OPERATION ENDURING FAMILIES

Information and Support for Iraq & Afghanistan Veterans and Their Families

A 5-session family education and support program for service members and veterans who have recently returned from a combat theater and their family members

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Based on the SAFE Program Manual by Michelle D. Sherman, Ph.D.

Oklahoma City VA Medical Center
Family Mental Health Program

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RATIONALE FOR OPERATION ENDURING FAMILIES PROGRAM

Returning Service Members and Veterans

Since September 11, 2001, more than two million American troops have been deployed in support of the Global War on Terrorism (VHA Office of Public Health, 2010). As of 2009 (the most recent data available), more than 40% of troops have served in multiple deployments and more than 263,150 service members have had more than two deployments (IOM report, 2010). Not since the Vietnam War has such a large group of soldiers returned from combat, and never before have troops faced such a rapid cycle of deployments.

The men and women serving in Iraq and Afghanistan face a range of difficult and stressful situations**.** Tanielian and Jaycox's (2008) RAND report on trauma exposure in Operation Enduring Freedom (OEF) / Operation Iraqi Freedom (OIF) veterans found that 50% report having a friend who was seriously wounded or killed, 45% report seeing dead or seriously injured noncombatants, 45% report witnessing an accident resulting in serious injury or death, 23% report being physically moved or knocked over by an explosion, 23% report being injured (with 10% requiring hospitalization), 10% report engaging in hand-to-hand combat, 5% report witnessing brutality toward detainees/prisoners and 5% report being responsible for the death of a civilian. While experiencing these events does not necessarily lead to psychological problems, research is clear that the amount and intensity of trauma exposure increases the risk of service members developing mental health problems, substance abuse problems and engaging in more risk-taking behaviors (Killgore, 2008).

Recent research suggests that the returning service members face a range of adjustment difficulties upon homecoming, including insomnia, irritability and concentration difficulties (Shea, Vujanovic, Mansfield, Sevin & Liu, 2010). Often service members and veterans report

feeling anxious, having difficulty connecting to others, and missing the structure and camaraderie of military service. While these problems often resolve on their own, they can be stressful for the returning service members/veterans and their families. Educating service members/ veterans about these reactions, normalizing their experiences, and educating service members/veterans and family members about areas of concern and mental health treatment options can be helpful in supporting these men and women settle back into life at home.

Some service members/veterans go on to develop more serious mental health issues including PTSD, depression, substance abuse, and relationship difficulties. For example, divorce rates and high rates of anger control problems are elevated for this population (Sayer et al., 2010). The most recent MHAT report found that at 6 months post deployment 35.5% of troops have symptoms of anxiety disorders or depression (MHAT V, 2008). Of those troops, between 5 and 15% meet criteria for PTSD (Tanielian & Jaycox, 2008). Substance abuse is another significant and common challenge for returning service members/veterans. One study found that 12.5% engaged in heavy weekly drinking, and 53% engaged in binge drinking (Jacobsen et al., 2008). Many returning service members and veterans are interested in seeking services to support them in reintegration. While stigma and other barriers currently prevent some service members and veterans who screen positive for a mental health disorder from getting care, slightly more than half currently do seek care (MHAT-V, 2008).

Including Families

The service member/veteran's deployment to a warzone and its aftermath do not occur in a vacuum. The family is actively involved in every step of the process, often shouldering increased responsibilities and experiencing considerable worry during deployment. Reintegrating the service member or veteran back into the family unit can be a challenging

experience for everyone, and all family members face important tasks associated with the transition (Bowling & Sherman, 2008). Some OEF/OIF veterans report difficulties reconnecting with their families. For example, of Global War on Terrorism veterans referred for a behavioral health evaluation at a large VA medical center, over ¾ reported at least one family issue, 40% reported feeling like a "guest in their home," and 25% said that their children were afraid of them or not warm to them (Sayers, Farrow, Ross & Oslin, 2009). Furthermore, it is well known that PTSD is related to a variety of difficulties in intimate relationships (Monson, Taft & Fredman, 2009). Thus, the ripple effects of deployment and trauma on family life are considerable.

The Department of Defense (DoD), VA and other mental health providers have a unique opportunity to work with this population to provide early intervention and support and to work to prevent more long-term problems. It has been our experience that a treatment approach that focuses on normalizing the common issues associated with readjustment, strengthening existing social support and family relationships, and providing appropriate referrals is most helpful. As such, the Operation Enduring Families Program is psycho-educational in nature and designed to work with both the returning service member/veteran and his/her family members. Family members are included in treatment for three reasons. First, given that reintegration into family life is one of the major challenges of returning from combat, it makes sense to include the family in services focused on reintegration. Second, family members themselves often face significant stressors while their service member is deployed and also often struggle with issues of readjustment. Many of the symptoms of PTSD, particularly avoidance symptoms, have a significant impact on family life and it is important to help families deal with these symptoms. Third, service members and veterans themselves report a strong desire to include their families in mental health services.

Inclusion of families in care is consistent with numerous recent VA, DoD and SAMHSA efforts. For example, two of the joint VA/DoD Integrated Mental Health Strategy (IMHS) plans (#16 on Family Resilience and #17 on Family Members' Roles) focus on increasing engagement and services to families across the continuum of care. Efforts to increase service members/veterans' understanding and coping abilities are encouraged by this program. In the VA system, Public Law 110-387: Veterans' Mental Health and Other Care Improvements Act of 2008, included "marriage and family counseling" in the list of services that can be provided in support of veterans' treatment plans. Similarly, SAMSHA's recent plan, *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014*, focuses on fostering recovery by including families in care. Thus, including families in care is supported by veterans/families' stated wishes, research findings, and recent national legislation and strategic plans.

Reducing Barriers to Care

Many returning service members and veterans are not receiving needed resources or support because of fears of the stigma associated with mental health treatment. This program was designed to be held outside of the mental health clinic, to be informational in nature, and to provide a relaxed atmosphere in which returning service members/veterans and their families can discuss their concerns. Our hope is that the structure of the group will make it more likely that people will attend and begin to access the services available to them through the DOD, VA, and other community agencies. It is also important that those developing a group select a time and location that is feasible to attend for those who work. We have found that evening classes are far more accessible and better attended than those held during work hours.

AN EXAMPLE OF PUBLICITY EFFORTS WITHIN THE OKLAHOMA CITY VA

Publicity is essential to the success of this program, and is an ongoing focus. Publicity is done in several ways:

1. Operation Enduring Families Pamphlet
2. Operation Enduring Families Flyer
3. Invitation Letter
4. Reminder Letter
5. Article for Mental Health Newsletters
6. Posting for VA Newsletter

Information is disseminated to several groups of people:

1. Eligible veterans
2. VA Medical Center providers who can refer veterans and share this resource
3. Community, state and federal agencies that work with returning veterans and can provide this group as a referral

Program Information for Veterans

1. Informational letters were sent to all returning OEF/OIF veterans who had received services at the Oklahoma City VA Medical Center.
2. Welcome packets for returning veterans were distributed to clinics throughout the VA. They include information on the Operation Enduring Families Group.
3. Brief presentations were regularly made in other mental health programs serving OEF/OIF veterans.
4. Flyers were posted throughout the medical center and brochures were distributed to all appropriate clinics before the start of each group.

Program Information for VAMC Providers and Other Referral Sources

1. Invitation letters and pamphlets were distributed to many VAMC providers.

2. A brief overview of the program was presented to the primary care providers at the medical center.

3. Articles were published in various newsletters, including the state psychological, psychiatric, and social work associations.

4. Pamphlets, flyers, and informational packets for returning veterans were distributed to:

    a. All psychology and psychiatry service associates
    b. Primary care teams
    c. Psychiatric nurse specialists
    d. Chaplains
    e. Social workers
    f. Local department of mental health
    g. Service benefits officers
    h. Life support units at local military bases
    i. Vet Centers

5. Flyers were posted in:
    a. Outpatient mental health clinic waiting room
    b. Chapel
    c. Primary care area bulletin boards and waiting areas
    d. Emergency room bulletin board
    e. Elevators

6. Informal, repeated contact with providers reminding them of the program and encouraging referrals is one of the most important components of increasing referrals.

Each site that implements Operation Enduring Families will be doing so within a unique organizational structure. The suggestions above were the methods that worked best in our facility. We encourage those seeking to implement the program to consider the ways in which information is generally communicated at your facility and to modify these suggestions for the particular needs of your setting.

OPERATION ENDURING FAMILIES INVITATION LETTER

OPERATION ENDURING FAMILIES

Insert Date Here

Dear _____

Greetings from the Oklahoma City Veterans Affairs Medical Center. We are pleased that you are coming to our hospital for your healthcare. We know that adjusting to life after deployment and creating new family routines can be challenging. We are here to support you and your family in making this transition the best it can be.

We are writing to invite you and your family members/close friends to a new program called Operation Enduring Families.

This is an ongoing program that will meet every Thursday night, starting on **Thursday, July 5th, 2007.** Meetings will be held from **5-6:15pm** in **room 9B 101** (located directly across from the main elevators on the 9th floor).

These meetings for adult family members and veterans are confidential. There is no charge and no need to pre-register. We believe that participating in this program can help you, your family, and your relationships. Specific topics to be discussed include:

- Coping with PTSD and other reactions to trauma
- Improving family relationships
- Communication and intimacy
- Dealing with anger
- Managing depression
- Traumatic brain injury

We hope that you and a family member will consider joining us on July 5th. Please invite other veterans and their families you know who might benefit from this group as well. If you have any questions regarding how to talk to a family member about the group or who you might want to invite, please feel free to contact us. You may call Dr. Ursula Bowling if you have any questions or concerns at (405) 456-5183). We hope to meet you soon.

Sincerely,

Ursula Bowling, Psy.D.
Psychologist
Family Mental Health Program

Michelle Sherman, Ph.D.
Director
Family Mental Health Program

ARTICLE FOR MENTAL HEALTH NEWSLETTERS

OPERATION ENDURING FAMILIES

Operation Enduring Families Program at OKC VA Medical Center

We are launching a new program for veterans and their families. We know that getting back together after deployments can be stressful on families and veterans. Operation Enduring Families offers both information and support.

The goals of this program include: 1) education on a variety of topics related to reunification after deployment such as improving family relationships, facilitating communication and intimacy, dealing with anger, managing depression, coping with PTSD and other reactions to trauma, reducing family stress and self care and 2) mutual support and encouragement.

Weekly 90-minute educational groups will be held each Thursday evening starting in July 2007. Each session has a specific topic such as "Returning to Family Life after Deployment" and "Communication Tips for Post OEF/OIF Family Members and Veterans." Half of each session is devoted to discussion of participants' concerns.

Each session is facilitated by Dr. Ursula Bowling, a psychologist with the VA Family Mental Health Program. There is **no charge** for this program and no reservations are needed.

Any referrals to this program would be greatly appreciated. Please contact Ursula Bowling, Psy.D., of the Family Mental Health Program at (405) 456-5183 if you have any questions. Veterans or family members who want to learn more about the program may also be given Dr. Bowling's name to contact her directly.

OPERATION ENDURING FAMILIES

THE GOALS OF THE OPERATION ENDURING FAMILIES PROGRAM ARE TO:

1. Provide information to returning service members/veterans and their family members about the common experiences of returning from combat and to help normalize their experiences.

2. Provide resources and coping tools for returning service members/veterans and their families who are adjusting to life after a deployment and to assist with the common challenges that arise in reintegrating into the civilian community.

3. Provide an atmosphere where service members/veterans and their families can support and encourage each other.

4. Link returning service members/veterans and their families with other opportunities for support both at the Oklahoma City VA Medical Center and with community resources.

FORMAT OF THE OPERATION ENDURING FAMILIES PROGRAM

Number of Sessions

This manual contains 5 modules, each of which lasts 1.5 hours, plus an optional module on traumatic brain injury. Each session can stand alone, and the order of the presentation of sessions can be varied according to participants' needs. Furthermore, all the sessions do not need to be presented, as facilitators can select the topics most relevant to their clients' needs.

Frequency of Sessions

The frequency of sessions can be variable and should be based on the needs of the particular facility and the participants involved. However, we have found that attendance tends to be best when meetings are held on a weekly basis.

Participants

The group is open to all returning service members/veterans from the wars in Iraq and Afghanistan, as well as their adult family members or close friends. Returning service members/veterans and their families are encouraged to attend the classes together, but this is not a requirement and either family members or returning service members/veterans can attend separately.

Facilitators

If possible, it is recommended that 2 providers co-facilitate this group, as this provides someone who can respond to crises and attend to logistical issues. If this is not possible, the curriculum is written such that one provider could facilitate the group. Facilitators should be mental health professionals who hold at least a master's degree in a mental health field and have experience leading psychoeducational groups and some familiarity with the needs of returning service members/veterans and their families.

Logistics

The curriculum is written such that the group can be held on a continuous or occasional basis. For those facilities that run the group intermittently, a set date for the start and end of the group should be made. For those facilities that choose to run the groups continuously, group members may begin at any session. Participants are not obligated to attend every session. To maximize group cohesion and the effectiveness of the group, it is encouraged that group members attend whenever possible. The sessions are broad enough that every session should be applicable to all returning service members/veterans and their families, with the exception of the optional TBI module.

A list of the necessary materials for each session is on the following page of this manual.

Flexibility

Although each session has a structured format and didactic material to cover, the facilitator should remain flexible in meeting the needs of the participants. For example, if those in attendance express concerns or questions during the check-in process about a certain issue related to readjustment, the facilitator may wish to abbreviate the prepared material and devote some time to discussing the more immediate concerns.

OPERATION ENDURING FAMILIES
MATERIALS NEEDED FOR EACH SESSION

1. Participant Notebook (3-ring binder or folder)
2. Handouts
   - Handouts for the particular module
   - Welcome to Operation Enduring Families (Handout A)
   - Resource List for OEF/OIF Returning Service Members/Veterans and Their Families (Handout B)
   - Operation Enduring Families Evaluation Form (Handout C)
   - Operation Enduring Families Background Information Form (Handout D)
3. Reminder cards or appointment letters for the next group
4. List of treatment options available at your facility should other services be recommended
5. Pens
6. Nametags
7. Box of tissues
8. Refreshments

OVERVIEW OF PROGRAM SESSIONS

I. Introduction and Welcome

A. As participants arrive, encourage them to enjoy the refreshments and ask them to complete Handout D: Background Information Form.

B. Introduce facilitators.

C. Thank participants for coming, recognizing the many barriers that may have been overcome in doing so (e.g., long drive, missing work, coming to an unfamiliar group).

D. Distribute 3-ring binders ("Participant Notebook") to all new participants. Encourage participants to keep all handouts in this notebook and to bring it to each session.

E. Distribute Handout A: "Welcome to Operation Enduring Families"

1. Review program goals.
2. Review group guidelines, especially confidentiality.

F. Encourage participants to ask questions at any time during the workshop.

G. Emphasize the importance of mutual respect. Note that each participant has a unique situation.

1. Service members/veterans and their families are the focus of this group.
2. Some people are here with their family members, while some are not. Of the families present, many different relationships are represented, including parents and children, siblings, spouses, etc.
3. There are families and service members/veterans here from different branches of the military, as well as members serving in active duty, the National Guard and the Reserves.
4. People may have returned recently from a deployment or may have been back for some time. Service members/veterans may have experienced multiple deployments. Some people may be anticipating more deployments, while others may no longer be in the armed services.
5. Every family has a different experience of life after deployment, and may be dealing with different stressors and challenges.
6. Every person has a unique set of strengths and coping skills for managing difficult experiences.
7. An important element of group safety is respecting the confidentiality of other group members. This means not sharing other group members' personal information with anyone outside the group.

H. Remind participants that even with these differences, they share a great deal in common with each other. Much of the learning that takes place in this group will come from other group members, and active participation, while not required, is encouraged.

II. Recognition of Group Members

- This group is unique in that its members are returning service members/veterans as well as their families and friends.

- Say to group members: *We want you to know that we value and respect your commitment to yourself and your family. We know that you are busy people dealing with all kinds of pressures; the fact that you took the time to come and learn about adjustment after deployment and improving family relationships shows a commitment to making your family great. We applaud you for that commitment.*

III. Introductions/Check-In

- Group members are invited to introduce themselves; they should include their names, who (if anyone) they came with, and a brief explanation of why they came and what they hope to get out of the group. After the initial session, group members can use this time as an update on how they and their families are doing. A 3-5 minute limit per person is generally suggested. Participants should never be forced to share if they prefer to simply listen to the discussion.

IV. Didactic Presentation and Discussion

- See each session outline for specific guidelines (**Provider Note:** *The length and amount of detail in each session outline varies across the workshops. In the longer outlines, the facilitators may choose certain selections that are most relevant to the needs of their participants*).

V. Review of Handouts in Participant Notebook

- Handout B: "Resource List for Returning Service Members/Veterans and Their Families"
  —Review the various books, websites, and community resources available.

- Other handouts (optional):
  —Distribute and discuss specific informational handouts related to the material being covered that day.

VI. Program Evaluation

- Express the commitment to make improvements in this series to better meet participants' needs and improve the quality of the program. At the end of each session:
    - Ask all participants to complete the Skills Assessment Handout (Handout D). As people complete the program, look for areas of growth and also for areas that would benefit from increased attention.
    - Ask all participants to complete the Evaluation Form (Handout E). This handout can provide valuable information for providers on how best to improve the quality of the presentations.

VII. Closing

A. Solicit any reactions from today's workshop.

B. Re-emphasize the importance of self-care and communication.

C. Encourage participants to PRACTICE any exercises or skills taught that week.

D. Remind participants of next week's topic and date.

E. Note availability of a short time after workshop for individual questions or to address crises.

F. Reemphasize confidentiality.

G. Thank each participant for coming.

OPERATION ENDURING FAMILIES

Handout A
WELCOME TO OPERATION ENDURING FAMILIES

We're glad you're here.
We hope this program will be helpful to you and your family.

Goals

These workshops are designed to meet some of the needs of families of service members/veterans who have recently returned from Iraq and Afghanistan. We hope that these sessions will provide opportunities to:

1. Learn more about the common experiences of service members/veterans returning from combat.

2. Provide resources and coping tools for adjusting to life after a deployment and assist with the common challenges that arise during this time.

3. Provide an atmosphere of support and encouragement.

4. Link you with other opportunities for support both at the Oklahoma City VA Medical Center and through community resources.

Guidelines

1. We ask that you promise to respect each other's confidentiality by refraining from discussing personal information that is shared at this workshop. Please feel free to share handouts and educational information with family and friends, but do not talk about specific participants or specifics of what other group members share.

2. Please be attentive, supportive listeners such that everyone will be heard and respected.

3. Ask questions at any time. We are here to educate and support you and allow you to educate and support each other.

4. If you have any concerns that we did not address in group, or if you have any concerns about your safety or well-being outside of group, please discuss these with the facilitators immediately following today's session.

Handout B
Resource List for OEF/OIF Service Members and Veterans

Compiled by Michelle D. Sherman, Ph.D. (Revised May 2011)

BOOKS

For Veterans / Service Members (and Adult family members)

A Handbook for Family and Friends of Service Members. (2010). Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and the Public Broadcasting Service. Free copies of this booklet can be ordered here: http://www.realwarriors.net/family/resources.php

After the War Zone: A Practical Guide for Returning Troops and their Families. (2008). Lori Slone & Matthew Friedman, Da Capo Press.

Back from the Front: Combat Trauma, Love, and the Family. (2007). Aphrodite Matsakis.

Courage After Fire: Coping Strategies for Returning Soldiers and Their Families (2006). Keith Armstrong, Suzanne Best, & Paula Domenici.

Once a Warrior--Always a Warrior: Navigating the Transition from Combat to Home--Including Combat Stress, PTSD, and mTBI. (2010). Charles Hoge.

While They're at War: The True Story of American Families on the Homefront (2006). Kristin Henderson

For Kids

Daddy, You're My Hero! // Mommy, You're My Hero! (2005). [for kids ages 4-8]. Michelle Ferguson-Cohen

My Red Balloon. (2005). Eve Bunting. [for kids ages 4-8; picture book focused on homecoming].

Night Catch. (2005). Brenda Ehrmantraut [for kids ages 4-8 about dealing with parental separation]

The Fathers Are Coming Home. (2010). Margaret Wise Brown. [for kids ages 6-12 about homecoming]

100 days and 99 nights (2008). Alan Madison [for kids ages 8-12 about parental deployment]

Sometimes We Were Brave. (2010). Pat Brisson. Honesdale PA: Boyds Mills Press. [for elementary school kids whose parent is deployed].

I Miss You: A Military Kid's Book About Deployment. (2007). Prometheus Books. [for elementary school kids whose parent is deployed]. Beth Andrews

Uncle Sam's Kids: When Duty Calls. (2003). [for kids ages 5-11]. Angela Sportelli-Rehak

You And Your Military Hero: Building Positive Thinking Skills During Your Hero's Deployment. (2009). [for kids ages 5-12 focusing on parental deployment]. Sara Jensen-Fritz, Paula Jones-Johnson & Thea L. Zitzow.

For Teens

Finding My Way: A Teen's Guide to Living with a Parent Who has Experienced Trauma. (2005). [for kids ages 12-18] . Michelle D. Sherman, Ph.D., DeAnne M. Sherman. (available at www.SeedsofHopeBooks.com)

My Story: Blogs by Four Military Teens (2009). [for kids ages 10-18] . Michelle D. Sherman, Ph.D., DeAnne M. Sherman. (available at www.SeedsofHopeBooks.com)

WEBSITES

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury: http://dcoe.health.mil/ and their Real Warriors Campaign: http://www.realwarriors.net/

Military OneSource (1-800-342-9647). http://www.militaryonesource.com/MOS.aspx

Military HOMEFRONT (Official DoD site). www.militaryhomefront.dod.mil

State Departments of Veterans Affairs: http://www.nasdva.net

Strategic Outreach to Families of All Reservists: www.sofarusa.org

US Department of Veterans Affairs: www.va.gov and http://www.oefoif.va.gov/

VA Caregiver Support website: www.caregiver.va.gov (Caregiver support line is 1-855-260-3274; this is a toll-free call)

Vet Centers: www.vetcenter.va.gov

Emotional Health:

Military Pathways (DOD sponsored mental health / alcohol screening and referral program offered to families and service members affected by deployment)
http://www.militarymentalhealth.org/Welcome.aspx

National Center for PTSD. www.ncptsd.org

National Mental Health Association. http://www.nmha.org/reunions/resources.cfm

Operation Enduring Families: A 5-session family education curriculum for OEF/OIF veterans/families. www.ouhsc.edu/oef

S.A.F.E. Program, Support And Family Education: Mental Health Facts for Families. An 18-session curriculum for people who care about someone who has a mental illness / PTSD. http://www.ouhsc.edu/safeprogram/

inTransition program: http://www.health.mil/InTransition/default.aspx. A voluntary and confidential program to support service members and veterans move between health care systems or providers, offering a personal coach, resources and tools.

Deployment:

After Deployment: http://www.afterdeployment.org/

Coming Home: What to Expect, How to Deal When you Return from Combat. S. Jacobson & E. Colon (2008). Comic booklet available for download at: http://www.militaryonesource.com/MOS.aspx

Deployment Guide For Families of Deploying Soldiers. Separation and Reunion Handbook
www.hooah4health.com/deployment/familymatters/reunion.htm#

Post-Deployment Stress: What Families Should Know, What Families Can Do.
http://rand.org/pubs/corporate_pubs/CP535-2008-03/

Post-Deployment Stress: What You Should Know, What You Can Do.
http://rand.org/pubs/corporate_pubs/2008/RAND_CP534-2008-03.pdf

Support Your Vet. Created by Iraq and Afghanistan Veterans of America, this site contains information for family and friends of OEF/OIF veterans about reintegration after deployment as well as personal stories and a place to post thoughts/experiences.
http://supportyourvet.org/

Surviving Deployment: Resources for Military Families.
www.survivingdeployment.com

Welcome Home: How to make a difference in the lives of returning war zone veterans (includes Dr. James Munroe's "Eight Battlefield Skills that Make Life in the Civilian World Challenging"). Washington Family Policy Council. http://www.fpc.wa.gov/publications/welcomehome.pdf

Injury / Traumatic Brain Injury

Courage to Care, Courage to Talk About War Injuries. www.couragetotalk.org/index.php: Educational information for providers and families about TBI and war injury developed by the Center for the Study of Traumatic Stress

National Resource Directory: www.nationalresourcedirectory.org: Online tool for wounded, ill and injured troops/veterans & their families, providing access to more than 11,000 services and resources at the national, state and local levels

Picking up the Pieces after TBI: A Guide for Family Members. A. Sander (2002). http://www.lapublishing.com/blog/wp-content/uploads/2009/08/TIRR-Picking-up-the-pieces.pdf

Traumatic Brain Injury: The Journey Home: www.traumaticbraininjuryatoz.org. Created by the Defense and Veterans Brain Injury Center (DVBIC), offers information to caregivers of Veterans/Service members who sustained a moderate, severe or penetrating TBI

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). http://dcoe.health.mil/

Defense and Veterans Brain Injury Center: www.dvbic.org

Team Up to Facilitate Functioning (TUFF). Interactive brochures for treatment of postconcussive symptoms in returning Veterans with history of traumatic brain injury. http://www.mirecc.va.gov/VISN16/providers/TUFF.asp

Issues about Children/Youth

For Kids:

Army Reserve Child and Youth Service's Online Teen Deployment Class www.arfp.org/skins/cys/display.aspx?moduleid=8cde2e88-3052-448c-893d-d0b4b14b31c4&mode=user&action=display_page&objectid=26860744-9f90-4009-a0ea-da1da0220edb&AllowSSL=true

Military Kids Connect: www.militarykidsconnect.org

Military Teen Online: Online community and support for teens: http://www.militaryteenonline.com/

My Life: A Kid's Journal (for during deployment- by Health Net Federal Services) https://www.hnfs.net/res/tricare/beneficiary/common/pdf/-1542306275/Kids_jrn_bw_coloringbook_12_07.pdf

National Guard Family Program / Guard Family Youth: www.guardfamily.org // www.guardfamilyyouth.org

Sesame Street Connections
http://www.sesamestreetfamilyconnections.org/login/

Tutor.com: (free, online tutoring) http://www.tutor.com/military

VA Kids: http://www.va.gov/kids/

For Parents and Educators:

American Association of School Administrators Toolkit: Supporting the Military Child.
http://www.aasa.org/content.aspx?id=9008

Building Resilient Kids. A course for school personnel focused on building resilience among students from military families. Johns Hopkins Bloomberg School of Public Health's Military Child Initiative.
http://jhsph.edu/mci/training_course

Courage to Care, Courage to Talk About War Injuries. www.couragetotalk.org/index.php
Educational information for providers and families about TBI and war injury developed by the Center for the Study of Traumatic Stress. Includes information about talking to children about war injuries.

Helping Children Cope with Deployments and Reunions:
http://www.realwarriors.net/family/children

Military K-12 Partners: A DODEA Educational Partnership Program (collaboration with the Department of Education to ease transitions of military youth)
http://militaryk12partners.dodea.edu/

Military Child Education Coalition: www.militarychild.org

National Child Traumatic Stress Network's Military Children and Youth Resource Page.
http://nctsn.org/nccts/nav.do?pid=ctr_top_military

Military Kids Bill of Rights
http://www.nmfa.org/site/DocServer/Military_Child_Bill_of_Rights5-08.pdf?docID=13201

National Military Family Association / Operation Purple Camp.
http://www.militaryfamily.org/

Operation Child Care (for National Guard and Reservists).
www.childcareaware.org/en/operationchildcare

Operation Military Kids: www.operationmilitarykids.org

Salute Our Services A Thousand Thanks to Military Kids Program (sends free personalized card to military child): http://www.saluteourservices.org/

SOAR (Student Online Achievement Resources) www.soarathome.com

Students at the Center: An Education Resource for Families, the Military, and Schools http://www.militaryk12partners.dodea.edu/studentsAtTheCenter/

Tackling Tough Topics: An Educator's Guide to Working with Military Kids. Washington State Office of Superintendent of Public Instruction. https://www.operationmilitarykids.org/resources/ToughTopics%20BookletFINAL.pdf

United Through Reading (deployed parents read children's books aloud via DVD for their child to watch at home): www.unitedthroughreading.org/military/

Veteran Parenting Toolkits (created by the Oklahoma City VA Family Mental Health Program): www.ouhsc.edu/VetParenting

Welcome Back Parenting: A Guide for Reconnecting Families after Military Deployment. www.welcomebackparenting.org

ZERO TO THREE. (2009). *Honoring our babies and toddlers: Supporting young children affected by a military parent's deployment, injury, or death*. http://www.zerotothree.org/

10 Things Military Kids Want You to Know (Revised 2010) http://www.militaryfamily.org/assets/2010-Teen-Toolkit-PDF.pdf

VIDEOS

For Adults/Parents

A Different Kind of Courage http://mentalhealthscreening.org/military/ Video to encourage help-seeking for psychological health by Military Pathways

Cover me. Injured Marine Semper Fi Fund (http://semperfifund.org/). 32-minute DVD encouraging warriors to seek care for mental health problems. Contains some graphic images of combat

Returning from the War Zone: A Guide for Families. A 58-minute video created by the National Center for PTSD. www.ptsd.va.gov/public/reintegration/warzone_family_guide/player.html

Young Children on the Homefront, ZERO TO THREE. Military families share their unique deployment experiences and professionals offer tips and strategies for dealing with difficult issues such as grief and loss from deployment and the challenges that often arise upon reunification.
Available to view at: http://www.zerotothree.org/about-us/funded-projects/military-families/children-on-the-homefront.html

For Youth

Talk, Listen, Connect: Deployments, Homecomings, Changes. Sesame Street DVDs for families with youth ages 2-5. Available through Military OneSource OR http://www.sesameworkshop.org/initiatives/emotion/tlc

The Price of Peace. Song by two military teens about deployment. Priceofpeace.org; http://www.nationalguard.com/priceofpeace/

Youth Coping With Military Deployment: *"Promoting Resilience in Your Family*" and "*Mr. Poe and Friends*." American Academy of Pediatrics. Video from Operation Purple summer camp with interviews by kids. Available: http://www.aap.org/sections/uniformedservices/deployment/index.html

Young Heroes: Military Deployment Through the Eyes of Youth. 18 minute video created by teens of the New Jersey Operation Military Kids' Speak out for Military Kids Program explaining the deployment cycle: http://www.operationmilitarykids.org/public/somk.aspx

For Providers

Cognitive Processing Therapy On-line Training (CPT Web): http://cpt.musc.edu/index

Focus Project: http://focusproject.org/

Joining Forces Online. http://www.joiningforcesonline.org/ Health Partners for Medical Education, MN National Guard, Minneapolis VAMC. Four 30-minute videos for PROVIDERS who work with returning troops.

Treating the Invisible Wounds of War. http://www.aheconnect.com/citizensoldier/ Created by the Citizen-Soldier Support Program (CSSP) at the University of North Carolina. Program for providers to learn about working with returning troops. Created by Harold Kudler, MD and Charlotte M. Wilmer, MSW, LCSW. CE credits available.

Defense Center of Excellence's Children of Military Service Members Resource Guide. http://www.dcoe.health.mil/Content/Navigation/Documents/DCoE%20Children%20of%20Military%20Service%20Members%20Resource%20Guide.pdf

Handout C

Welcome to Operation Enduring Families!

We're glad you're here!

Today's Date:_____

Name:_____ Age:_____

Social Security Number:_____ ---- _____ ----- _____ Date of Birth: _____

For family members only: Name of your veteran:_____

Last 4 digits of veteran's social security number: _____

Address:_____

_____

Phone numbers: _____(home)_____(work)_____(cell)

Currently employed? Yes No If yes, where?_____

How did you hear about our program?_____

Present physical health problems:_____

Marital Status: _____Married _____Engaged _____Separated _____Cohabiting _____Divorced

Date of marriage (if applicable):_____

Names and ages of children:_____

Names of individuals currently living in your home:_____

_____

How often and how much alcohol do you consume?_____

_____

What other drugs or herbal products do you use and how often?_____

_____

Have you had any previous mental health treatment? Yes No
→ If so: what?_____

Please give a brief description of your goals for coming to this program (what do you hope to improve, change, or understand by being here):

Handout D

Participant Name:_____Date:_____

Please circle the number for each question that describes how you feel now. These questions ask about how much you <u>understand</u> and know how to handle various situations.

	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1. I understand how to improve family relationships after a deployment.	1	2	3	4	5	6	7
2. I know about how to improve our family communication.	1	2	3	4	5	6	7
3. I know the major signs and symptoms of Post Traumatic Stress Disorder (PTSD).	1	2	3	4	5	6	7
4. I know what to do when a family member becomes very angry.	1	2	3	4	5	6	7
5. I know what to do if a family member talks about suicide.	1	2	3	4	5	6	7
6. I know about books, websites, and other post-deployment resources that are available.	1	2	3	4	5	6	7
7. I know how to create a low stress environment at home.	1	2	3	4	5	6	7

These questions ask about how well your family actually deals with certain situations. Please circle the number for each question that describes how you feel now.

	Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
8. In our family, we communicate well with each other.	1	2	3	4	5	6	7
9. Our family is good at coping with stressful life events.	1	2	3	4	5	6	7
10. Our family does a good job of dealing with strong emotions.	1	2	3	4	5	6	7
11. The stress level in our household is low most of the time.	1	2	3	4	5	6	7
12. Our family does a good job of solving problems.	1	2	3	4	5	6	7
13. Our family has a lot of fun together.	1	2	3	4	5	6	7
14. I'm worried about the mental health or safety of my spouse.	1	2	3	4	5	6	7
15. I'm worried about the mental health or safety of my child.	1	2	3	4	5	6	7
16. I'm worried about the mental health or safety of my parent.	1	2	3	4	5	6	7
17. I feel safe at home.	1	2	3	4	5	6	7

Handout E

Operation Enduring Families

Evaluation Form

Please indicate your rating on each of the following items by circling the appropriate number on the scale:

TOPIC:

DATE:

1. Overall quality of the workshop:	1 Poor	2	3 Average	4	5 Excellent
2. Style of presenter(s):	1 Poor	2	3 Average	4	5 Excellent
3. Relevance of topic for you	1 Poor	2	3 Average	4	5 Excellent
4. How much new information did you gain from this workshop?	1 Poor	2	3 Average	4	5 Excellent

5. How could this session be improved to better meet your needs?

6. Are there any specific topics that you'd like to see addressed in future workshops?

Thank You

MODULE 1

Returning to Family Life after a Deployment

Materials Needed:

- Handout 1: What the Returning Service Member/Veteran Can Do
- Handout 2: What Family Members at Home Can Do
- Handout 3: Caring Behaviors Exercise
- Handout 4: Understanding and Supporting the Children in Your Life
- Handout 5: Parenting Tips
- Copies of the Veterans Parenting Toolkit, available for free at www.ouhsc.edu/vetparenting

Provider Note: *Today's session covers several topics regarding the changes families make during and after a deployment and tips for how families can succeed during this transition. The class begins with a group discussion on the changes each member of the family made to cope with the deployment.*

The following discussions are aimed at helping both the returning service membe/veteran and the family member(s) who were at home understand some of the unique challenges that the other faced, both during and after the deployment. The goal here is to have a discussion that increases each family member's understanding of the other's experience.

I. Understanding the Returning Service Member/Veteran's Experience of Deployment and Reintegration

Discussion Question (for the service members/veterans):

- What were some of the challenges you faced during the deployment?

Provider Note: *Write the answers the group gives on the board. The following is a list of some of the things you might want to include:*

A. The deployment involved living in a hot, dry desert without the comforts of home. Service members go without the privacy, food, housing, and other comforts that many of us take for granted.

B. The deployment involved difficult work and enormous responsibility, with very few breaks or time to relax.

C. On dangerous deployments, service members form extremely strong bonds with their units. This is often what sustains them in the midst of difficult circumstances. Leaving behind these relationships can be a major loss when a service member returns from combat.

D. During deployment service members participated in stressful events and may have taken part in operations that exposed them to life-threatening situations. They may have been shot at, and/or seen the death or injury of other soldiers, the enemy, or civilians.

Discussion Question (for the service members/veterans):

- What were some of the challenges you faced upon your return home?

Provider Note: *Write the answers the group gives on the board. The following is a list of some of the things you might want to include:*

A. The returning service member/veteran may seem preoccupied with the experiences deployment. He or she may be unable to talk about it or may excessively talk about it.

B. The returning service member/veteran may have suffered physical or emotional injury or disability.

C. The service member/veteran may expect extra attention and support for some time after returning from combat.

D. The returning service member/veteran may have serious concerns about their financial or employment future. Many Guard and Reserve members left behind their jobs and careers and may continue to worry about their employment prospects after returning.

II. Understanding the Adult Family Members Who Stayed Home

Discussion Question (for the family members who stayed home):

- What were some of the challenges you faced during your service member/veteran's deployment?

Provider Note: *Write the answers the group gives on the board. The following is a list of some of the things you might want to include:*

A. The family member that remained at home had to assume many responsibilities, such as assuming additional work, making household decisions alone, dealing with parenting issues without support, etc.

B. The adult at home has to navigate many of the changes that families undergo without being able to discuss them with the partner. These changes may come as a surprise to the returning service member/veteran.

C. The family member at home had to live with significant anxiety and uncertainty while their service member/veteran was deployed.

Discussion Question (for the family members who stayed home):

- What were some of the challenges you faced upon your service member/veteran's return home?

Provider Note: *Write the answers the group gives on the board. The following is a list of some of the things you might want to include:*

A. The adult at home may feel ambivalent about giving up some of the responsibilities assumed while the service member was deployed. He or she may not want to return to their previous role, and may want to maintain their increased independence.

B. For someone whose service member/veteran was injured (physically or psychologically) as a result of his or her combat experience, there can be a considerable adjustment to the "new normal."

C. Family members often report being unsure of how to talk about the war with their veteran/service member or of how be most supportive.

Provider Note: *After you have completed these lists, have group members share what it was like to hear about other group member's experiences. Ask if any participants now have a better understanding of their service members/veterans or family members. Explain that understanding is often the first step in building more supportive relationships and that continuing a dialogue about each other's experiences may be a helpful way to rebuild a sense of connection. Explain that the next portion of the module will focus on increasing support and positive interactions in the relationship.*

Provider Note: *Break the group into two, a group of service members/veterans and a group of family members. Have each group choose someone to take notes. Have the service members/veterans write down a list of ideas they have for how to be supportive of the family members who were home while they deal with reintegration adjustments. Have the group of family*

members who stayed home make a list of ideas they have for how to be supportive of the service members/veterans during the reintegration process. See Handouts 1 & 2 for examples of things they might include. Once the groups are finished with their lists, bring the group together to share their lists. Allow time for the group to discuss. Distribute Handouts 1 & 2 to the appropriate group members and allow some additional times to discuss the suggestions and any other ideas the group generated.

III. Caring Behaviors Exercise

- In addition to the ideas just discussed for increasing support and strengthening relationships, research has found that simple, regular caring behaviors can go a long way toward improving relationships and relationship satisfaction.

- Caring behaviors are simple, meaningful behaviors that express our love for our family members. These behaviors do not have to be complicated or expensive, but they should be thoughtful and done regularly. They are a great way to strengthen a relationship after being separated by a deployment.

Provider Note*: Distribute Handout 3: "Caring Behaviors Exercise" worksheet. Ask each person to write down a few simple behaviors that the family member could do every day. Remind the group to phrase their requests in terms of things they want rather than things they do not want. Examples include: kissing me goodbye before I leave for work, putting lotion on my back, picking up your things at the end of the day, sitting next to me on the couch, asking how my day went, helping give the kids their baths, watching a TV show I enjoy with me, exercising together, etc.*

Ask the group members to read their lists to their family members. Encourage group members attending alone, to share this activity with their family members when they get home.

Group members should post their lists in a prominent place in their homes and do 2-3 things from their family member's lists each day. Remind the group that consistency is key, and that saying "thank you" is essential.

IV. Supporting Children

Provider Note: *Ask the group members who have regular contact with children to raise their hands. Spend a moment finding out about the children in the veterans'/ service members' and family members' lives. Explain that while everyone does not have children, most of us currently have or will have relationships with children, and that the group is going to spend a few minutes during this session discussing the needs of children. If you have more than one group leader, you may want to divide the group into those members with children to focus on this module and spend the time with those who do not have children reviewing the caring behaviors exercise.*

A free toolkit called the "Veteran's Parenting Toolkit" by Sherman, Bowling, Wyche & Anderson is available at www.ouhsc.edu/vetparenting. Print and have available copies of these toolkits to distribute to the class.

V. Understanding Children's Experience of Parental Homecoming

Provider Note: *Ask those who have some regular time with children to state the names, ages, and interests of the children. As you discuss each of the developmental stages of children and common reactions in this next section, first ask the group members what behavioral changes they would expect. Praise group members for their awareness of children's behavior under stress.*

Discussion Questions:

- What changes did you notice in your children during the deployment?
- How did your children adjust to your spouse's return?
- How can you support your children in meeting their needs?

A. Children generally are excited about a reunion with their returning parents. However, the excitement of the reunion can also be stressful for children. Children may be anxious and uncertain about the reunion for some time.

B. Children may need a period of time to warm up and readjust to the returning parent. This is common and should not be taken personally by the service member/veteran.

C. Children's responses may differ depending on their developmental level. The following are some of the responses you may expect in various ages of children upon the service member/veterans return:

1. Infants (Birth-12 months) may respond to disruptions in their schedule, environment, or availability of their caregivers with changes in appetite, sleep, increased crying and irritability. They may not initially recognize the parent who was deployed and may need extra time to be reacquainted.
2. Toddlers (1-3 yrs) may become sullen and tearful, throw tantrums, develop sleep problems, or act younger than their age. They may need time to become reacquainted with their returning parent and may be clingy and needy.
3. Preschoolers (3-6 yrs) may act younger than their age and develop problems with toilet training, sleep, separation fears, etc. They may believe that the absence of their parents was somehow their fault and may need reassurance that they did not cause it. Children at this age are also likely to "test the limits." These children thrive on consistency and structure.

4. School-age children (6-12 yrs) are far more aware of the realities surrounding their parents' absence and the potential dangers of deployment. During deployment, they may have been more irritable, whiny, or sullen. They may have difficulty adjusting to the parents return and may be slow to warm up to that parent, or they may cling to the new parent and become critical of the parent who cared for them during the deployment. They may also try to monopolize the returning parent. Scheduling special times and activities with children will help them to "share" their parent during the rest of the week.
5. Teenagers (13-18 yrs) may be rebellious, irritable, or challenging of their parents' authority. They may act "cool" towards the returning parents, or may be very interested in learning about their parent's experience. Expect teenagers to vary widely in their emotional responses and maturity level on a moment-to-moment basis. If a teenager seems distressed, parents need to be alert to high-risk behaviors such as problems with the law, sexual acting out, and drug use.

VI. Parenting Tips

Discussion Questions:

- What changes did you notice in your children during the deployment?
- How did your children adjust to your spouse's return?
- How can you support your children in meeting their needs?

Provider Note: *Ask the group members to write on the board a list of tips that they think would be helpful in parenting children who are experiencing a parent's deployment or adjusting to their return. Some tips you might want to consider include:*

A. Share information with your children about your family member's experience in a way they can understand based on their age and level of maturity. Show your children a map of where the veteran/service member was, read them children's books about deployment and return, or watch videos (such as the Sesame Street series) that talk about the reintegration experience. Answer questions directly and simply, using language your child can understand.

B. Continue or resume family traditions, discipline, and structure.

C. Monitor children's exposure to media about the war, especially if redeployment is a possibility.

D. Encourage your child's open and honest expression of worries, feelings, and questions.

E. Have each parent continue to make an effort to spend a few minutes of one-on-one time with each child on a daily basis. Try to make this something that you both enjoy, like riding bikes, playing a board game, or reading a book.

F. Remember that change is just as stressful for children as it is for adults.

G. Work with your spouse to agree on rules and discipline. Present a united front on matters of discipline.

H. Re-engage with your children at their level, through their activities.

VII. Wrap-Up

- Distribute Handouts 4 & 5 to group members.
- Ask that the group members complete the Caring Behaviors Worksheet in the next day or two, then practice for the next week.
- Answer any questions the group may have.
- 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.

HANDOUT 1

What the Returning Service Member/Veteran Can Do

1) Make time for your family.
2) Work with your family to reestablish a consistent routine at home.
3) Take time to talk to your spouse or partner. To the extent that you are comfortable doing so, share your experiences while away and make time to listen to your spouse. You have both had new experiences and likely would benefit from talking about the changes that took place while you were apart.
4) Intimacy and sexual relations may be awkward at first. Take your time. Make an effort to be patient with your partner and to "romance" them, much as you did when you were first dating.
5) Take time to learn how your family dealt with your absence. Find out how they dealt with household matters, parenting, etc. Try hard to understand and compliment your partner's approach to this adjustment rather than criticizing them. Remember that your partner did his/her best to run the household single-handedly. Give them credit for their efforts.
6) Spend time alone with each member of your family. Make "date nights" with your spouse, and arrange to have "special time" with your children.
7) Remember that time with your spouse and children is more important than money or fancy gifts. Be careful not to end up in the stress of excessive debt following your return.
8) Be gentle with yourself and your family. Give yourself time to ease back into family relationships.
9) Acknowledge the many responsibilities your spouse had to shoulder while you were gone. Express your gratitude.
10) It is normal to feel some apprehension about discussing your experience with your family members. Take your time with this, while recognizing that your family members may be able to listen more supportively than you realize.

Other ideas from my group:

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HANDOUT 2

What the Family Member who Stayed at Home Can Do

1) Make sure to continue to make time to care for yourself. If you have developed habits or hobbies (such as exercise, time alone to read, etc.), try to continue to make this time for yourself.

2) Spend time talking to each other. You've each taken on extra responsibilities and endured extra stress during the time apart. Take time to share about each of your experiences.

3) Understand that your spouse has had a very intense emotional experience. He or she may have difficulty describing feelings or experiences or may want to talk about the experience quite a bit. Either way, do your best to allow your partner time to settle back into life at home. Your spouse may not want to share about everything that happened; this is very normal. Do your best not to take it personally.

4) You may find the deployment has strained your relationship. Time and negotiation will help you work toward a new loving relationship.

5) Family problems that existed before the deployment frequently reappear after the deployment. Be patient with the issues that arise, and don't be afraid to seek professional help if needed.

6) Extended family members such as grandparents, aunts, and uncles may have helped you during the deployment. They may have difficulty redefining their roles with the family after the service member/veteran's return. Talk openly about these changes with all concerned.

7) All family members will need time to adjust to the changes that accompany the return of the deployed family member.

8) Open discussions of expectations prior to the return home are helpful if they are possible.

9) Families should utilize the help offered by the military and other organizations to readjust to the reunion.

10) Most families will change. Children have been born or have grown. You may have become more independent. Be aware that this can be difficult for a returning service member/veteran to adjust to.

11) Your service member/veteran may be a little hurt by how well you did during the deployment. Make sure your spouse that you missed him or her and that you are happy they are home.

12) Despite the difficulty your spouse has gone through, violence towards you is never an acceptable response. If you are a victim of domestic violence, get help. There are many free or low cost counseling programs available. A list is available in the Anger Management Module of this program, you can speak to your group leader and ask for phone numbers, or you can call the National Domestic Violence Hotline at (800) 799-SAFE.

Other ideas from my group:

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HANDOUT 3

Caring Behaviors Exercise

Instructions:

Please list specific behaviors that you would like your family member to do for you. It's better to phrase the requests in terms of what you'd like your partner to increase or do more of (rather than what he or she should *not* do).

After completing your lists, post both lists together in a place where you both can see them often. Every single day for the next 3 weeks, initiate 2-3 of these caring behaviors for your partner.

TIPS: *** Take the first risk! ***
*** Do at least one caring behavior daily NO MATTER HOW YOU FEEL! ***

This exercise is designed to strengthen the emotional bond in your relationship. Like any exercise, the effectiveness of the outcome will depend on your discipline and commitment to the procedure.

CARING BEHAVIORS to be done for _____by _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

HANDOUT 4

Understanding and Supporting the Children in Your Life

1) Children generally are excited about a reunion with their returning parent. However, the excitement of the reunion can also be stressful for children. Children may be anxious and uncertain about the reunion for some time.

2) Children may need a period of time to warm up and readjust to the returning parent. This is common and should not be taken personally by the service member/veteran.

3) Children's responses may differ depending on their developmental level. The following are some of the responses you may expect in various ages of children upon the service member/veterans return:

- Infants (Birth-12 months) may respond to disruptions in their schedule, environment, or availability of their caregivers with changes in appetite, sleep, increased crying, and irritability. They may not initially recognize the parent who was deployed and may need extra time to be reacquainted.

- Toddlers (1-3 yrs) may become sullen and tearful, throw tantrums, develop sleep problems, or act younger than their age. They may need time to become reacquainted with their returning parents, and may be clingy and needy.

- Preschoolers (3-6 yrs) may act younger than their age and develop problems with toilet training, sleep, separation fears, etc. They may believe that the absence of their parents was somehow their fault and may need reassurance that they did not cause it. Children at this age are also likely to "test the limits." These children thrive on consistency and structure.

- School age children (6-12 yrs) are far more aware of the realities surrounding the parent's absence and the potential dangers of deployment. During deployment, they may have been more irritable, whiny, or sullen. They may have difficulty adjusting to the parent's return and may be slow to warm up to that parent, or they may cling to the new parent and become critical of the parent who cared for them during the deployment. They may also try to monopolize the returning parent. Scheduling special times and activities with children will help them to "share" during the rest of the week.

- Teenagers (13-18 yrs) may be rebellious, irritable, or challenging of their parents' authority. They may act "cool" towards the returning parent, or may be very interested in learning about their parent's experience. Expect teenagers to vary widely in their emotional responses and maturity level on a moment-to-moment basis. If a teenager seems distressed, parents need to be alert to high-risk behaviors such as problems with the law, sexual acting out, and drug use.

HANDOUT 5

Parenting Tips

1) Share information with your children about your family member's experience in a way they can understand based on their ages and levels of maturity. Show your children a map of where their family member is/was; read them children's books about deployment, etc.
2) Continue family traditions, discipline, and structure during and after deployment.
3) Monitor children's exposure to media coverage of the war.
4) Encourage your child's open and honest expression of worries, feelings, and questions.
5) Have each parent continue to make an effort to spend a few minutes of one-on-one time with each child on a daily basis. Try to make this something you both enjoy, like reading a book, riding bikes, or playing a board game together.
6) Remember that change is just as stressful for children as for adults.
7) Work with your spouse to agree on rules and discipline. Present a united front on matters of discipline.
8) Take time to play with your children at their level, doing the activities they most enjoy.

For more information on connecting with the children in your life and dealing with common parenting challenges, please see the Veterans Parenting Toolkit at www.ouhsc.edu/vetparenting.

Other ideas from my group:

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MODULE 2

Communication Tips for Post OEF/OIF Service Members/Veterans and Their Families

Materials Needed:

- Handout 6: Communicating With Your Loved One
- Handout 7: Practicing "I" Messages
- Handout 8: Softened Start-up

Provider Note: *Today's class focuses on improving communication skills. The first portion of the module is a discussion of the importance of communication skills, while the second portion focuses service members/veterans and their families on learning some specific communication tools.*

Check-In from Previous Week & Introduction:

- Ask any new group members to introduce themselves and review the group guidelines and confidentiality with them.
- Ask if any group members have questions from the previous week.
- Check-in regarding how the caring behaviors homework went.
- Introduce today's topic of communication and explain that the focus of today's class will be on developing and strengthening communication strategies.

I. The Importance of Communication Skills

Discussion Question:

- Why should we work on improving our communication skills?

Provider Note: *Write down the answers the group brings up. Some of the topics to make sure the group covers are:*

A. Improving communication skills can reduce the level of frustration and stress in the family and can facilitate healthy interactions.

B. When family members of post OEF/OIF service members/veterans are asked about their concerns, they often report significant worry about the high level of stress in the household and the nature of the relationships within the family.

C. Being able to communicate and genuinely trying to understand each other's feelings can be very meaningful.

D. "The most healing gift you can give to someone in pain is the awareness that you are honestly trying to understand what they are going through, even if you get it wrong" (Hudson, 1996).

Provider Note: *Ask the group to discuss what they think about this statement: "The most healing gift…" Do group members agree? Disagree? What does it mean to the group?*

II. Understanding How the OEF/OIF Experience Can Impact Communication

Provider Note: *Individuals who have gone through the experience of war often process information differently. Help family members understand these points in order to facilitate more effective communication with post OEF/OIF service members/veterans* (material adapted from Woolis, 1992):

Issue #1: Sometimes post OEF/OIF service members/veterans withdraw (physically and/or emotionally) due to feeling over-stimulated. They may turn to excessive use of substances, videogames, or other "escapes" rather than engaging with family members. They may have a reduced capacity for emotion, so they can feel overwhelmed more easily and quickly.

> **Family Member Tip:** Family members are encouraged to avoid taking the withdrawal personally and to remain available if the service member/veteran wants to talk later. You may wish to initiate a discussion about the pattern at a later time.

Issue #2: Social situations can sometimes be stressful for post OEF/OIF service members/veterans, as groups or crowds can be threatening and anxiety-provoking (especially for individuals with depression, post-traumatic stress disorder, and other anxiety disorders).

> **Family Member Tip:** The returning service member/veteran may feel more comfortable with having only one or a few visitors at a time. The length and/or frequency of large group activities may also need to be limited. It may be helpful to work out a compromise in advance of social situations. For example, the service member/veteran may not go to an event, but the family member still can, or you may agree to go for a short time. Sometimes it is helpful to ride to events in separate cars, so that the service member/veteran can leave if the need arises. It may also be helpful to develop a special signal or phrase to let the other person know you are ready to leave.

Issue #3: Returning service members/veterans may have an impaired ability to express emotions. In a war zone, emotional numbing often becomes a way of coping with the intensity of combat experiences. Emotional numbing may be a symptom of PTSD, depression, or substance abuse problems. Consequently, he or she may appear detached, cold or emotionally aloof.

Family Member Tip: Family members will feel better if they can see this emotional distance as part of the post OEF/OIF adjustment process rather than as a reflection of some sort of relationship problem or some wrongdoing on their parts.

Issue #4: On the other hand, some veterans show strong emotional displays and high levels of reactivity. For example, individuals with post-traumatic stress disorder (PTSD) often have intense angry outbursts, which can be quite frightening for family members and other observers.

Family Member Tip: Family members can recognize the heightened emotionality as a symptom of the illness (PTSD) and try not to take it personally. However, regardless of mental health diagnosis, emotional or physical violence is never appropriate, and it is essential that family members seek appropriate support if this becomes an issue. For more information on referrals see the handouts from the Anger Management Module.

Issue #5: During the deployment, communication was limited and, if it took place, was not face-to-face.

Family Member Tip: While communication can be easier when face-to-face, it is also easier for emotions to escalate and intensify. Talk about strategies for reducing negative emotions or disengaging from each other when conversations become too intense.

Issue #6: OEF/OIF veterans find a number of different professional treatments helpful for dealing with relationship issues.

Family Member Tip: Be flexible in learning new communication skills and be willing to consider marital therapy, family education classes, and/or family therapy.

Issue #7: It is easy for families to get stuck in old, familiar patterns of communication. Some of these habits may be effective, but your family has changed and some may not work any longer.

Family Member Tip: Be willing to experiment and try out new ways of communicating to see what works best.

III. Effective Communication

Provider Note: *Explain that in addition to specific communication tips related to the OEF/OIF deployment experience, there are some general communication skills that can be helpful in any relationship, and that the remainder of the class will focus on learning some of these skills.*

Discussion Question:

- What are some important issues to remember in effective communication?

Provider Note: *Distribute Handout 6: "Communicating With Your Loved One" and discuss/explain the following points to facilitate effective communication:*

DO's

1. "2 Sentence Rule." Keep your communication simple, clear, and brief.
2. Ask only ONE question at a time.
3. Stick to the current issue rather than bringing up "old issues."
4. Stay calm. People often become uncomfortable and withdrawn if you express intense emotions, especially anger.
5. Minimize other distractions by turning off cell phones, the television, the computer, video games, and music.
6. Pay attention to nonverbal behavior – both the message that you are sending with your body language and the verbal message and body language message of your family member. Sometimes those returning from combat struggle to identify and express their needs and feelings; consequently, focusing on their behavior and emotional state rather than just their words can be important. Sometimes the family member who's been "holding down the fort" has difficulty sharing their feelings and adjusting to having support again.
7. Help your loved one identify his/her feelings by suggesting several choices (e.g., are you feeling angry, sad, or worried right now?).
8. Acknowledge what you have heard him/her express. Show empathy or caring for his/her feelings. Remind each other that you are not alone and many people have had similar feelings. If appropriate, share a time when you felt the same way or talk about other people you know who have faced similar challenges.
9. Decide together on a regular time for communication. Even if you are together most of the time, families benefit from having a set time to routinely talk about delicate matters. Choosing a low-stress time when both of you are apt to feel at your best is important.

DON'Ts

1. Avoid giving advice unless asked – or if the person cannot make the decision on his/her own. Rather, make decisions together whenever possible.
2. Avoid interrupting each other.
3. Don't talk down to each other (e.g., "you are acting like a child").
4. Avoid name-calling.
5. Don't generalize ("always" or "never"). Focus on the specific behavior rather than the individual.
6. Don't yell or shout.
7. Don't personalize each other's behavior. Recognize that the symptom may be part of the normal post-deployment adjustment and may have nothing to do with you.
8. Physical violence is never an acceptable way of dealing with conflict. If you or your family member is becoming violent, leave the situation and focus on regaining safety.

Provider Note: *Ask for questions regarding this list of "do's and don'ts." If time allows, ask class members to share one specific tip they are going to try in the next week.*

IV. Specific Skill and Role Play: "I" Statement

Provider Note: *Explain that you are now going to focus on teaching a tool for expressing yourself in a way that can help reduce conflict and more clearly communicate your message, called the "I" statement.*

A. Families can get entrenched in old, familiar patterns of communication. Some habits may be effective, whereas others may not work any longer.

B. An essential skill in relationships is learning how to give feedback (and express complaints) without criticizing your partner.

Today we're going to teach you a specific tool for a direct communication called the "I" statement. This skill requires the speaker to take responsibility for his/her feelings and desires.

Write on Board: When you_____ , I feel _____, and I would really like _____.

C. The "I" statement can be used in a variety of situations such as:

1) To make a request
   - When you leave your cigarette burning, I feel…and I would like….

2) To give praise
   - When you give me a hug, I feel….and I would like….

3) To express negative feelings
   - When you threaten me, I feel… and I would like….

4) To ask the individual to change his/her behavior
   - When you burst in my room without knocking, I feel… and I would like….
   - When you sleep all day, I feel… and I would like….

D. The "I" statement has many advantages, including:

1) These messages get the listener's attention. Individuals often become overly self-involved and may be unaware of the other person's feelings.

2) These messages are non-blaming, so they minimize defensiveness.

3) These messages force the speaker to identify, express, and take responsibility for his/her own feelings.

E. In addition to thinking about the words you use, it's also very important to pay attention to HOW you approach the other person. Leading in with an angry tone of voice, getting in the

other person's space, and jumping into "attack" mode will likely lead to an argument (even if you use the exact "I" message script!).

F. We recognize that using the "I" statement and approaching each other gently can be easier said than done. **Therefore, it's very important to practice these skills!**

Provider Note: *Distribute Handout 7: Practicing "I" Messages." Have participants get into dyads with the individuals they came with and complete the worksheet together. For participants who came alone, pair them with other participants who did not come with a family member, or complete the activity with them yourself. When participants are finished, return to the large group and discuss participants' reactions. Encourage participants to practice these skills.*

V. Specific Skill and Role Play: Softened Start-up Exercise

Provider Note: *Pass out copies of Handout 8: "Softened Start-up" and introduce the activity with a story like this one: "My friend's dad had a '37 Ford Pickup with a very cantankerous 85 horsepower flat head engine. If you were not sensitive to and careful about the 'start up' (choke pulled out exactly ¾ inch, all power to accessories off, precisely three pumps of gas pedal, and transmission in neutral, etc.) – you were destined to walk. Similarly, thinking about how you start up your next conversation with your significant other is critical to success. Bouncing along at 40 mph beats walking any day!" You may substitute the details of this story with the first car you had in college or a friend's car that was difficult to start.*

Alternate lead-in: How you approach a sensitive horse you are about to saddle for the first time. OR, how you plan for a special meeting with your boss or supervisor about a sensitive topic.

All families have "touchy or sensitive" issues that need to be addressed. Research by Dr. John Gottman (2000) indicates that how we bring up these touchy/sensitive issues is critical. A hard, "in your face" start-up rarely succeeds. On the other hand a "soft start-up" frequently ends with a pleasant, successful resolution.

A. General rules for a softened start-up

1. Sandwich technique – begin and end with something pleasant.
2. Keep it short and simple (KISS).
3. Lead in sentence – complain don't blame. This means stating what behavior you would like to be different without attacking the person.
4. Use "I feel _____ and I would appreciate if you…."

   instead of "You_____."
5. Describe what is happening – do not judge or blame.
6. Define clearly what it is you need.

7. Be respectful/polite – treat your significant other with at least the same consideration you'd give a roommate.
8. Don't "gunny sack," focus on the current issue – don't bring up the fact that he/she forgot to pick up the kids after a soccer match three years ago
9. Sandwich technique – don't forget to end with something pleasant.

Provider Note: *After discussing the gentle communication guidelines above, lead your group in rewriting the hard start-ups in Handout 8 so that they are softer.*

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 choose one of the communication skills presented today and to practice it regularly this week.
- 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.

HANDOUT 6

Communicating with Your Loved One

DO's:

1) "2 Sentence Rule." Keep your communication simple, clear, and brief.
2) Ask only ONE question at a time.
3) Stick to the current issue rather than bringing up "old issues."
4) Stay calm. Your spouse may become even more uncomfortable and withdrawn if you express intense emotions.
5) Minimize other distractions by turning off the television and radio.
6) Pay attention to nonverbal behavior – both the message that you are sending with your body language and the verbal message and body language message of your family member. Sometimes combat veterans struggle to identify and express their needs and feelings, so focusing on their behaviors and emotional states rather than just their words can be important.
7) Help your loved one identify his/her feelings by suggesting several choices (e.g., are you feeling angry, sad, or worried right now?).
8) Acknowledge what you have heard him/her express. Show empathy or caring for his/her feelings. You may wish to normalize that emotion and share a similar experience that you have had in the past.
9) Decide together on a regular time for communication. Even if you are together most of the time, families benefit from having a set time to routinely talk about delicate matters. Choosing a low-stress time when both of you are apt to feel at your best is important.

DON'Ts:

1) Avoid giving advice unless asked – or if the person cannot make the decision on his/her own. Rather, make decisions together whenever possible.
2) Avoid interrupting each other.
3) Don't talk down to each other (e.g., "You are acting like a child!").
4) Avoid name-calling.
5) Don't generalize ("always" or "never"). Focus on the specific behavior rather than the individual.
6) Don't yell or shout.
7) Don't personalize the family member's behavior. Recognize that the symptom may be part of the normal post OEF/OIF adjustment and may have nothing to do with you.
8) Do not allow or engage in physical violence.

HANDOUT 7

PRACTICING "I MESSAGES"

I MESSAGE: - **Expressing Appreciation**

Insert a feeling or emotion word(s), such as mad, sad, glad, afraid, surprised, excited, disgusted, hopeful, worried, etc.

WHEN YOU _____ I FEEL _____.

Example: When YOU *give me a big hug*, I FEEL *happy, loved, and close to you.*

1. When you say something nice to me, I feel _____
2. When I was sick and you fixed me dinner, I felt_____
3. When you listen to me when I'm upset, I feel _____
4. When you talk about our special memories, I feel _____
5. When you make dinner for me, I feel _____
6. When you keep the house clean, I feel _____
7. When you _____, I feel _____.

I MESSAGE – **Asking for Change**

Insert a feeling or emotion word(s)

WHEN YOU _____ I FEEL _____.

IN THE FUTURE, I WOULD APPRECIATE:_____

Be specific!

1. When you *don't come home on time*, I feel_____
   In the future, I would appreciate_____

2. When you *are rude to me in front of your friends*, I feel _____
   In the future, I would appreciate_____

3. When *you clam up and won't talk*, I feel_____
   In the future, I would appreciate_____

4. When *I'm talking to you and you turn on the TV*, I feel _____
   In the future, I would appreciate_____

5. When *you yell at me*, I feel_____
   In the future, I would appreciate_____

6. When *you criticize me*, I feel _____
   In the future, I would appreciate_____

7. When you_____, I feel _____
   In the future, I would appreciate_____

HANDOUT 8

Softened Start-up

Background: All families have "touchy or sensitive" issues that need to be addressed. Research by Dr. John Gottman (2000) indicates that how we bring up these touchy/sensitive issues is critical. A hard, "in your face start-up" rarely succeeds. On the other hand a "soft start-up" frequently ends with a pleasant, successful resolution.

The general rules for a softened start-up are the following:

1) Sandwich technique – begin and end with something pleasant.
2) Keep it short and simple (KISS).
3) Gentle lead-in sentence – explain your complaint and don't blame.
4) Use the classic "I feel _____ and in the future I would appreciate_____" …instead of "You_____."
5) Describe what is happening – do not judge or blame.
6) Define clearly what it is you need.
7) Be respectful/polite – treat your significant other with at least the same consideration you'd give a roommate.
8) Don't "gunny sack," focus on the current issue – don't bring up the fact that he/she forgot to pick up the kids after a soccer match two years ago.
9) Sandwich technique – don't forget to end with something pleasant.

Practice these techniques by rewriting the following hard start-ups so that they are softer:

Subject	Scenario
Guests	Your significant other's brother has been staying with you for over a month. Originally, he was to visit for two weeks. You are upset because he is eating you out of house and home and has not lifted a finger to help. You want your significant other to set some limits.

Hard start-up:
"Your brother is a lazy, free-loading hog."

*Your softened alternative:*_____

_____

Housework You wish your family member would help more around the house.

Hard start-up:
"You are an unappreciative slob who expects me to be your mother! Ain't happening!"

*Your softened alternative:*_____

_____

Parties You want to go to a party with your spouse. He/she is by nature shy and has become more withdrawn since coming back from Iraq. It is really important that your partner comes to this event with you, and you are upset that he/she does not want to.

Hard start-up:
"For once in your life, could you think about someone besides yourself? I'm really lonely and am sick of spending all my time sitting around here watching the grass grow. For once in our lives, could we please have a little fun?"

Your softened alternative: _____

_____

Sex It has been some time since you and your partner were last sexually intimate. You are wondering if your partner still finds you attractive. In your mind, making love tonight would be nice, very nice.

Hard start-up:
"Good grief! If you were any colder toward me – the furnace would kick on when you walk into the room. Do I have bad breath? Are you having an affair with the UPS person? Or what?"

*Your softened alternative:*_____

_____

Finances You want to save more money for your dream home. Your spouse likes to live more for the moment. Saving is less important to her/him.

Hard start-up:
"I can't believe the crap you buy! How are we ever going to get ahead when you keep spending, spending, spending every penny we make!? Do you want to live in this cramped hovel for the rest of our lives?"

*Your softened alternative:*_____

_____

MODULE 3

How to Manage Our Anger Well and Prevent Situations from Getting Out of Control

Materials Needed:

- Handout 9: Anger Management — Time-Out Process
- Handout 10: Hot Thoughts and Cool Thoughts
- Handout 11: Referrals for Domestic Violence
- Brochures on local treatment options for people with anger management difficulties

Provider Note: *Today's class focuses on strategies for effectively managing anger. Affect regulation difficulties and problems with anger in interpersonal relationships are an important theme for many OEF/OIF service members/veterans and their families. As a provider, be sure to emphasize that skills for managing anger can be learned and that there is no excuse for violence or abuse in relationships.*

Check-In from Previous Week & Introduction:

- Ask any new group members to introduce themselves and review the group guidelines and confidentiality with them.
- Ask if any group members have questions from the previous week.
- Check-in regarding how the communication skills homework went.
- Explain to group that today's session will focus on anger, its impact on interpersonal relationships, and strategies for managing anger effectively.

I. Anger Is a Normal Human Emotion

Provider Note: *Use whichever questions are relevant / appropriate for your group in order to engage participants in session (i.e., to elicit their goals / what they want to learn in session) and to be able to use their examples in the rest of the session.*

Discussion Questions:

- What are the situations/issues that cause the most conflict in your relationship?

- What situations set the stage for conflict in your house (e.g., your family member refusing to participate in family activities, drinking too much alcohol, sarcasm, withdrawing/refusing to communicate, being told what to do, overwhelming situations, feeling out of control)?
- Describe a typical argument. What happens? Are things resolved to your satisfaction? (If so, how?) Are there attempts to resolve the conflict or "make peace"? (If so, who usually initiates? How? What is the outcome?)
- Are children involved in the conflicts? How does this impact them?
- Rate yourself on a 1-10 scale (1 being having very poor skills and 10 being having excellent skills) on how you feel you handle anger.

Facts about anger:

A. Just like other feelings (e.g., sadness, joy), humans experience anger at different times and express the emotion in different ways.

B. Although many people think that being angry is wrong or bad, anger (in the mid-level range) itself is not a problem. Extreme behaviors that stem from this emotion can become problematic.

II. Important Issues to Consider about Anger and Violent Behavior

A. Intense emotions may be part of PTSD or other responses to trauma. Having a lot of anger and aggressive feelings can be a major element of PTSD. However, even if someone has the worst case of PTSD, he/she can learn to control and be accountable for his/her behavior.

B. Anger and its expression may be strongly affected by substance use.

C. Sometimes people become angry even when we have done nothing to provoke the anger. Regardless of the cause, you are never responsible for your family member's acting-out behavior (even if your behavior upsets him/her). Your family member may try very hard to blame you for his/her behavior in anger.

D. Although it is very difficult to predict violent behavior, the best predictor of future violence is past violent behavior. Reflecting on the situations that surrounded previous acts of violence can provide clues as to potentially difficult situations in the future. This information may also guide efforts to prevent future violence. Stressors such as returning from a deployment, job changes, or pregnancy can make violent behavior more likely but are never an excuse for violence.

E. Anger may be the emotion that is expressed directly, but the individual may be experiencing a great deal of fear underneath the anger.

Discussion Questions:

- Do you see this combination of anger and fear in your relationship? If so, how?
- How might it change things if you understood the feelings behind the anger that you see?

III. Irritability / Low-Grade Chronic Anger

Provider Note: *Lead the group in learning how to differentiate between chronic irritability/ anger and isolated angry outbursts. Discuss how many people experience both. Explain to the group that some trauma survivors don't have many distinct angry outbursts – but, rather, experience chronic irritability. They're easily "set off," and become angry easily – even over little things.*

Discussion Questions:

- Can you relate to this type of chronic anger or irritability in your relationship?
- How does chronic anger affect people? How does it affect relationships?

Provider Note: *Write down the answers the group mentions on the board. Some of the effects of chronic anger to make sure the group covers are:*

A. Irritability strains interpersonal relationships.

B. Chronic anger may lead to feelings of guilt, regret, and shame.

C. It can have adverse effects on communication. For example, family members may not feel safe to express their feelings honestly for fear of consequences, and significant emotional distance may result.

D. Family members may feel like they are "walking on eggshells."

E. Chronic anger may manifest as somatic / physical effects in family members (e.g., migraines, stomach problems, difficulty sleeping, tension, and jaw / TMJ pain).

F. Anger may lead to physical violence, which is never acceptable, regardless of the cause.

IV. Angry Outbursts / Violence:

Provider Note: *Discuss how some OEF/OIF service members/veterans may feel OK most of the time, but then have angry outbursts. Sometimes, the trigger for the outburst is easy to identify, whereas other times it is unclear. However, the patterns leading up to the outburst are often predictable. More specifically, episodes of violence have a predictable beginning, middle, and*

end. One of the first steps in dealing with anger is recognizing that people do not go from "0 to 60" instantly. The better people become at recognizing the stages of anger and warning signs they are becoming angry, the better able they will be to manage their anger. Write the following stages on the board (material adapted from Woolis, 1992):

• PHASE ONE	**Activation**	Stress occurs
• PHASE TWO	**Escalation**	Intervene now if possible
• PHASE THREE	**Crisis**	Violence may occur
• PHASE FOUR	**Recovery**	Less agitation
• PHASE FIVE	**Stabilization**	Guilt and remorse

Discussion Questions:

- In what phase do you generally become aware that you are feeling angry?
- In which phase do you tend to intervene? How does that work? What are the consequences?
- In what phase do you think intervention is most effective when the other person is angry?

Provider Note: *Listen and respond to group members' questions and comments about angry outbursts. Make sure to emphasize*:

A. Family members often try to step in during the most heated moments (in crisis or recovery phases). During these phases, people are not ready or able to take in information and discuss issues calmly.

B. Intervening in the escalation stage has the highest likelihood of preventing an angry outburst.

C. Most effective communication can occur (and efforts made to prevent future violence) in phase five (stabilization).

D. **If you ever feel in danger, immediately remove yourself and your children from the situation and/or call 911. You should never stay in a frightening or dangerous situation.**

V. Angry Interactions and Children

Provider Note: *During this session, you should emphasize to the group that it's very important for parents to minimize the amount of parental conflict that children witness. Research has*

documented numerous adverse effects on kids when they see / overhear parents engaged in yelling and screaming or violence, so it's really important to keep heated arguments away from the kids. On the other hand, children can benefit from seeing parents calmly and appropriately resolve conflict. Lead the group members who have children in their homes through the following discussion questions:

Discussion Questions:

- What have you noticed about your kids' reactions to the anger in your household? What do your kids do or say when you fight?
- How have you tried to keep the kids out of your conflicts? How has this worked?

A. Even if parents THINK they're keeping the arguments "behind closed doors," kids are often perceptive and know when parents are fighting. They may hear the angry words or actual hitting from the other room—or they may hear / see the aftermath of the fights (crying, bruises, flowers, etc.).

B. It can be useful to talk to your children after the angry interaction. During these discussions, it's helpful to emphasize to the children that:

1. They didn't do anything wrong! Because kids often blame themselves for parental conflict, it's really important for parents to reassure kids and make sure they know that it's not their fault.
2. We, your parents, are trying to work things out—and want to get along better. (And we are getting help in order to do so!)
3. Your parents are sorry that you heard / saw their argument.

C. You may also expect that your kids may be especially crabby or needy / clingy after a parental argument. It may be helpful for you to try to spend extra "quality time" with them during these times.

D. Teach and role-model family rules for anger in front of your children. These rules should include:

1. It's OK to be mad.
2. It's NOT OK to hurt yourself, other people, or things.
3. It's always OK to talk about your feelings.

E. If your child appears depressed, withdrawn, or is becoming chronically aggressive or angry, seek professional help.

VI. Coping Strategies for (Adult) Family Members in Dealing with Another Individual's Anger

A. Be prepared.

1. Decide in advance what the limits are regarding your family member's expression of anger. These limits need to be consistently enforced to be effective.
    - Example: I will tolerate my family member raising his/her voice, but I will not put up with swearing or name-calling.
2. Decide in advance the consequences of such a behavior.
    - Example: I will walk away from the discussion if name-calling or swearing begins.
3. Discuss these limits with your family member during a calm time. Clearly and concisely explain the limit without getting into a debate or justifying your rationale.
4. Follow through on the consequence every time. Otherwise, your family member will learn that he/she doesn't have to abide by this limit and will push you the next time.

B. Stay calm and nonjudgmental.

C. Attempt to understand and acknowledge the person's angry feelings. Often, individuals increase their expression of anger when feeling misunderstood. The amount of anger usually decreases when the person feels that the listener is genuinely trying to understand.

D. Choose your words wisely. Avoid generalizations (e.g., "you always…" or "you never…"), as these evoke retorts, counter-attacks, and further tension.

E. Avoid asking too many questions (which can spark defensiveness and further anger).

F. At a calm time, use "I" statements to report your own feelings.
    - Example: "When you yell at me, I feel hurt, and I would really like…."

VII. Time-Out Process

Provider Note: *The following is a valuable skill that can make a significant difference in how people in any committed relationship (couples, parents and adult children, siblings, friends, etc.) resolve conflict. Explain that this skill takes practice, and that the people who are able to implement it in challenging moments are those who have practiced in advance.*

A. Many parents use a time-out process in disciplining their children. Although the discipline strategy and this anger management tool share the common goal of giving each party some time to cool down, the techniques are quite different.

B. This time-out process is a mutually-agreed upon strategy between equals (rather than involving a power differential such as in a parent-child relationship). Further, this technique helps people stop a conflict early in the argument (to avoid further tension), rather than being used as a form of punishment.
C. This is an excellent process to negotiate in advance (during a calm time).

Provider Note: *Distribute Handout 9: "Anger Management – Time-Out Process," and review the process step by step. Have group members role play the time out process in session and encourage them to brainstorm possible obstacles in applying it in their relationships; then, problem-solve possible solutions.*

VIII. Violence in Relationships

A. Threats of physical violence and/or actual violence are very important issues to address in families. Abuse should never be tolerated, as it is damaging to both of you and to your relationship.

B. Domestic violence is very common, as 25% of American couples experience at least one act of physical aggression in their marriages (Bogard, 1984). The FBI estimates that a woman is beaten every 15 seconds in the United States.

C. Most people with PTSD are not violent; in fact, many are quite socially withdrawn. However, research with Vietnam veterans who have PTSD has found that they are at increased risk for perpetrating acts of domestic violence (Jordan, 1992; Riggs, 1997).

Provider Note: *Distribute list of local referrals for domestic violence (example shown in Handout 11: "Referrals for Domestic Violence"). Explain that this list includes 24-hour crisis hotlines and emergency shelters. Shelters provide a safe place to stay, without the guilt of imposing on friends or extended family. Contact numbers for low-cost legal aid and victim protective orders (VPOs) are also listed.*

IX. Hot Thoughts Versus Cool Thoughts

Provider Note: *Discuss that in addition to learning some tools for dealing with anger in others and/or violence in relationships, there is also a lot each of us can do to learn how to manage anger more effectively. One of the best ways of doing this is to monitor the thoughts we have about an event and the impact those thoughts have on our anger levels. Explain that the next portion of the class will focus on strategies for reducing anger by modifying thinking.*

Explain the idea that while certain events may tend to provoke anger, it is really our beliefs about the event that lead to anger. For example, if someone cuts you off in traffic, you are likely to become angry. If you knew that person was racing to the hospital with an injured child, your feeling would probably change from anger to concern. In any situation, we can either reduce or escalate our anger by the way we think about an event. Distribute Handout 10 and work through

the "Hot Thoughts and Cool Thoughts" exercise. The following are examples of situations you can use, or have the class provide their own scenarios:

- It's been a bad day on the job, and the AC is broken in the car.
- Traffic is thick on your way home and your spouse tells you she bounced another check. This will cost $35 you can't afford.

A. What are some "Hot Thoughts" you could run through your mind that will increase your anger?
   1. "This is awful!"
   2. "She's an idiot!"
   3. "We will never get out of debt!"

B. What are some "Cool Thoughts" you could run through your mind and reduce your anger?
   1. "This is not good, but it isn't the end of the world."
   2. "She is not the only person who ever bounced a check…in fact, I've bounced a few myself."
   3. "We have to get a bounce-proof account set up today."

X. Provide Local Treatment Options for Individuals Dealing with Anger Management Issues

Example: Oklahoma City VA Medical Center

A. Anger Management Class

- This 6-week class assists veterans in identifying the triggers for their anger and learning effective ways of expressing this emotion.

B. Couples or Family Therapy

C. Psychiatric Medications

XI. Wrap-Up

- Ask if group members have any questions about the communication or issues discussed in today's class. Discuss questions.
- Ask participants to choose one of the anger management tools presented today and practice it regularly this week.
- 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.

HANDOUT 9

Time Out Process

Why? The goal of a Time Out is to prevent an argument from escalating/getting out of control to the point that either of you later regret your words/behavior. Use of the Time Out procedure is good for both partners, their relationship, and for children/others in the home.

Who? Time outs are helpful to use in relationships that you want to maintain. You would not use them with people with whom you have not already discussed the use of the procedure.

When? Either partner can call a time out **for themselves** if a discussion/argument is starting to feel out of control. You would never tell someone else to "go take a time out!"

Remember: Most people cannot think clearly when angry, so postponing the discussion until a time when both people are calmer is often helpful. As opposed to the old saying, it really IS ok to go to bed angry if you will be able to talk about the issue more effectively the next day!

VERY IMPORTANT: You need to discuss the Time Out process with the other person at a calm time.

Key points to discuss:

1. A mutually agreed-upon signal* for use of time-out

* Best to have a verbal and nonverbal (hand signal) way of communicating need to take a time out

2. When a time out is called, the discussion ends immediately. It is not helpful to persist in trying to get in the last word.

3. The person who called the time out must physically remove him/herself from the room. The partner will not follow the person who is taking the time out.

4. Before leaving for your time out, you need to tell the other person:
    a. What you are going to do
    b. Where you are going (e.g., next room, for a drive, to friend's house, etc.)
    c. When you'll be back (certain number of minutes/hours)

While taking the time out:

It is not helpful to obsess about how angry you feel at the other person during this time…or to call someone else and vent about how "wronged" you have been.

Rather, each person has two tasks during the time out:

1. Do some activity that is calming.

2. Brainstorm possible solutions to the problem. Strive to consider the other's perspective/feelings and what YOU can do to improve the situation.

Upon returning to discuss:

1. The person who called the time out approaches his or her partner (preferably within a few hours – but definitely within 24 hours) with KINDNESS. You may choose to apologize, express affection (hug/kiss), or express hopefulness ("let's try this again"…"we can do better this time'). Remember Dr. Gottman's "softened start-up" research that shows how you START a conversation has a big impact on how it goes.

2. Each person presents his/her solution to the problem, and the other person listens without interrupting.

3. Both people focus on what aspects of the solution will work, rather than focusing on what won't work.

4. Together, the couple chooses parts of both solutions that will make both parties happy.

Note: If tempers rise and another argument is brewing, take another time out!

Local Treatment Options for Veterans Dealing with Anger Management Issues

1. *Anger Management Class*

2. *Couples or Family Therapy*

3. *Psychiatric Medications*

Adapted from presentation by Dan Jones, Ph.D.

HANDOUT 10

Hot Thoughts and Cool Thoughts

EVENT: *Traffic is thick on your way home and your spouse calls to tell you she bounced another check. This will cost you $35 you can't afford.*

What are some "Hot Thoughts" you could say to yourself that will increase your anger?

- "This is terrible!"
- "She is an idiot!"
- "We will never get out of debt!"

What are some "Cool Thoughts" you could say to yourself that will reduce your anger?

- "This is not good, but it isn't the end of the world."
- "She is not the only person who ever bounced a check…in fact I've bounced a few myself."
- "We have to get a bounce proof account set up today."

Think of another event that frequently causes you to become angry or upset:

EVENT:_____

_____

What are some "Hot Thoughts" you could say to yourself that will increase your anger?

- _____
- _____
- _____

What are some "Cool Thoughts" you could run through your mind that will reduce your anger?

- _____
- _____
- _____

HANDOUT 11

Referrals for Domestic Violence

Hotlines:

National Domestic Violence Hotline: (800) 799-SAFE (7233)

- crisis intervention
- information about shelters
- legal referrals
- treatment options

YOUR LOCAL Sexual Assault Hotline: (405) 943-RAPE

Domestic Violence Intervention Services of YOUR AREA: (918) 585-3163

Shelters:

YOUR LOCAL Emergency Shelter: (405) 949-1866
(405) 917-9922

Counseling:

YOUR LOCAL YWCA: (405) 948-1770

- Both individual (sliding scale) and group (free) services are available.

Legal Aid:

Low-Cost Legal Assistance:

- YOUR LOCAL CITY: (405) 521-1302
- YOUR LOCAL COUNTY: (405) 360-6631

Victims Protective Order (VPO):

Affiliated with both the police dept and YWCA:

- Local Contact: _____ (405) 297-1139 (phone)

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.

I. 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.

<u>Discussion Question</u>:

- 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.

HANDOUT 12

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
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. 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

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.

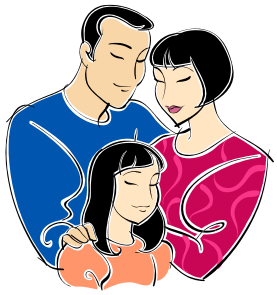
*Material adapted from *Trust after Trauma: A Guide for Relationships for Survivors and Those Who Love Them* by A. Matsakis (1998).

HANDOUT 13

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.



MODULE 5

Depression and the Family

Materials Needed:

- Handout 14: What to Do When a Loved One Is Depressed
- Handout 15: Tips for Managing Depression
- Brochures on local treatment options for veterans/service members with depression

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 previous week.
- Check-in regarding how the previous week's homework went.
- Introduce today's topic of depression, and explain that class will focus on learning more about depression. Ways in which depression can be related to other mental health/relationship issues and coping strategies will be addressed.

I. Symptoms of Depression

Provider Note: *Begin this group session by explaining that depression can manifest itself in many different ways. All human beings feel depressed or down at times; however, the disorder of Major Depression is more than just feeling the "blues" every once in a while. Lead the group in a discussion of the common symptoms of depression.*

Discussion Question:

- What are some symptoms of depression?
    1. Feeling sad, blue, or down
    2. Loss of interest in previously enjoyed activities
    3. Change in appetite or weight
    4. Change in sleep patterns
    5. Feeling tired and fatigued OR feeling restless

6. Feeling worthless or guilty
7. Trouble concentrating, thinking, or making decisions
8. Thoughts of death or suicide

A. The diagnosis of a major depressive episode is made when a person experiences 5 or more of these symptoms that occur nearly every day for at least 2 weeks – with at least one symptom being depressed mood or loss of pleasure in previously enjoyed activities (DSM-IV).

B. Approximately 6.6% of the nation (13-14 million people) suffer from some type of depression every year (Kessler, Berglund, Demler, 2003). It is often called the "common cold" of mental illness. Many famous people have struggled with clinical depression, including television reporter Mike Wallace; British Prime Minister Sir Winston Churchill; Pulitzer Prize-winning newspaper columnist Art Buchwald; and Academy Award-winning actor Rod Steiger.

C. According to a large community study, the lifetime prevalence of major depression in adults is approximately 16%, making it one of the most common psychological disorders. The average duration of an episode is 16 months (Kessler, 2003). For OEF/OIF veterans, researchers have found that between 4 and 38% of returning veterans meet criteria for major depression (Tanielian & Jaycox, 2008).

D. Women who have had at least one episode of depression outnumber men by a ratio of 1.7 to 1. Also, people living in poverty are about 4 times more likely to suffer from chronic depression than more affluent people (Kessler, 2003).

E. Depression also tends to be recurrent, as about 80% of individuals with depression experience another episode within one year (Coryell, 1994).

F. Often an individual with major depression also has another psychiatric disorder. For example, one large study found that almost ¾ of people with major depressive disorder also met criteria for another disorder (commonly, anxiety disorders and substance use disorders) (Kessler, 2003).

G. Due to the very nature of depression (decreased concentration, decreased motivation, social withdrawal, fatigue, etc.), depressed individuals are often less productive in the workforce. In fact, US workers with depression cost employers approximately $44 billion per year in lost productive time (Stewart, 2003). Depression has been described as the leading cause of disability.

H. Depression and PTSD often go together. A large national study found that depression is 3-5 times more likely in people with PTSD then those without PTSD (Kessler et al, 2003).

II. The Impact of Depression on Relationships

Discussion Questions:

- Have you or a family member experienced depression?
- If so, what was the impact on your family life?
- How did your experience with depression affect your view of yourself?

Provider Note: *As you discuss group members' responses to these questions, distribute Handout 14 and be sure to cover the following points:*

A. Depression affects a person's behavior and style of communication (less eye contact, slower and softer speech, negative thinking, reduced problem-solving abilities).

B. Depression is often accompanied by an increase in marital tension and arguments.

C. Depressed people have greater difficulty interacting with others. Therefore, the social life of the couple / family may be altered.

D. Some depressed people are unable to work. Therefore, other family members may have to get a job for the first time or work two jobs to compensate for the reduced income.

E. Family members often become frustrated with the depressed person's behavior, thinking the veteran/service member should just "get over it" or "cheer up."

F. Depressed people often have decreased interest in physical intimacy and sexual activity. Partners often worry that the veteran/service member is no longer physically attracted to them, which can increase the tension in the relationship.

III. Some Notes About Suicide

Provider Note: *Avoid spending too much time on the demographic issues. Spend most of the time in this section on strategies for managing suicidal thoughts or behaviors. As you discuss this difficult topic, help group members realize that they are not alone and that they always have resources to get help. If they don't know what to do in a certain situation, they should call a professional (e.g., suicide hotline, mental health professional, police, or the local hospital). Make these resources available by nothing the* ***National SUICIDE Hotline Number:*** *1-800-SUICIDE, the Veterans Crisis Line, 1-800-273-TALK and the number for the suicide hotline in your local area: (405) 848-CARE, and any other relevant information.*

A. Whenever we talk about depression, it's important to address the issue of suicide. Many people who experience depression think about ending their lives, and some take action to harm themselves.

B. Research has found that individuals with mental illness commit suicide at a rate that is 12 times higher than the general population.

C. The U.S. Army reports that suicides are at a record high.

D. It is very difficult to predict if someone would harm themselves, but there are some red flags that are important to know. A person is at higher risk for suicide if he/she:

- Has a specific plan for how they would kill themselves
- Has access to lethal means (such as weapons, pills, etc.)
- Feels hopeless and worthless
- Has previously attempted suicide
- Talks about killing him/herself (e.g., "everyone would be better off without me")
- Increases use of alcohol or other drugs

E. What do I do if my veteran or family member is suicidal? This can be a scary, difficult situation, so it's helpful to think about what to do during a calm, non-crisis time. You can help the person you care about by doing the following things:

1. **TALK ABOUT IT! Asking about suicide will NOT put ideas in the person's head and will not make the situation worse. Your family member may even feel relieved to be able to talk about it.**

    - Discussing suicidal thinking can be very important, as over half of people who complete suicide communicate their intent in advance, usually to a family member

2. Offer emotional support by:

    a. LISTENING in a nonjudgmental, compassionate manner
    b. Empathizing with their feelings (e.g., "it must be awful to feel that way")
    c. Reminding them of recent accomplishments
    d. Normalizing depression and thoughts of suicide
    e. Expressing your concern, care, and willingness to help

3. **Ask if he or she a plan about how to kill or harm him/herself.**

    a. Seek professional help immediately
    b. Try to get him to make an agreement with you that he will not act on these plans without first talking to you, a hotline, or a mental health professional

c. Put away any objects that she may use to harm herself (guns, knives, pills, razors, etc)

Provider Note: *Remind participants of how to access emergency services at your facility. At our facility, the instructions are as follows:*

Remember the walk-in policy of 8-4pm, Monday-Friday, in our outpatient mental health clinic; after these hours, go to the ER. In an emergency, call 911. If you don't know what to do, call a professional (e.g., suicide hotline, mental health professional, police)

- **Veterans Crisis Line: 1-800-273-TALK**
- **Suicide hotline in Oklahoma City: (405) 848-CARE**

Provider Note*: Distribute Veterans Crisis Line materials (e.g., stress balls, bumper stickers, pens, etc.) to all class members, noting family members can call if concerned about their veterans.*

4. Know that sometimes suicide happens without warning, and nothing can prevent it from occurring. Even with warning signs, there still may be nothing you can do. Ultimately, it's the person's decision if he/she chooses to commit suicide.

Provider Note: *Encourage group members struggling with this issue in their families to consider seeking professional help for themselves. Family members often experience intense anxiety, worry, and feelings of powerlessness when patients make suicidal threats (Jones, Roth & Jones, 1995). Although it is hard to admit, help the group understand that sometimes suicide happens without warning and nothing can prevent it from occurring. Even with warning signs, there still may be nothing they can do.*

IV. Provide Local Treatment Options for Individuals Struggling with Depression

Example: Oklahoma City VA Medical Center

A. Depression Management Class

- This 8-session class consists of two modules addressing issues of: increasing pleasant activities and modifying dysfunctional thought patterns.

B. Individual Therapy through the OEF/OIF Program

C. REACH Project

- This 9-month psychoeducational program provides information and support for veterans living with depression and their family members.

D. Antidepressant Medications

- Primary care providers can prescribe many anti-depressant medications. In addition, psychiatrists in the mental health units have special training in prescribing and monitoring psychiatric medications.
- Antidepressant medications are not habit forming, so people do not have to worry about becoming addicted to the drug.
- Antidepressants are quite effective. Most studies demonstrate at least a 50% decrease in symptoms for approximately 70% of people (Tamminga, 2002).

V. Coping Strategies for Managing Depression

Provider Note: *At various times, people may have a difficult time adjusting to a new situation, coping with a loss or uncertainty or just may feel "blue." Depressed feelings that are persistent and last for more than 2 weeks may mean you are depressed. In these times, self-care, support and possibly professional help are warranted. Emphasize that depression is a treatable condition and that, with proper treatment, most people get better.*

Discussion Questions:

- What are some ideas you have for how people can cope with depression?
- What are some of the ways that you have managed episodes of feeling down or dealing with difficult life circumstances?
- What are some activities that you have enjoyed doing?
- Who is one person you enjoy spending time with?

Provider Note: *Write these answers on the board, then distribute Handout 15 and incorporate the following list of suggestions into the discussion*:

1. Have a Regular Bedtime
    - Sleep disruption is very common for people struggling with depression and can be very challenging to deal with. A regular sleep schedule can help train the body to get restful sleep and make it easier to get out of bed in the morning.
2. Get Daily Exercise
    - Research has proven the importance of daily moderate exercise in reducing depression. You can start small by going for short walks and build up your endurance as you feel better.

3. Manage Stress

    - Develop strategies for coping with difficult circumstances or situations. Practices such as taking time for yourself, deep breathing, meditation, prayer, and other forms of relaxation can make difficult times in life feel more manageable. If you have a religious faith, use it as a resource for managing challenging situations.

4. Avoid Isolation

    - Depression isolates. Social contact and relationships can help break the stronghold of depression. Research has shown that social support can protect people against depression. Ideas include spending time with friends and family that are supportive; joining a sporting team or civic organization; participating in church activities; or volunteering.

5. Keep Your Appointments and Follow Your Providers' Advice

    - Keeping your doctor's and counseling appointments is important for managing your depression. You can't get the benefit of the help being offered if you aren't there to receive it! If you have trouble remembering your appointment dates, ask for a reminder card, and keep all your appointments in one centralized location. Make sure you find a provider you respect, and then follow his or her advice.

6. Record and Report ALL Medication Side Effects

    - Medication management depends on your doctors having accurate information regarding the side effects of the medications you are taking. To make the most of your appointments, try keeping a log of any problems or concerns so that you will be ready to discuss them with your physician.

7. Eat a Healthy Diet

    - Problems with weight gain or weight loss are common for people experiencing depression. In either case, regular healthy meals can help to manage these symptoms. A nourishing diet can help to improve memory and mood.

8. Avoid Taking on New or Difficult Tasks at Work or at Home

    - Go easy on yourself. Avoid taking on stressful new tasks if at all possible. Wait on any major life decisions. Especially if you are engaged in dangerous work, it may be important to talk to a supervisor about your depression.

9. Avoid Alcohol or Illegal Drugs

    - Many people begin drinking or using increased alcohol and drugs during a depressive episode. This initial strategy for managing pain tends to actually make things worse in the long run and can lead to addiction, legal trouble, and other negative consequences. Excessive alcohol or drug use increases the risk of depression. If you believe you may have a substance abuse problem, help is available.

10. Schedule Enjoyable Activities and DO THEM (even if you don't feel like it at first)

    - Research shows that engaging in regular, enjoyable activities reduces depression. Unfortunately, people experiencing depression often are not motivated to engage in these types of activities. However, most people find that once they start doing just a couple of things, they start to feel better and additional activity becomes easier. Make a plan for some fun things you can do that will get you out of the house and active again.

(This material was adapted from *Beating Depression: The Journey to Hope* by Maga Jackson-Triche)

VI. Wrap-Up

- Encourage group members to practice at least one of the tips for managing depression.
- Encourage group members to set a date and time to try a new coping skill.
- Have a discussion about other services available in your community and provide referrals and/or enroll participants in those services. Review information on local treatment options from this and previous modules.
- Answer any questions the group may have.
- 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.

HANDOUT 14

What to Do When a Loved One Is Depressed

DO's:

1. Acknowledge that clinical depression is a legitimate illness. Learn about depression and its impact on the family.

   Some Good Books on Depression:

   - *Beating Depression: The Journey to Hope* (2002).
     — M. Jackson-Triche
   - *What to Do When Someone You Love Is Depressed* (1996).
     —M. & S. Golant.
   - *Overcoming Depression* (1987).
     —D. & J. Papolos.
   - *When Someone You Love Is Depressed* (1996).
     —L. Rosen & X. Amador.
   - *The Feeling Good Handbook* (1980).
     —D. Burns.
   - *I'm Not Alone: A Teen's Guide to Living With a Parent Who Has a Mental Illness* (2006).
     —M.D. Sherman & D.M. Sherman (Available at www.seedsofhopebooks.com)

   Relevant Web Sites:

   - www.depression.com – comprehensive resources about depression
   - www.depressionfallout.com – help for those dealing with depressed loved one
   - www.depressionoptions.com –depression and sexual functioning
   - www.intimacyanddepression.com – examines effects of depression on relationships
   - www.nimh.nih.gov/publicat/depression.cfm – National Institute of Mental Health
   - www.dmda.org – Depression and Bipolar Disorder Alliance
   - www.familyaware.org – Families for Depression Awareness

2. Have realistic expectations (e.g., depression cannot go away overnight) but also maintain hope.

   - New antidepressants and treatment strategies are being studied and released on the market. Many people with depression are able to lead constructive lives. For example, the movie "Patch Adams" starring Robin Williams depicts a young man

admitted to a psychiatric unit due to major depression and suicidal ideation who later becomes a successful physician.

3. Be an active team member in the care of your loved one. Ask questions of doctors, nurses, psychologists, and other health care providers.

4. Offer emotional support, patience, and compassion. Encourage your loved one to exercise and do activities that he/she used to enjoy. Allow your loved ones to care for themselves as much as possible.

5. Stay in contact with your social support network.

6. Obtain professional help for yourself when needed.

7. Maintain good sleep habits, both for you and your loved one (e.g., go to bed and get up at the same time every day; reduce caffeine intake).

8. Make healthy lifestyle choices (healthy diet; regular exercise; avoid use of alcohol).

DON'Ts:

1. Try not to take the depression personally – it's not your fault! You cannot cure depression with love any more than you can cure cancer with love.

2. Don't exclude the depressed person from family discussions or decisions.

3. Don't try to do everything for the depressed person.

4. Don't criticize the person for their depressed behavior or expect him/her to be able to simply "snap out of it."

5. Don't feel that you need to apologize for your loved one.

HANDOUT 15

Tips for Managing Depression

1. Have a Regular Bedtime

    - Sleep disruption is very common for people struggling with depression, and can be very challenging to deal with. A regular sleep schedule can help train your body to get restful sleep and make it easier to get out of bed in the morning.

2. Get Daily Exercise

    - Research has proven the importance of daily moderate exercise in reducing depression. You can start small by going for short walks and build up your endurance as you feel better.

3. Manage Stress

    - Develop strategies for coping with difficult circumstances or situations. Practices such as taking time for yourself, deep breathing, meditation, prayer and other forms of relaxation can make difficult times in life feel more manageable. If you have a religious faith, use it as a resource for managing challenging situations.

4. Avoid Isolation

    - Depression isolates. Social contact and relationships can help break the stronghold of depression. Research has shown that social support can protect people against depression. Ideas include spending time with friends and family that are supportive; joining a sporting team or civic organization; participating in church activities or volunteering.

5. Keep Your Appointments and Follow Your Providers' Advice

    - Keeping your doctor's and counseling appointments is important for managing your depression. You can't get the benefit of the help being offered if you aren't there to receive it! If you have trouble remembering your appointment dates, ask for a reminder card and keep all your appointments in one centralized location. Make sure you find a provider you respect, and then follow their advice.

6. Record and Report ALL Medication Side Effects

    - Medication management depends on your doctors having accurate information regarding the side effects of the medications you are taking. To make the most of your appointments, try keeping a log of any problems or concerns so that you will be ready to discuss them with your physician.

7. Eat a Healthy Diet

    - Problems with weight gain or weight loss are common for people experiencing depression. In either case, regular healthy meals can help to manage these symptoms. A nourishing diet can help to improve memory and mood. Websites such as mypyramid.gov are a great resource for getting information on health eating, as are nutritionists or primary care providers.

8. Avoid Taking on New or Difficult Tasks at Work or at Home

    - Go easy on yourself. Avoid taking on stressful new tasks if at all possible. Wait on any major life decisions. Especially if you are engaged in dangerous work, it may be important to talk to a supervisor about your depression.

9. Avoid Alcohol or Illegal Drugs

    - Many people begin drinking or using increased alcohol and drugs during a depressive episode. This initial strategy for managing pain tends to actually make things worse in the long run and can lead to addiction, legal trouble, etc. Excessive alcohol or drug use increases the risk of depression. If you believe you may have a substance abuse problem, help is available.

10. Schedule Enjoyable Activities and DO THEM (even if you don't feel like it at first)

    - Research shows that engaging in regular, enjoyable activities reduces depression. Unfortunately, people experiencing depression often are not motivated to engage in these types of activities. However, most people find that once they start doing just a couple of things, they start to feel better and additional activity becomes easier. Make a plan for some fun things you can do that will get you out of the house and active again.

(Material adapted from *Beating Depression: The Journey to Hope* by Maga Jackson-Triche)

MODULE 6 – Optional Additional Module

Traumatic Brain Injury

Materials Needed:

- Handout 16: TBI Frequently Asked Questions
- Handout 17: Coping with TBI

Provider Note: *Traumatic Brain Injury (TBI) has been called a "signature wound" of the conflicts in Iraq and Afghanistan. This module is intended to provide some basic information and support for service members/veterans dealing with TBI. We STRONGLY encourage you to access the other neuropsychology or polytrauma resources at your facility to help lead this module and/or to provide information regarding how service members/veterans can access other resources focused on TBI.*

In presenting the FAQ's, remember that even with the fairly didactic style of the presentation, we encourage you to solicit feedback from the group members, answer questions and solicit their experiences of coping with the TBI.

I. Traumatic Brain Injury FAQs

A. What is a traumatic brain injury?

A traumatic brain injury occurs when something outside the body hits the head or the head strikes an object with significant force and causes damage to the brain. In combat, the most common causes are being involved in blasts or explosions, vehicular accidents or crashes, fragment wounds above the shoulder, and falls (VA polytrauma website).

B. What are the symptoms of a TBI?

These vary significantly depending on the type and severity of the injury. Many people have immediate onset of symptoms, but recover relatively quickly. Others may be asymptomatic at first, but develop symptoms at a later time. Some people who experience a head injury do not develop any symptoms afterwards and therefore don't have a TBI.

Mild TBIs may cause symptoms such as:

- Sleep problems
- Fatigue
- Difficulty completing tasks
- Problems with organization

- Trouble making decisions
- Sensitivity to lights and sounds
- Headaches
- Feeling depressed, sad
- Trouble with concentration, memory, and/or attention
- Easily overwhelmed
- Irritable, angry
- Impulsive, outbursts

(Parts adapted from the *Courage to Care: Courage to Talk About War Injuries* website)

Each person's experience of TBI is unique. Some may experience several of these symptoms, while others may experience none. Another significant challenge in diagnosing a TBI is that many of the above symptoms are also symptoms of PTSD and/or depression. This can make it difficult to identify the cause of the symptoms and to provide the appropriate treatment.

C. How are Traumatic Brain Injuries (TBIs) classified? (adapted from the Defense and Veterans Brain Injury Center's website)

TBIs are classified as mild, moderate, or severe. Approximately 3/4 of all brain injuries are mild. Of those returning from Iraq and Afghanistan, the approximate percent of each type of TBI is:

Mild (76%): More commonly known a concussion, most make a full recovery from a mild TBI within minutes to hours after the injury. A small percentage may take up to three months to recover. An even smaller number of veterans have a post-concussion syndrome that persists beyond the usual recovery period of one to three months.

Moderate (16%): Veteran has had a loss of consciousness (of up to 36 hours), and may experience confusion (days to weeks) following the injury. Cognitive deficits can last months or be permanent.

Severe (1%): Veteran has had a significant head injury, and there often are considerable deficits of brain function. Recovery typically occurs over 18 to 36 months after the injury. Some cognitive deficits and behavioral symptoms, including personality changes, may be permanent.

Moderate and severe TBIs cause more serious symptoms than mild TBI, including difficulty with communication (not being able to speak or find correct words), regression (exhibiting childlike behaviors), significant memory loss, seizures, difficulty remembering how to complete basic tasks, inability to take initiative to get things done, impulsivity, inappropriate behaviors, and at its most severe, the inability to move, speak, or initiate tasks.

II. The Impact of TBI on Veterans/Service Members, Caregivers and Family Members

Discussion Questions:

- Which of these symptoms have you dealt with in your family?
- How has the TBI impacted your family life?

Provider Note: *Write the answers the group gives on the board. The following is a list of some of the things you might want to include:*

A. Grief (including anger) related to changes in behavior, expectations, and plans for the future

B. Changes in roles

C. Increase in irritability or conflict in family

D. Loneliness, changes in relationships, sadness

E. Uncertainty about the future and future plans (e.g. having children, career decisions, where to live)

F. More medical appointments and new schedule based on obtaining services

As a family member of someone with a TBI, it is important for you to remember that: "The changes that result from TBI are the direct result of the injury, and not a result of your loved one intentionally trying to act or think in a way that may be different from how he or she used to act and think" (Traumatic Brain Injury A-Z).

III. Coping with TBI

Discussion Question:

- For veterans/service members: What has helped to reduce the frequency or severity of your symptoms?
- For family members: What have you noticed you or your family can do that help to reduce symptom severity?
- What has helped each of you cope with the impact the TBI has had on your lives?

Provider Note: *Help lead group members in discussing both coping strategies they have used as a family AND resources in their community that have been helpful.*
Potential strategies include:

- Joining a support group for people who have experienced a TBI.
- Working as a family to develop schedules and writing these down or keeping them in a planner or in their phone
- Working with medical staff to understand the diagnosis, severity, and treatment plan. This often includes working to understand which providers are particularly helpful and can be allies in navigating the system.
- Focusing on good self-care (diet, sleep, routine, exercise, etc.) for all members of the family.
- Enlisting the support of other military or veteran families, church groups, family members, and/or neighbors.
- Minimizing unnecessary commitments or "time drains"
- Developing a plan for coping with stressful circumstances in advance (how long to stay, ways service member/veteran may be able to excuse themselves from situation, staying only for beginning or end of an event when things are less crowded, etc.).
- Focusing on the relationships and things you most value, while lowering your expectations of yourself for things that are less important.
- Practicing the Do's and Don'ts of managing a TBI:
    - Do:
        - Get appropriate amounts of sleep and rest
        - Set a regular schedule and stick to a daily routine
        - Focus on one thing at a time and reduce distractions while you work
        - Increase activity slowly
        - Write things down or keep a calendar in our phone to help you remember important things
        - Try activities that require fine motor skills and use of strategy (e.g. playing an instrument, games, writing, Sudoku, or crossword puzzles).

- Don't:
    - Participate in contact sports or other activities that could cause another head injury
    - Drink alcohol, use drugs, or excessive amounts of caffeine
    - Use over-the-counter sleep medications

IV. Instillation of Hope

Provider Note: *Coping with a TBI can be very stressful. While it is important to provide facts about the struggles people with a TBI face, it is equally important to remind group members of reasons to hope.*

Discuss that:

- Science is learning a great deal about how best to treat TBIs and support families
- New technology is available that can make a big difference for TBI survivors.
- While recovery can be slow, most people do recover some over time.
- Many resources are available that may be helpful for families living with a TBI. A few of the resources are listed below:
    - *Courage to Care, Courage to Talk About War Injuries.* www.couragetotalk.org/index.php: Educational information for providers and families about TBI and war injury developed by the Center for the Study of Traumatic Stress
    - National Resource Directory: www.nationalresourcedirectory.org: Online tool for wounded, ill and injured troops/veterans & their families, providing access to more than 11,000 services and resources at the national, state and local levels
    - *Picking up the Pieces after TBI: A Guide for Family Members.* A. Sander (2002). http://www.lapublishing.com/blog/wp-content/uploads/2009/08/TIRR-Picking-up-the-pieces.pdf
    - Traumatic Brain Injury: The Journey Home: www.traumaticbraininjuryatoz.org. Created by the Defense and Veterans Brain Injury Center (DVBIC), offers information to caregivers of Veterans/Service members who sustained a TBI
    - Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). http://dcoe.health.mil/
    - Defense and Veterans Brain Injury Center: www.dvbic.org
    - Team Up to Facilitate Functioning (TUFF). Interactive brochures for treatment of postconcussive symptoms in returning Veterans with history of traumatic brain injury. http://www.mirecc.va.gov/VISN16/providers/TUFF.asp

Parts adapted from the *Courage to Care: Courage to Talk About War Injuries* website

HANDOUT 16

Traumatic Brain Injury FAQs

A. What is a traumatic brain injury?

A traumatic brain injury occurs when something outside the body hits the head or the head strikes an object with significant force and causes damage to the brain. In combat, the most common causes are being involved in blasts or explosions, vehicular accidents or crashes, fragment wounds above the shoulder, and falls (VA polytrauma website).

B. What are the symptoms of a TBI?

These vary significantly depending on the type and severity of the injury. Many people have an immediate onset of symptoms, but recover relatively quickly. Others do not experience any symptoms at first, but develop difficulties at a later time. Some people who experience a head injury do not develop any symptoms afterwards and therefore don't have a TBI.

Mild TBIs may cause symptoms such as:

- Sleep problems
- Fatigue
- Difficulty completing tasks
- Problems with organization
- Trouble making decisions
- Sensitivity to lights and sounds
- Headaches
- Feeling depressed, sad
- Trouble with concentration, memory, and/or attention
- Easily overwhelmed
- Irritable, angry
- Impulsivity, outbursts

Adapted from the *Courage to Care: Courage to Talk About War Injuries* website

Each person's experience of TBI is unique. Some may experience several of these symptoms, while others may experience none.

Another significant challenge in diagnosing a TBI is that many of the above symptoms are also symptoms of PTSD and/or depression. This can make it difficult to identify the cause of the symptoms.

Moderate or severe TBIs cause far more significant symptoms, including difficulty with communication (not being able to speak or find correct words), regression (exhibiting childlike behaviors), significant memory loss, seizures, difficulty remembering how to complete basic tasks, inability to take initiative to get things done, impulsivity, inappropriate behaviors, and at its most severe, the inability to move, speak, or initiate tasks. (adapted from the Defense and Veterans Brain Injury Center's website)

As a family member of someone with a TBI, it is important for you to remember that: "The changes that result from TBI are the direct result of the injury, and not a result of your loved one intentionally trying to act or think in a way that may be different from how he or she used to act and think" (Traumatic Brain Injury A-Z).

HANDOUT 17

Strategies for Coping with TBI

- Joining a support group for people who have experienced a TBI.
- Working as a family to develop schedules and writing these down or keeping them on phone in a way everyone can keep track of.
- Working with medical staff to understand the diagnosis, severity, and treatment plan. This often includes working to understand which providers are particularly helpful and can be allies in navigating the system.
- Focusing on good self-care (diet, sleep, routine, exercise, etc.) for all members of the family.
- Enlisting the support of other military or veteran families, church groups, family members, and/or neighbors.
- Minimizing unnecessary commitments or "time drains."
- Developing a plan for coping with stressful or difficult circumstances in advance (how long to stay, ways service member/veteran may be able to excuse themselves from situation, etc.).
- Focusing on the relationships and things you most value, while lowering your expectations of yourself for things that are less important.
- Do:
    - Get appropriate amounts of sleep and rest
    - Set a regular schedule and stick to a daily routine
    - Do one thing at a time and reduce distractions while you work
    - Increase activity slowly
    - Write things down or keep a calendar in our phone to help you remember important things
    - Do activities that require fine motor skills and use of strategy (e.g., playing an instrument, games, writing, sudoku or crossword puzzles)
- Don't:
    - Participate in contact sports or other activities that could cause another head injury
    - Drink alcohol, use drugs, or excessive amounts of caffeine
    - Use over-the-counter sleep medications

References

Adamec, C. (1996). *How to live with a mentally ill person: A handbook of day-to-day strategies*. New York, NY: John Wiley.

Bowling, U.B., & Sherman, M.D. (2008). Welcoming them home: Supporting soldiers and their families in navigating the tasks of reintegration. *Professional Psychology: Research and Practice, 39*(4), 451-458.

Coryell, W., Winokur, G., Shea, T., Maser, J.W., Endicott, J., & Akiskal, H.W. (1994). The long-term stability of depressive subtypes. *American Journal of Psychiatry,151*, 199-204.

Curran, E. (1997). Fathers with war-related PTSD. *National Center for PTSD Clinical Quarterly, 7*(2), 30-33.

Defense and Veterans Brain Injury Center. (2011). TBI Numbers by Severity – All Armed Forces. Retrieved from Defense and Veterans Brain Injury Center Web Site: http://www.dvbic.org/images/pdfs/TBI-Numbers/2009-2010Q4-updated-as-of-17-FEB-2011/dod-tbi-2000-2010Q4-as-of-110217.aspx

Gottman, J. & Silver, N. (2000). *Seven principles for making marriage work.* New York, NY: Three Rivers Press.

Hudson, T. (1996). *Christ-following: Ten signposts to spirituality*. Grand Rapids, MI: Fleming H Revell Co.

Institute of Medicine. (2010). *Returning home from Iraq and Afghanistan: Preliminary assessment of readjustment needs of veterans, service members, and their families.* Washington, DC: The National Academies Press.

Jackson-Triche, M., Wells, K.B., & Minnium, K. (2002). *Beating depression: The journey to hope.* New York, NY: McGraw-Hill Companies.

Jacobson, I.G., Ryan, M. A. K., Hooper, T. I. Smith, T. C., Amoroso, P. J., Boyko, E. J., et al. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *Journal of the American Medical Association, 300*, 663-675.

Jones, S.L., Roth, D., & Jones, P.K. (1995). Effect of demographic and behavioral variables on the burden of caregivers of chronic mentally ill persons. *Psychiatric Services, 46*(2), 141-145.

Jordan, B.K., Marmar, C.R., Fairbank, J.A., Schlenger, W.E., Kulka, R.A., Hough, R.L., et al. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 60*, 916-926.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R., et al. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *Journal of the American Medical Association, 289*(23), 3095-3105.

Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month *DSM-IV* disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 617-627.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52, 1048-1060.

Killgore, W. D., Cotting, D. I., Thomas, J. L., Cox, A. L. McGurk, D., & Koffman, R. L., (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13-22.

Matsakis, A. (1998). *Trust after trauma: A guide for relationships for survivors and those who love them*. Oakland, CA: New Harbinger.

Mental Health Advisory Team (MHAT)-V. (2008). *Operation Iraqi Freedom 06-08 final report*. Office of the Surgeon Multinational Force-Iraq and Office of the Surgeon General United States Army Medical Command. Retrieved from Mental Health Advisory Team Web site: http://www.armymedicine.army.mil/reports/mhat/mhat_v/mhat-v.cfm

Monson, C. M., Taft, C. T., & Fredman, S. J. (2009). Military-related PTSD and intimate relationships: From description to theory-driven research and intervention development. *Clinical Psychology Review, 29*, 707-714.

Moscicki, E.K. (1995). Epidemiology of suicidal behavior. In Silverman, M.M. & Maris, R.W. (Eds.), *Suicide prevention: Toward the year 2000* (pp. 22-35). New York: Guilford.

Riggs, D.S. (1997). Post-traumatic stress disorder and the perpetration of domestic violence. *NC-PTSD Clinical Quarterly, 7*(2), 22-25.

Riggs, D.S., Byrne, C.A., Weathers, F.W., & Litz, B.T. (1998). The quality of intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress, 11*(1), 87-101.

Sayers, S. L., Farrow, V. A., Ross, K., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70, 163-170.

Sayer, N.A., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services, 61*, 589-597.

Shea, M. T., Vujanovic, A. A., Mansfield, A. K., Sevin, E. & Liu, F. (2010). Posttraumatic stress disorder symptoms and functional impairments among OEF and OIF National Guard and Reserve veterans. *Journal of Traumatic Stress*, 23, 100-107.

Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. *Journal of the American Medical Association, 289(*23*)*, 3135-3144.

Tamminga, C.A., Nemeroff, C.B., Blakely, R.D., et al. (2002). Developing novel treatments for mood disorders: Accelerating discovery. *Biological Psychiatry, 52*, 478-502.

Tanielian, T., & Jaycox, L. H. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Arlington, VA: RAND Corporation.

VHA Office of Public Health and Environmental Hazards. (2010). Analysis of VA health care utilization among operation enduring freedom (OEF) and operation Iraqi freedom (OIF) veterans. Retrieved from VHA Office of Public Health and Environmental Hazards Web Site: http://www.acatoday.org/ppt/4thQtrFY09OEF_OIF_HCU.ppt

Woolis, R. (1992). *When someone you love has a mental illness: A handbook for family, friends, and caregivers*. New York, NY: Jeremy Tarcher / Putnam.