavior during a nightmare can be very frightening for the spouse and family. In the midst of a nightmare or flashback, some people become physically aggressive, thinking that their spouse/partner is the enemy in a combat situation. Partners often report extreme terror and confusion about these experiences, as they do not understand the out-of-control behavior.

E. Difficulty managing family roles and responsibilities

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

1. Given the veteran's emotional instability, the spouse/partner may assume some traditionally male roles, such as primary breadwinner, head of the household, manager of family finances, and chief disciplinarian. Partners may feel overwhelmed by all the demands in their lives and may resent the veteran's withdrawal from familial responsibilities.
 2. Given that the partner has taken over many of the veteran's responsibilities, he/she may be unable to pursue his/her own goals, which can breed further bitterness.
 3. Children may acquire adult responsibilities at an earlier age, resulting in their maturing quickly and sometimes taking on the role of a "parentified child."
 4. Individuals with PTSD often have difficulty keeping their jobs, thereby creating financial duress on the family.
- F. Given these potentially difficult family issues, the fact that Vietnam veterans with PTSD and their partners experience high levels of marital instability (Kessler, 2000), including greater levels of marital conflict (Riggs et al., 1998) and less marital satisfaction (Jordan et al., 1992) than do comparison families without PTSD, is not surprising.
- G. Furthermore, for some families, the relationship problems among veterans with PTSD and partners are quite chronic (Cook et al., 2004). Veterans with PTSD are twice as likely to have been divorced (in comparison with veterans without PTSD) and almost three times as likely to have had multiple divorces (Jordan et al., 1992).

IV. Treatment options for PTSD

- A. Participating in treatment for PTSD can be challenging, as people are invited to directly face memories and feelings that they may have avoided for many years. An individual is much more likely to succeed in treatment if the following prerequisites are in place:
1. He/she is not abusing alcohol or using any street drugs. As stated earlier, substance abuse is often an issue for people with PTSD. Survivors need to learn skills (such as through a substance abuse treatment program) to cope with strong emotions so that they can directly face the traumatic memories without numbing themselves with substances.
 2. He/she has adequate coping skills (not suicidal or homicidal).
 3. He/she has sufficient social support.
 4. He/she has a safe living situation (not homeless or in an abusive environment).
- B. In light of high operational tempo and the high rate of redeployment in the Global War on Terrorism, selection of the appropriate approach and proper timing for addressing PTSD issues is essential. For example, it would most likely be contraindicated to start an intensive exposure-based treatment for a traumatized veteran who would soon be returning to the war zone. Rather, enhancing coping skills and maximizing resiliency would likely be most effective for him/her at that time.
- C. Although each person's individualized treatment plan is unique, the following goals are often important aspects of therapy for individuals living with PTSD:
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 intense.
 3. Discover ways to relax (possibly including physical exercise).
 4. Increase the frequency of pleasant activities.
 5. Re-invest energy in positive relationships with family and/or friends.
 6. Enhance sense of personal power and control in his/her environment.

- D. Components of treatment for PTSD – Most treatment programs involve a comprehensive approach, including several modalities, including psychiatric medications, education for client and family, group therapy, cognitive behavioral therapy and writing exercises.
1. Psychiatric medications
 - a. Choice of medication(s) depends on the specific symptoms and any co-morbid difficulties (e.g., depression, panic attacks)
 - b. In general, medications can decrease the severity of the depression, anxiety and insomnia. However, there is no “cure” for PTSD.
 - c. Medications may be prescribed by the primary care provider or psychiatrist.
 2. Education for survivor and family about PTSD
 - a. Education is very important, both for the survivor and the family and typically addresses the nature of PTSD (e.g., symptoms, course, triggers), communication skills, problem-solving skills, and anger management.
 - b. Education can occur in a variety of modalities, such as couples/family therapy, psychoeducational programs, support groups, etc.
 3. Group therapy
 - a. Groups can decrease the sense of isolation that many trauma survivors experience. Group members can share their stories and support one another, providing assurance that they are not alone and that others can support them in the journey of recovery. Survivors can build trusting relationships in a safe group context, therein building their courage and confidence about interacting with others in their daily lives.
 - 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 people to examine their thinking processes and replace irrational thoughts with more realistic thoughts. It has received strong research support. Cognitive restructuring is a cognitive therapy approach used with PTSD.
 - b. Behavioral therapy involves inviting people 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., flooding, desensitization) involves teaching the person coping/relaxation strategies and then supporting him/her in repeatedly “re-telling” the traumatic experience in great detail, so that the memory becomes less upsetting. Researchers have found specific exposure-based treatments such as “Prolonged Exposure” (Rothbaum, Meadows, Resick, & Foy, 2000) and “Cognitive Processing Therapy” (Resick, Nishith, Weaver, Astin & Feuer, 2002) to be very effective in decreasing symptoms of PTSD.

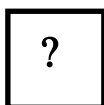
5. Writing exercises

- a. A psychologist, James Pennebaker, Ph.D, at The University of Texas at Austin has performed extensive research over the past 15 years on the power of writing. He has studied many survivors of trauma and discovered interesting results about the healing potential of writing.
- b. Pennebaker reports that people who write about traumatic events have many positive outcomes (e.g., fewer doctor appointments, decreased pain for arthritic patients, lower blood pressure, happier mood, increased lung capacity for asthmatics, etc.) (Pennebaker, 1997).
- c. Writing may be associated with these positive outcomes because it helps people to
 - Feel a greater sense of control over their lives
 - Gain greater understanding of their feelings
 - Break the situation into smaller pieces
 - Pay more attention to their feelings

V. Opportunity for growth

- A. Over the past decade, researchers and clinicians have begun to focus on the opportunities for growth that arise for some people who have experienced trauma. Drs. Richard Tedeschi and Lawrence Calhoun coined the term *post-traumatic growth* (PTG), and they have studied survivors of a wide range of traumatic events (sexual assault, disasters, car accidents, being taken hostage, combat, house fires, the Holocaust, etc.) (Tedeschi, Park & Calhoun, 1998).
- B. Importantly, this growth is viewed as emerging from the struggle with coping with the trauma and its aftermath – not from the negative event itself. In addition, experiencing growth usually involves emotional suffering. Considering the possibility of growth does not negate the very real distress commonly associated with trauma.
- C. In studying this construct, five factors/themes have emerged. Growth may occur in one or more of these domains:

1. Awareness of new possibilities in life
2. Closer relationships with others (sometimes including greater connection with others who have survived trauma)
3. Increased sense of personal strength
4. Greater appreciation of life
5. Deepening of spiritual life OR significant change in belief system – may include greater wisdom



Discussion Questions:

- Have you noticed any positive changes in your family member as he/she deals with the trauma? If so, what have you seen?
- Have you noticed any positive changes in your relationship since the trauma? If so, what have you seen?
- Have you shared this with your family member? (He/she would probably really like hearing it from you.)

VI. Tips for family members and friends on being in a relationship with someone who has PTSD

Distribute [Handout F: PTSD and its Impact on the Family](#)

- A. Educate yourself about PTSD through reading, attending lectures, talking to others in similar situations, etc.



Books on PTSD:

Courage After Fire: Coping Strategies for Returning Soldiers and Their Families. (2005). K. Armstrong, S. Best, and P. Domenici. Berkeley, CA: Ulysses Press.

Down Range: To Iraq and Back. (2005). B. Cantrell & C. Dean. Washington: WordSmith Books.

Trust After Trauma: A Guide to Relationships for Survivors and Those Who Love Them. (1988). A. Matsakis. Oakland, CA: New Harbinger.

Recovering After the War. (1990). P. Mason. New York: Penguin Books.

Vietnam Wives: Facing the Challenges of Life with Veterans Suffering from Post-traumatic Stress Disorder. (2nd ed.) (1998). A. Matsakis. Baltimore: Sidran Press.

Support And Family Education:
Mental Health Facts for Families
Michelle D. Sherman, Ph.D.

Books for Youth:

For Young Children:

Why Are You So Sad? A Child's Book about Parental Depression. (2002). B Andrews. Magination Press.

Tell Me a Story, Paint Me the Sun: When a Girl Feels Ignored by her Father. (1991). R. Chaplan. New York: Magination Press. American Psychological Association. (illustrated book describing a young girl whose father is depressed).

Wishing Wellness: A Workbook for Children of Parents with Mental Illness. (2006). L.A. Clarke. New York: Magination Press.

Daddy, You're My Hero! // Mommy, You're My Hero! (2005). M. Ferguson-Cohen. Little Redhaired Girl Publishing

Please Don't Cry, Mom. (1993). H. Denboer. Minneapolis, MN: Carolrhoda Books, Inc. (illustrated book depicting young boy's experience of his mother's recurrent major depression)

For Teenagers:

Finding My Way: A Teen's Guide to Living with a Parent Who Has Experienced Trauma. (2005). M. D. Sherman & D.M. Sherman. Edina, MN: Beaver's Pond Press.
Available at www.seedsofhopebooks.com

Relevant Web Sites:

www.ncptsd.org – National Center for PTSD

www.patiencepress.com – Site with examples of the *Post-Traumatic Gazette*

www.sidran.org – Sidran Traumatic Stress Foundation

www.trauma-pages.com – David Baldwin's Trauma Information Pages

www.adaa.org – Anxiety Disorders Association of America

www.giftfromwithin.org – Gift From Within: Resources for Survivors and Professionals

- B. 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 with his/her therapist than with you. Rather, try to be grateful that your family member has a confidant with whom he/she feels comfortable.

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

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Discussion Question: What have you noticed about your family member's behavior around anniversary times?

- F. Recognize that the social and/or emotional withdrawal may be due to his/her own issues and have nothing to do with you or your relationship. If you do not feel emotionally supported by your loved one, foster relationships with others (friends, family, etc.) from whom you can get that connection and support.
- G. 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. People may try to rationalize their behavior by stating that they were “not themselves” or “not in control” or “in another world.” However, survivors should always be held responsible for their behavior.
- H. Pay attention to your own needs.
- I. Take any comments that your loved one makes about suicide very seriously, and seek professional help immediately.
- J. Do not tell your loved one to just “forget about the past” or just “get over it.”
- K. Explore the available treatment options in your community, and encourage your loved one to seek professional help. However, remember that confronting past hurts can be a very frightening and overwhelming experience. Therefore, respect that your loved one knows if/when he is ready to take this courageous step, and do not pressure him/her excessively.

VII. Tips veterans want their family members and friends to know

- A. Veterans from the Oklahoma City VA Medical Center were asked to create “Top 10 Lists” of “What We’d Like our Family Members and Friends to Know About Living with PTSD.”

Distribute [Handout G](#): (reproduced with permission of the veterans)

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Discussion Question: How is this list similar and different from the above list of suggestions that professionals have made?

VIII. Local treatment options for veterans with symptoms of PTSD

Example: Oklahoma City VA Medical Center

- A. PTSD Recovery Program – This 6-week intensive outpatient program focuses on unresolved feelings about combat experiences, as well as present-day coping skills. Specific groups address issues of anger management, communication skills, dealing with emotions, insomnia management, etc.
- B. OIF/OEF Program – This program involves group and individual therapy to support veterans during the reintegration process. Composed of a psychiatrist, psychologist, social worker, and a patient liaison, this team works solely with veterans from the Global War on Terrorism. Because the VA system can initially be complex and confusing, these staff members help new veterans access a wide range of both physical and mental health treatment options.
- C. Women/Men of Courage Programs – This 12-week, weekly, 90-minute psychotherapy group focuses on healing from a sexual trauma (experienced in childhood and/or in the military). Specific sessions address issues of safety, self-esteem, telling one’s story, and empowerment.
- D. The Reaching out to Educate and Assist Caring, Healthy Families (REACH Project) – This 9-month family psychoeducation program provided by the Family Mental Health Program supports veterans and their family members in dealing with PTSD. The program involves both single-family therapy and multi-family groups/psychoeducational classes. Sessions are held in the evenings to accommodate participants’ work schedules.
- E. Some other VA facilities (including Little Rock, AK; Topeka, KS) offer time-limited inpatient programs for veterans with combat-related PTSD. Some also offer inpatient programs for veterans with sexual-assault-related PTSD.