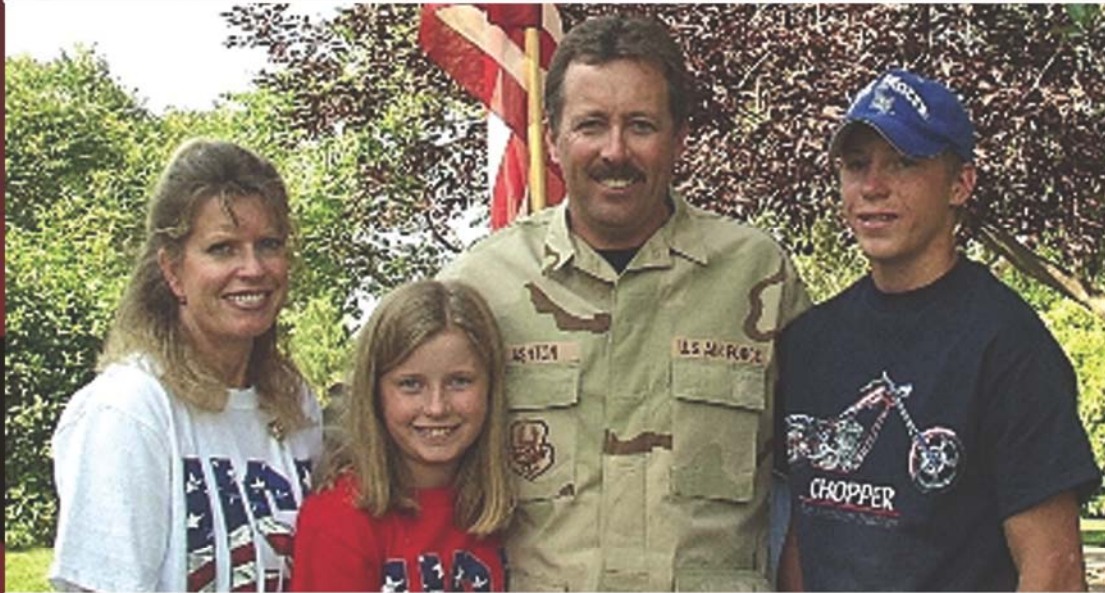


OPERATION ENDURING FAMILIES

INFORMATION AND SUPPORT FOR IRAQ &
AFGHANISTAN VETERANS AND THEIR FAMILIES



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

by
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Alan Doerman, Psy.D.
Michelle Sherman, Ph.D.

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 Veterans

Since September 11, 2001, more than 1 million American troops have been deployed to the Global War on Terror. 430,000 of these troops have now separated from the military, and 119,000 have come to the VA system. More than 1/3 of deployed soldiers have served at least 2 tours in a combat zone. Not since the Vietnam War has such a large group of soldiers returned from combat (DOD website).

The men and women serving in Iraq and Afghanistan face a range of difficult and stressful situations. A recent study by Hoge (2004) found that in a survey of 894 Army soldiers from Iraq: 95% observed dead bodies or human remains, 93% were shot at or received small-arms fire, 89% were attacked or ambushed, 65% observed injured or dead Americans, and 48% were responsible for the death of an enemy combatant.

Recent research suggests that the returning soldiers are facing a range of adjustment difficulties and mental health issues including PTSD, depression, substance abuse, and relationship difficulties. A study of 1,700 Army and Marine soldiers back from Iraq found that 15-17% of soldiers met criteria for major depression, generalized anxiety disorder, or PTSD, and 24-33% of soldiers admitted to using more alcohol than they meant to. In addition to those veterans who develop a mental illness following a deployment, many more veterans face adjustment reactions. While these problems often resolve on their own, they can be stressful for the returning veterans and their family. Often veterans report feeling anxious, having difficulty connecting to others, struggling with sleep problems, and missing the structure and camaraderie of military service. Educating veterans about these normal

reactions and normalizing their experience can be helpful in supporting veterans settle back into life at home. Many veterans are interested in seeking services to support them in reintegration. Although one study found that while stigma continues to be a barrier to receiving care, an average of 35% of veterans who served in Iraq have sought some type of mental health care within the first year of homecoming (Hoge, 2006).

Including Families

The 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 observation that many of the issues facing returning soldiers are relational and 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 veteran and his/her family members. Family members are included in treatment for two 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 soldier 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.

Public policy leaders are beginning to recognize the importance of including families in mental health care. The President's Freedom Commission on Mental Health Care requires

that “mental health care is consumer & family driven” and recommends that providers “reduce barriers to working with families.” Operation Enduring Families attempts to integrate and welcome family members into the VA system and to provide them with helpful resources in supporting their veteran.

Reducing Barriers to Care

Many returning 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 veterans and their families can discuss their concerns. Our hope is that by providing such a group, veterans will be more likely to attend and to begin to access the services available to them through the VA and other community agencies. It is also important that those developing a group select a time and location that is feasible for veterans and their families who work. We have found that evening classes are far more accessible and better attended than those held during work hours.

PUBLICITY EFFORTS

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 patients 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 OIF/OEF 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 are regularly made in other mental health programs serving OIF/OEF veterans.
4. Flyers are posted throughout the medical center and brochures are distributed to all appropriate clinics before the start of each group.

Program Information for VAMC Providers and Other Referral Sources

1. Informational 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 have been published in various newsletters, including the state psychological, psychiatric, and social work associations.
4. Pamphlets, flyers, and informational packets for returning veterans have been 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 are 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

OPERATION ENDURING FAMILIES INVITATION LETTER

Insert Date Here

Dear _____

Greetings from the Oklahoma City Veteran's 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
- Creating a low-stress environment

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 (**405-270-5183**). 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

OPERATION ENDURING FAMILIES

ARTICLE FOR MENTAL HEALTH NEWSLETTERS

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 to the Middle East 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; 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 OIF/OEF 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) 270-5183 if you have any questions. Patients who want to learn more about the program may also be given Dr. Bowling's name to contact her directly.

POSTING FOR VA NEWSLETTER

Operation Enduring Families, a support and information group for returning veterans and their families, begins Thursday, July 5th @ 5:00 pm. Veterans and/or their family members are invited to participate. Groups will meet every Thursday from 5-6:15 pm. For more information please contact Dr. Ursula Bowling at (405) 270-5183.

OPERATION ENDURING FAMILIES

GOALS OF THE OPERATION ENDURING FAMILIES PROGRAM

1. To provide information to veterans and their family members about the common experiences of veterans returning from combat and to help normalize their experiences.
2. To provide resources and coping tools for veterans and their families who are adjusting to life after a deployment. To assist veterans and families with the common challenges that arise in reintegrating into the civilian community.
3. To provide an atmosphere where veterans and their families can support and encourage each other.
4. To link 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 consists of 2 sessions lasting 1.5 hours. There are 2 additional 1.5 hour sessions for family members only. Each session can stand alone, and the order of the presentation of sessions can be varied according to participants' needs. Further, all the sessions do not need to be presented, as facilitators can select topics that are relevant to their client's needs.

Frequency of Sessions

The program is designed to have bi-monthly meetings. The first meeting of the month is for veterans and their families. The second meeting of the month is for family members only. However, we encourage facilitators to modify the session frequency to best serve the needs of the specific veterans they serve.

Participants

The group is open to all returning veterans from the wars in Iraq and Afghanistan, as well as their family members or close friends. The individual does not have to be biologically related to the patient. Mature adolescents may attend the workshops. Veterans and their families are encouraged to attend the classes together, but veterans can attend the workshops without their families, and family members can attend even if their veteran chooses not to participate.

Facilitators

If at all possible it is recommended that at least 2 providers co-facilitate this group, as several activities in the curriculum require breaking up into smaller groups.

Logistics

Participants are not obligated to attend every session. The group has an open format, such that new group members can begin at any time. 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 veterans and their families. There is no cost to attend the sessions.

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)
2. “Welcome to Operation Enduring Families” (Handout A)
3. “Resource List of OIF/OEF Veterans and Their Families (Handout B)
4. “Operation Enduring Families Evaluation Form” (Handout C)
5. “Operation Enduring Families Background Information Form” (Handout D)
6. Flyers and pamphlets
7. Group reminder cards for next group
8. Family resource library (books and videotapes family members and veterans can borrow)
9. List of treatment options available at your facility should other services be recommended
10. Pens
11. Nametags
12. Box of Kleenex
13. Refreshments

OVERVIEW OF THE PROGRAM SESSIONS

Materials Needed:

- Handout A: “Welcome to Operation Enduring Families”
- Handout B: “Resource List for OIF/OEF Veterans and Their Families”
- Handout C: “Operation Enduring Families Evaluation Form”
- Handout D: “Operation Enduring Families Background Information Form”

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

I. Introduction and Welcome

- A. Introduce facilitators.
- B. 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).
- C. 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.
- D. Distribute Handout A: “Welcome to Operation Enduring Families”
 1. Review program goals.
 2. Review group guidelines, especially confidentiality.
- E. Encourage participants to ask questions at any time during the workshop.
- F. Emphasize the importance of mutual respect for each other. Note that each participant has a unique situation.
 1. Service members and their families are the focus of this group.
 2. Some people are here with their family members, while some are not.
 3. There are families and service men and women here from different branches of the military, from the Reserves, and from the Guard.
 4. People may have returned recently from a deployment or may have been back for some time.
 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 difficulty 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.
- G. 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.

II. Recognition of Group Members

- This group is unique in that our members are veterans as well as their families and friends.
- 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 outline session for specific guidelines (**Leader's 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 relevant to the needs of their participants*).

V. Review of Handouts in Participant Notebook

- Handout B: "Resource List for Veterans and Their Families"
—Review the various books, internet sites, and community resources available
- Other Handouts (optional):
—Distribute and discuss specific informational handouts related to the material being covered that day.

VI. Resource Library

- Explain available resources (books, videos, etc.) that participants may check out. Distribute a list of available books and tapes that participants may enjoy.

VII. Program Evaluation

- Express the commitment to make improvements in this series to better meet participants' needs. Ask all participants to complete the brief evaluation form regarding the session (see Handout C).

VIII. Closing

- A. Solicit any reactions from today's workshop.
- B. Re-emphasize the importance of self-care and communication.
- C. Remind participants of next week's topic and date.
- D. Note availability of a short time after workshop for individual questions.
- E. Reemphasize confidentiality.
- F. Thank each participant for coming.

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 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 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.
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 this with the facilitators immediately following today's session.

RESOURCE LIST FOR OIF/OEF VETERANS AND THEIR FAMILIES

Compiled by Michelle D. Sherman, Ph.D. (Revised 6/07)

BOOKS (available at amazon.com unless otherwise noted)

For Veterans / Soldiers (and Families)

- *Courage After Fire: Coping Strategies for Returning Soldiers and Their Families* (2006).
—Keith Armstrong, Suzanne Best, Paula Domenici
- *Down Range: To Iraq and Back* (2005).
—Bridget Cantrell, Ph.D., Chuck Dean

For Families

- *My Love, My Life: An Inside Look at the Lives of Those Who Love and Support Our Military Men and Women* (2004).
—Dianne Collier (of Canada)
- *Heroes at Home: Help and Hope for America's Military Families* (2002).
—Ellie Kay
- *Trust After Trauma: A Guide to Relationships for Survivors and Those Who Love Them* (1998).
—Aphrodite Matsakis

For Kids & Teens

- *Daddy, You're My Hero! // Mommy, You're My Hero!* (2005).
[for kids ages 4-8]
—Michelle Ferguson-Cohen
- *Uncle Sam's Kids: When Duty Calls* (2003).
[for kids ages 5-11; focusing on deployment issues]
—Angela Sportelli-Rehak
- *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)

WEBSITES

General

- *National Center for PTSD*
—www.ncptsd.org
- *Military OneSource*
—www.militaryonesource.com
- *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 or PTSD. Entire curriculum is available for free download on website.
—www.ouhsc.edu/safeprogram
- *Mental Health Self-Assessment Program*
—DOD sponsored anonymous mental health / alcohol screening and referral program offered to families and service members affected by deployment or mobilization – available online 24/7
—www.MilitaryMentalHealth.org
- *VA's Seamless Transition Office*
—www.seamlesstransition.va.gov
- *My Health Vet: The Gateway to Veteran Health and Wellness*
—www.myhealth.va.gov

Focus on Soldiers / Veterans (Post-Deployment)

- “Returning from the War Zone: A Guide for Military Personnel”
A National Center for PTSD Fact Sheet
—www.ncptsd.va.gov/war/guide/GuideforMilitary.pdf

Emotional Responses:

- “When the Letdown Doesn’t Let Up”
National Mental Health Association
—www.nmha.org/reunions/infoLetdown.cfm
- “How to Get Back to ‘Normal’”
National Mental Health Association
—www.nmha.org/reunions/infoBacktoNormal.cfm
- “Help for Veterans with PTSD”
A National Center for PTSD Fact Sheet
—www.ncptsd.va.gov/facts/veterans/fs_help_for_vets.html

Employment Issues:

- “Information Specific to National Guard and Reserve Personnel and Their Employers”
A National Center for PTSD Fact Sheet
—www.ncptsd.va.gov/facts/veterans/fs_info_ngrsvspecific.html
- “Returning to Work: Tips for Service Members and Employers”
National Mental Health Association
—www.nmha.org/reunions/infoReturnWork.cfm

Parenting:

- “Reconnecting With Your Children”
National Mental Health Association
—www.nmha.org/reunions/infoChildren.cfm
- “Healthy Parenting Initiative”
Military HOMEFRONT (DOD)
—www.militaryhomefront.dod.mil

Focus on Families

- *National Military Family Association*
—www.nmfa.org
- *National Guard Family Program*
—www.guardfamily.org
- *Operation Healthy Reunions* (part of the National Mental Health Association)
—www.nmha.org/reunions/index.cfm
- *TAPS* (Tragedy Assistance Program for Survivors). [Includes camp for kids.]
—www.taps.org
- *Deployment Effects on Child and Adolescent Mental Health*
—www.aap.org/sections/unifserv/deployment/index.htm

Post-Deployment:

- “Homecoming Preparedness for Veterans and Families: A Self-Help Guide to Ease the Transition from Deployment and the Military to Civilian Life”
Veterans and Families Homecoming Support Network
—mrs.marketingresultsgroup.com/ClientFiles/38FD2B5A75F34F31.pdf

- “Being a Couple Again”
National Mental Health Association
—www.nmha.org/reunions/infoCouple.cfm
- “A Soldier and Family Guide to Redeploying”
DOD Deployment Health Clinical Center
—chppm-www.apgea.army.mil/deployment/FamilyReunionTrifold19Dec03.pdf

Focus on Adult Family Members

Post-Deployment:

- *Deployment Guide for Families of Deploying Soldiers: Separation and Reunion Handbook.*
—www.hooah4health.com/deployment/familymatters/reunion.htm
- *Returning from the War Zone: A Guide for Families*
—www.ncptsd.va.gov/war/guide/GuideforFamilies.pdf

Focus on Youth

- *Guard Family Youth Website*
—www.guardfamilyyouth.org

OTHER

- *Operation Purple: Free Summer Camps for Military Kids*
[Funded through the Sears American Dream Campaign]
—www.operationpurple.com
- *Turning Your Heart Toward Home Workbook* (curriculum)
[A class for war veterans and their families by Bridget Cantrell, Ph.D.]
—www.heartstowardhome.com/workbook.htm

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):

Participant Name: _____ **Date:** _____

Please circle the number for each question that describes how you feel now. These questions ask about how much you understand 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 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

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: | <u>1</u> | 2 | 3 | 4 | <u>5</u> |
| | Poor | | Average | | Excellent |
| 2. Style of Presenter: | <u>1</u> | 2 | 3 | 4 | <u>5</u> |
| | Poor | | Average | | Excellent |
| 3. Relevance of topic for you | <u>1</u> | 2 | 3 | 4 | <u>5</u> |
| | Poor | | Average | | Excellent |
| 4. How much new information did you gain from this workshop? | <u>1</u> | 2 | 3 | 4 | <u>5</u> |
| | Poor | | Average | | 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 Deployment”

Materials Needed:

- Handout 1: “What the Returning Service Member 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”

Leader’s Guide: *Today’s group 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 second session will focus on reviewing the information presented in Week One and further discussing how to apply it.*

I. Understanding the Returning Soldier



Discussion Questions (for the veterans):

- What did you do to cope during the deployment?
- What did you do to cope with the adjustment when you came back?

Leader’s Guide: *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. Service members work long hours without significant breaks or “down time.”
- B. The deployment involved difficult work and enormous responsibility, with very few breaks or time to relax.
- C. On dangerous deployments, soldiers form extremely strong bonds with their fellow service members. 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. The returning family member may seem preoccupied with the experience of their deployment. They may be unable to talk about it or may excessively talk about it.
- E. The returning family member may have suffered physical or emotional injury or disability.
- F. The veteran may expect extra attention and support for some time after their return.
- G. The returning family member may have serious concerns about their financial or employment future. Many veterans left behind their jobs and careers, and may continue to worry about their employment prospects after returning.
- H. 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, seen the death or injury of other soldiers, the enemy, or civilians.

II. Understanding the Adult Family Members Who Stayed Home



Discussion Questions (for the family members):

- What did you do to cope during the deployment?
- What did you do to cope with the adjustment when your family member came back?

Leader's Guide: *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. They have adjusted to assuming additional work, making household decisions on their own, 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 their partner. These changes may come as a surprise to the returning family member.
- C. The adult at home may feel ambivalent about giving up some of the freedom and responsibilities they had while the service member was deployed. They may not want to return to their previous role, and may want to maintain their increased independence.
- D. The family member at home had to live with significant anxiety and uncertainty while their significant other was deployed.

Leader's Guide: Break the group into two, a group of veterans and a group of their family members. Have each group choose a secretary. Have them write down a list of what they can do to be supportive of their family member. 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.

III. “Caring Behaviors Exercise”

- Showing caring behaviors towards our family members is one of the most important things we can do to strengthen and build relationships. Caring behaviors are simple, meaningful behaviors that express our love for our family members. These behaviors do not have to be complicated or elaborate, but they should be consistent and thoughtful.

Leader's Guide: Distribute Handout 3: “Caring Behaviors Exercise” worksheet. Ask each person to write down a few simple behaviors that their 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 trade lists with their family members. If group members are there without their family members, encourage them to share this activity with their family member 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

Leader's Guide: 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' 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.

Ask those who have some regular time with children to state the ages of the children they know. As you discuss each of the developmental stages of children and common reactions, ask the group members to first predict what behavioral changes they would expect. Write these down on the board and praise group members for their awareness of children's behavior under stress.

V. Understanding the Children

- A. Children generally are excited about a reunion with their returning parent. However, the excitement of the reunion is stressful for children. Children may also 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.
- 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:
 - 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 parent was somehow their fault, and may need reassurance that the absence is not their fault. Children at this age are also likely to "test the limits." Children this age thrive on consistency and structure.
 - 4. School age children (6-12 yrs) are far more aware of the realities behind their parent leaving and the potential dangers of deployment. During deployment, they may have been more irritable, whiny, or sullen. They may have difficulty adjusting to the return of their parent 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 was with 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 parent's 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.

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?

Leader's Guide: *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 their family member is/was, read them children's books about deployment, etc.
- B. Continue family traditions, discipline, and structure.
- C. Monitor children's exposure to media exposure about the war.
- 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 child at their level, through their activities.

Leader's Guide: *Distribute Handouts 4 & 5 to the group members. Ask that the group members complete the "Caring Behaviors Exercise" this week with a family member with whom they interact on a regular basis.*

“What the Returning Service Member 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 spouse 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 the best they could 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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-
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“What Family Members 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. They may have difficulty describing their feelings or experiences, or they may want to talk about their experience quite a bit. Either way, do your best to allow your partner time to settle back into their 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) Couples may find the deployment has strained their 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 provided support and service to the family during the deployment. They may have difficulty redefining their role with the family after the veteran’s return.
- 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 veteran’s 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. An adult at home may have become more independent. Be aware that this can be difficult for a returning service member to adjust to.
- 11) Your spouse may be a little hurt by how well you did in their absence. Make sure they know that you missed them and that you are happy to have them 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.

Other ideas from my group:

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“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.

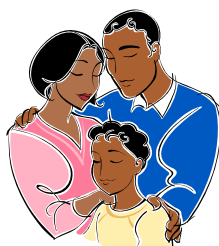
TIPS: *** Take the first risk! ***

*** 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. _____



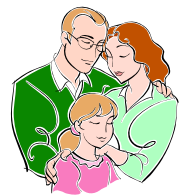
“Understanding and Supporting the Children in Your Life”

- 1) Children generally are excited about a reunion with their returning parent. However, the excitement of the reunion is stressful for children. Children may also 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.
- 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:
 - 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 parent, 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 parent was somehow their fault, and may need reassurance that the absence is not their fault. Children at this age are also likely to “test the limits.” Children this age thrive on consistency and structure.
 - School age children (6-12 yrs) are far more aware of the realities behind their parent leaving and the potential dangers of deployment. During deployment, they may have been more irritable, whiny, or sullen. They may have difficulty adjusting to the return of their parent 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 was with 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.
 - Teenagers (13-18 yrs) may be rebellious, irritable or challenging of their parent’s 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.



Questions to Consider:

- 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 them?



“Parenting Tips”

- 1) 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 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 child at their level, doing the activities they most enjoy.



MODULE 2

“Communication Tips for Post OIF/OEF Family Members & Veterans”

Materials Needed:

- Handout 6: “Communicating With Your Loved One”
- Handout 7: “Practicing ‘I’ Messages”
- Handout 8: “Softened Start-up”
- Handout 9: “Listening Exercise”

Books:

- *Messages: The Communication Skills Book* (1995).
—McKay, Davis & Fanning
- *Couple Skills: Making Your Relationship Work* (1994).
—McKay, Fanning & Paleg
- *Ten Lessons to Transform Your Marriage: America’s Love Lab Experts Share Their Strategies for Strengthening Your Relationship* (2006).
—Gottman, Gottman & Declair
- *Why Marriages Succeed or Fail: And How to Make Yours Last* (1995).
—Gottman
- *The Seven Principles for Making Marriage Work: A Practical Guide from the Country’s Foremost Relationship Expert* (1999).
—Gottman
- Brochures on local treatment options for individuals who wish to improve their communication skills.

Leader’s Guide: *Today’s group focuses on developing and improving communication skills. The first portion of the module is a discussion of the importance of communication skills, while the second portion focuses veterans and their families on learning some specific communication tools.*

I. The Importance of Communication Skills



Discussion Question:

- Why should we work on improving our communication skills?

Leader's Guide: 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 OIF/OEF 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, 37).

Leader's Guide: Ask family members and veterans to discuss what they think about this statement: "The most healing gift..." Do group members agree? Disagree? What does it mean to the group?

- E. Research has revealed that families who learn and use good communication skills can significantly reduce the amount of time that the veteran is likely to spend in treatment (Falloon, 1982; Lam, 1991).

II. Understanding the OIF/OEF Experience and Its Impact on Communication

Leader's Guide: 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 OIF/OEF veterans (material adapted from Woolis, 1992):

Issue #1: Sometimes the post OIF/OEF veterans withdraw (physically and/or emotionally) due to feeling over-stimulated. They may have a limited 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 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 OIF/OEF 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 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 may not go to an event, but the family member still can or you may agree to go for a short time.

Issue #3: Veterans may have an impaired ability to express emotions. Consequently, they 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 OIF/OEF adjustment process rather than as a reflection of some sort of relationship problem or some wrongdoing on their part.

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: Although veterans should be held responsible for their behavior and face appropriate consequences, family members can recognize the heightened emotionality as a symptom of the illness (PTSD) and try not to take it personally.

Issue #5: The National Center for PTSD recommends both responsible assertiveness and interpersonal communication (talk about it).

Family Member Tip: Remember assertive communication is HARD (honest, appropriate, respectful, and direct).

Issue #6: People with PTSD can create and maintain successful intimate relationships with dedication, perseverance, hard work, and commitment.

Family Member Tip: Share feelings honestly and openly with an attitude of respect and compassion; continually strengthening cooperative problem-solving and communication skills and assist your OIF/OEF veteran in establishing a personal support network that will help him/her cope.

Issue #7: OIF/OEF 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 #8: 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



Discussion Question:

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

Leader's Guide: *Distribute Handout 6: "Communicating With Your Loved One" and discuss/explain the following points to facilitate effective communication:*

DOs

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; consequently, focusing on their behavior and emotional state 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. Remind the veteran that they are not alone and many people have had similar feelings. If appropriate, share a time when you felt the same way.
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 OIF/OEF 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.

IV. Specific Skill and Role Play: “I” Statement

Leader’s Guide: *One specific tool for making a direct communication is 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 _____.” Give examples such as:*

- When you don’t let me know where you are going, I feel...
- When you don’t let me in on what you are thinking and feeling, I feel...
- When you threaten me, I feel...
- When you sleep all day, I feel...

A. Advantages of using the “I” statement

1. These messages get the listener’s attention. Individuals often become overly self-involved and may be unaware of other family members’ 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.
4. You’re modeling good communication of feelings for your spouse.

B. Various uses of the “I” statement

1. To make a request
 - Example: “I want you to go to the PTSD treatment program. When you have a structured schedule, I feel relieved and proud of you.”
 - People feel motivated to do what you ask when you express pride in them.
2. To give praise
 - Example: “When you clean up the house, I feel happy.”
 - Praise strengthens the relationship and increases the likelihood that the individual will do the behavior again in the future.
3. To express negative feelings
 - Example: “When you don’t talk to me I feel sad, left out, and worried.”
 - Family members often feel quite frustrated with their loved ones, and they may express their irritation in destructive ways (e.g. “You aren’t even trying to help yourself!” or “You’re just going to end up back in the hospital again if you keep this up!”).
 - The “I” message redirects the focus back to the family member’s concern about the patient’s behavior.

4. To ask the individual to change his/her behavior
 - You need to include three parts when giving this form of feedback:
 - a. exactly what the person did
 - b. how you feel about the behavior
 - c. how you would like him/her to behave in the future
 - Example: “When you left the kitchen a mess last night, I felt irritated. I would feel happy if you would put the dishes away and wipe off the counter.”
5. Use of the “I” statement is truly “easier said than done.” Family members benefit from practicing the skill in various situations. Family members have reported success in using this skill in various relationships (with friends, children, co-workers, other family members, etc.).

Leader’s Guide: *Distribute Handout 7: “Practicing ‘I’ Messages.” Have participants get a partner and complete the worksheet together. When participants are finished, return to the large group and discuss participants’ reactions. Encourage participants to share this activity with other family members and to practice this skill.*

V. Alternate Activity: “Softened Start-up Exercise”

Leader’s Guide: *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. The current research (Gottman) 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 the classic "I feel _____" ...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 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 in 1989. "Gunny sackers" carry around a bag full of errors their significant other committed over the past years – they pull them out whenever they are disgruntled about any issue past or present.
9. Sandwich technique – end with something pleasant.

Leader's Guide: *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. Alternate Activity: "Listening Exercise"

Leader's Guide: *Pass out copies of Handout 9: "Listening Exercise" and distribute small pieces of carpet to represent "the floor" while leading the group through the following instructions:*

1. Think of a recent book, TV show or movie you enjoyed. Everyone have one in mind? (*Make sure everyone gives you a head nod. Sometimes, someone will not be able to think of a book, TV show or movie, so you can prime the pump by suggesting: a favorite story from childhood? A fairy tale? A Bible story you enjoyed?*). Designate a Person "A" and a Person "B" for this exercise.
2. Now, get knee to knee with your family member.
3. Person A, please take the carpet square – you are the first holder of "the floor."
4. When I say "start," Person A will have 90 seconds to describe the book, TV show or movie they enjoyed.
5. Person A holds the floor – so they speak and Person B listens. Person B, when you listen – do so with both your eyes and ears. What I mean is listen and observe both the verbal and non-verbal (Body, Eyes, Affect, Voice) message. (*Review directions a second time to be sure everyone comprehends. Make sure all heads nod to confirm they have the picture.*)
6. Please start. (*Look at your watch. Give them about 90 seconds. If someone is mid-sentence, you can give more time, or if the action has dried up at 80 seconds feel free to stop earlier.*)

7. Please stop. Good work. Now, Person A, please hand over the “floor” to your partner.
8. Person B, in a moment when I say “start,” your assignment is to share with your partner what you heard him or her say – tell them what words you heard and what you observed non-verbally (Body, Eyes, Affect, Voice). Does that make sense? (*Pause to look for nods.*) You will have 90 seconds. Person A, you are only listening now – no talking please.
9. Ready. Please start. (*Again, give them about 90 seconds. If someone is mid-sentence, you can give more time, or if the action has dried up at 80 seconds feel free to stop earlier.*)
10. Please stop. Excellent. Person A, how did they do? Did they capture the major points of your message? Did they observe and report on your non-verbals? (*You do not have to solicit input from every couple, but you do want to give everyone a chance to speak if they like.*)
11. Very good. Now we will give Person B a chance to talk about a recent book, TV show or movie you enjoyed. Everyone have one in mind? (*Make sure everyone gives you a head nod. Occasionally, someone will not be able to think of a book, TV show or movie – prime the pump by giving suggestions: a favorite story from childhood? a fairy tale? or a Bible story you enjoyed?*)
12. Person B, please hold on to the carpet square – you are the holder of “the floor.”
13. When I say “start,” Person B will have 90 seconds to describe the book, TV show or movie they enjoyed.
14. Person B holds the floor – so they speak and Person A listens. Person A, when you listen – do so with both your eyes and ears. What I mean is listen and observe both the verbal and non-verbal (Body, Eyes, Affect, Voice) message. (*Review directions a second time to be sure everyone comprehends. Make sure all heads nod to confirm they have the picture.*)
15. Please start. (*Look at your watch. Give them about 90 seconds. If someone is mid-sentence, you can give more time, or if the action has dried up after 80 seconds feel free to stop earlier.*)
16. OK, please stop. Good work. Now, Person B, please hand over the floor to your partner.
17. Person A, in a moment when I say “start,” your assignment is to share with your partner what you heard him or her say – tell them what words you heard and what you observed non-verbally (Body, Eyes, Affect, Voice). Does that make sense? *Look for nods.* You will have 90 seconds. Person B, you are just listening – no talking please.
18. Ready. Please start. (*Again, give them about 90 seconds. Feel free to shorten or extend the time as needed.*)
19. Please stop. Excellent. Person B, how did they do? Did they capture the major points of your message? Did they observe and report on your non-verbals? (Body, Eyes, Affect, Voice) (*You do not have to solicit input from every couple, but be sure to give everyone a chance to speak if they like.*)

Recommended Bibliography on Communication Skills

- *Messages: The Communication Skills Book* (1995).
—McKay, Davis & Fanning
- *Couple Skills: Making Your Relationship Work* (1994).
—McKay, Fanning & Paleg
- *Ten Lessons to Transform Your Marriage: America's Love Lab Experts Share Their Strategies for Strengthening Your Relationship* (2006).
—Gottman, Gottman, and Declair
- *Why Marriages Succeed or Fail: And How to Make Yours Last* (1995).
—Gottman
- *The Seven Principles for Making Marriage Work: A Practical Guide from the Country's Foremost Relationship Expert* (1999).
—Gottman

“Communicating with Your Loved One”



DOs:

- 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 behavior and emotional state 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 OIF/OEF adjustment and may have nothing to do with you.
- 8) Do not allow or engage in physical violence.

Other ideas from my group:

-
-

“Practicing ‘I’ Messages”

FORMAT OF “‘I’ MESSAGE” = “WHEN YOU _____, I FEEL _____”

The purpose is to tell someone how you feel about his/her behavior without degrading, accusing, or arousing anger in the other person.

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 you don't come home on time, I feel _____
3. When you are rude to me in front of your friends, I feel _____
4. When I am sick and you take care of me, I feel _____
5. When you clam up and won't talk, I feel _____
6. When you listen to me when I'm upset, I feel _____
7. When I'm talking to you and you turn on the television, I feel _____
8. When you yell at me, I feel _____
9. When you talk about our special memories, I feel _____
10. When you make dinner for me, I feel _____
11. When you criticize me, I feel _____
12. When you keep the house clean, I feel _____
13. When you stay to yourself and don't interact with the kids and me, I feel _____
14. When you fuss and fume over some minor issue, I feel _____
15. At night when you can't sleep, I feel _____
16. When we don't socialize the way I would like, I feel _____

“Softened Start-up”

Background: All families have “touchy or sensitive” issues that need to be addressed. The current research (Gottman) 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 _____”...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 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 in 1989. “Gunny sackers” carry around a bag full of errors their significant other committed over the past years – they pull them out whenever they are disgruntled about any issue past or present.
- 9) Sandwich technique – 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: _____

“Listening Exercise”

Background

It is easy to forget how important it is to simply listen to our significant others. There is a sweetness in knowing that another human being has truly understood us. Not that they are going to solve our problems or come up with a fix. Just that they have listened and understood. Research supports the benefits of using this listening technique in families who want to improve their “good times” communication.

Listening is not easy. It takes a lot of concentration and energy to focus on another with all your attentive powers.

The holder of “the floor” does most of the speaking while the non-holder practices listening.

A speaker should remember the magical number: “seven plus or minus two.” That means that on average a human being can remember seven ideas in one batch. On a good day the average person may stretch it to nine. On a bad day it may fall to as few as five. The message you should take home is: don’t overload your listener. Try to keep each batch of information to somewhere between five and seven ideas. When you describe a TV show you enjoyed – cut it down to five major points. Do not go on and on and on – you will overwhelm your listener.

Beyond hearing and remembering the major points it is important to consider how the message was delivered.

20/80 Rule:

20% of what is communicated is verbal,
80% of what is communicated is non-verbal.



Remember “Leave it to Beaver?” Wally (the older brother) used to call his younger brother, “BEAV.”

BEAV is a good way to remember the non-verbal elements of communication:

B – Body – posture, hands, arms, gestures

E – Eyes – and facial expressions

A – Affect (emotions) – what feeling is the speaker showing?

V – Voice – excited, slow, deep, cracking, flood, or trickle?

Listening to our significant others requires more than just our ears...to truly listen we need to use eyes and ears. What does this tell us about e-mail, letters and phone conversations with our significant others? Why is it often important to deal with controversial topics in a face-to-face forum?

MODULE 3

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

Materials Needed:

- Handout 10: “Anger Management — Time-Out Process”
- Handout 11: “Referrals for Domestic Violence”
- Brochures on local treatment options for people with anger management difficulties

I. Anger Is a Normal Human Emotion



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 repair attempts? (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.

Leader’s Guide: *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.*

- 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. As you know, 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. You as the family member may not have done anything to upset the person showing signs of anger. Further, 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 we are not very good at predicting 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 shown in your relationship? If so, how?
- How might it change things if you understood the feelings behind the anger that you see?

Leader's Guide: *Lead the group in learning how to differentiate between chronic irritability/anger and isolated angry outbursts. Discuss how many people experience both.*

III. Irritability / Low-Grade Chronic Anger

Leader's Guide: *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?

Leader’s Guide: Write down the answers the group brings up. 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 (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, jaw / TMJ pain).
- F. Anger may lead to physical violence, which is never acceptable, regardless of the cause.

IV. Angry Outbursts / Violence:

Leader’s Guide: Discuss how some OIF/OEF 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’s unclear. However, the patterns leading up to the outburst are often predictable. More specifically, episodes of violence have a predictable beginning, middle, and end. 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 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?

Leader's Guide: *Listen and respond to group members' questions and comments about angry outbursts. Make sure to cover the following material:*

- 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 from the situation and/or call 911. You should never stay in a frightening or dangerous situation.**

V. Some Cognitive Concepts for Responding to Life Stressors (Albert Ellis)

Leader's Guide: *Use this time to teach the A/B/C Model of responding to various situations. With the class, define an "A" (activating event) that would drive up a person's "Mad Feeling Thermometer." What might be your beliefs (B) about this event? Help the class learn to distinguish between "hot" and "cool" beliefs and discuss the consequences (C) of each belief. Distribute Handout 11 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 drive the "Mad Feeling Thermometer" up to around 100%?
 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 that will drive the "Mad Feeling Thermometer" down to the mid range?
 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."

VI. Angry Interactions and Children

Leader's Guide: *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. Therefore, it can also 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.

VII. 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 relative'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 loved one 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. Use "I" statements to report your own feelings.

- Example: "When you yell at me, I feel hurt."

VIII. Time-Out Process

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).

Leader's Guide: *Distribute Handout 10: “Anger Management – Time-Out Process” and review 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.*

IX. 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).

Leader's Guide: *Distribute list of local referrals for domestic violence (example shown in Handout 12: “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.*

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

Example: Oklahoma City VA Medical Center

- A. Anger Management Class
- This 4-week class assists patients in identifying the triggers for their anger and learning effective ways of expressing this emotion.
- B. Couples or Family Therapy
- C. Psychiatric Medications

“Anger Management – Time-Out Process”

Who? Time-outs are helpful to use in relationships that you want to maintain. You would not choose to use this procedure with strangers or with others with whom you have not already discussed the process. Allowing destructive arguments to stop is a sign you both want the relationship to work.

When? Either partner can call a time-out if a discussion/argument is starting to feel out of control. Most people cannot think clearly when angry, so postponing the discussion until a time when both people are calmer is helpful.

**** VERY IMPORTANT:** Discuss the use of this procedure at a calm time.

Key points to discuss before the first time-out is taken:

1. A mutually agreed-upon signal for the use of time-out
Note: It is best to have both a verbal and nonverbal (hand signal) way of communicating the need to take a time-out.
2. Both agree that the partner will not follow the person who is taking the time-out.
3. When a time-out is called, the discussion ends immediately. Trying to get in the last word is not helpful.
4. When you choose to take a time-out, you need to tell the other person the following:
 - a. What you are going to do
 - b. Where you are going (e.g., next room, for a drive, to a friend’s house)
 - c. When you will return (certain number of minutes/hours)

Example: “I’m going to Wal-Mart to cool off and I’ll be back in an hour.”

While taking the time-out:

- It is not helpful to obsess about how angry you feel at the other person during this time. Rather, it’s a time to cool down so the discussion later can be more productive. Thinking about options for how to solve the problem can be helpful. One can consider what he/she can do to improve the situation and make things work for both partners.

Upon returning to the discussion:

1. Each person presents his/her solution to the problem, and the other person listens without interrupting.
2. Both people focus on what aspects of the solution will work (rather than focusing on what won’t work).
3. Together, they choose parts of both solutions that will make both parties satisfied.

Pointers to help manage anger problems during a discussion:

DO:

- Be flexible
- Listen carefully
- Be open to compromise
- Use “I” statements

DON'T:

- Focus on “all or none” solutions
- Be rigid in only being open to your solution (e.g., “my way or the highway”)
- Criticize the other person for their ideas



Local Treatment Options for Veterans Dealing with Anger Management Issues

1. *Anger Management Class*

-

2. *Couples or Family Therapy*

-

3. *Psychiatric Medications*

-

“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 run through your mind that will drive your “Mad Feeling Thermometer” up to around 100%?

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



What are some “Cool Thoughts” you could run through your mind that will drive your “Mad Feeling Thermometer” down to the mid range?

- “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 run through your mind that will drive your “Mad Feeling Thermometer” up to around 100%?

- _____
- _____
- _____

What are some “Cool Thoughts” you could run through your mind that will drive your “Mad Feeling Thermometer” down to the mid range?

- _____
- _____
- _____

“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 patients with symptoms of PTSD

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 patient who has been diagnosed with PTSD may look very different from another patient with the same disorder. The specific traumatic experience and the impact on the patient 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 falls in the diagnostic category of anxiety disorders. Not every symptom will be discussed here, but each type of symptom will be reviewed.
- C. First, the patient experienced or witnessed an event that involved actual or threatened death or serious injury, and the patient 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., Oklahoma City Bombing in April 1995)
 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. Patients 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. Patients 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 very 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. Patients may AVOID certain triggers or reminders of the trauma (e.g., conversations, places, and thoughts associated with the event). For example, many veterans have strong reactions to the sound of helicopters, firework displays, thunderstorms, humid weather, and sand.

G. Patients may report feeling NUMB:

1. May feel emotionally distant from other people
2. May engage in previously enjoyed activities less often

H. Some researchers (Lineberry, Ramaswamy, Bostwick, and Rundell, 2006) have summarized the “3 Domains of PTSD Symptoms” as follows:

<u>Domain</u>	<u>Symptoms</u>
Re-experiencing	<ul style="list-style-type: none"> • Recurrent, intrusive, distressing recollections or dreams of traumatic event • Acting of feeling as if the event were re-occurring • Intense psychological distress or physiological reactions when exposed to internal or external cues
Increased Arousal	<ul style="list-style-type: none"> • Difficulty falling or staying asleep • Irritability or angry outbursts • Difficulty concentrating • Hyper-vigilance • Exaggerated startle response
Avoidance & Numbing	<ul style="list-style-type: none"> • Efforts to avoid thoughts, feelings, or conversations about the trauma or activities, places or people that arouse recollections • Inability to recall an important aspect of the trauma • Markedly less participation or interest in significant activities • Feeling detached or estranged from others • Restricted range of affect • Sense of a foreshortened future

Leader's Guide: Show the 10-minute film, "Hope for Recovery." Before running the film, explain that PTSD affects traumatized individuals from all spectrums of life, not solely war veterans. Go to: <http://www.ncptsd.va.gov/video/index.html>.

II. Background Information on PTSD

- A. Community-based research has revealed a lifetime prevalence of PTSD in the United States today ranging from 1-14%.
- B. Although not formally labeled PTSD until recently, the symptoms have been recorded throughout history (Khouzam, 1999):
 - 1. Biblical accounts describe PTSD symptoms in the stories of Job, Joseph, and David.
 - 2. Egyptian, Greek, and Roman mythology refer to similar symptoms.
 - 3. Shakespeare describes nightmares and intrusive thoughts in Henry IV.
 - 4. WWI: phenomenon was called "shell shock" or "soldier's heart."
 - 5. WWII: symptoms were called "combat neurosis" or "operational fatigue."
 - 6. The formal diagnosis of "PTSD" first emerged in 1980 in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III).
- C. 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).
- D. Although symptoms of PTSD usually emerge within 3 months of the trauma (DSM-IV), some individuals have a delayed onset. Some individuals avoid facing the painful emotional residue from the trauma for many years, often using substance abuse or other addictive behaviors to distract themselves from the feelings. When the person begins to exhibit symptoms of PTSD many years after the event, caregivers may feel confused.
- E. The course of the disorder is quite variable, as some symptoms may diminish rapidly while others may fluctuate in intensity throughout the individual's life. Approximately 30% of those who have PTSD develop a chronic form that persists throughout their lifetime (National Center for PTSD).
- F. Who develops chronic PTSD? Several variables can be considered, including (DSM-IV, 1994):
 - 1. Severity of the trauma

2. Duration of exposure
 3. Level of involvement
 4. Functioning before the trauma
 5. Extent of social support
 6. Amount, variety, and practice using coping skills before the trauma
- G. Research has shown that 20% of men wounded in Vietnam meet the criteria for PTSD (Helzer, Robins & McEnvoy, 1987; DSM-IV). The Veterans Health Administration was the first institution to develop treatment programs for PTSD. Much-needed treatment programs began to emerge in the mid-1970s in response to pressure from Vietnam veterans.
- H. If a patient has PTSD, he/she is at greater risk for also having another diagnosis of a mental illness. For patients diagnosed with PTSD, the lifetime prevalence rates of other disorders include (Khouzam, 1999):
1. Alcohol dependence – 75%
 2. Drug abuse – 23%
 3. Major depression – 30%
 4. Generalized anxiety disorder – 53% (Davidson, 1997)

III. Effects of Combat Veterans' PTSD on Relationships and Families

Leader's Guide: *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 a veteran with PTSD?
- How do you cope? What techniques have worked? What hasn't worked?

Leader's Guide: *PTSD can result from a variety of different traumatic events; the intensity and duration of patients' reactions differ depending on many factors (e.g., nature of the trauma, extent of social support, level of pre-morbid functioning, participation in treatment, repertoire of coping skills). Lead the group through the following questions on common PTSD-related issues: 1) social anxiety; 2) angry outbursts; 3) emotional unavailability; 4) sleep disturbance; 5) difficulty managing family roles and responsibilities:*



Discussion Question:

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



Discussion Questions:

- How have your loved one’s anger management problems affected your relationship? Your family?
- Do you have any concerns for your children?
 1. Anger is often a “weapon” in the veteran’s arsenal of protection against painful feelings, memories, and thoughts. Anger can function as a barrier and further isolate the veteran, as other people often pull away from the frightening hostility and rage.
 2. If the veteran has difficulty in managing his anger, the family will live in an atmosphere of constant chaos. This lack of emotional and sometimes physical safety can be damaging to the mental health and development of all family members.
 3. Family members may be at greater risk for being exposed to verbal abuse (e.g., yelling, name calling) and physical abuse (e.g., throwing things, aggression). Both veterans with PTSD and their family/partners engage in higher levels of physical violence than do comparable family members when the veteran does not have PTSD (Jordan, 1992). These repeated negative interactions damage the trust and cohesion within the family.
 4. Children may acquire maladaptive patterns for the expression of anger. A large nation-wide survey revealed that the children of Vietnam veterans with PTSD are more apt to have behavioral problems than children of Vietnam veterans who do not have this disorder (Jordan, 1992).
 5. Spouses are often torn between caring for the acting-out veteran and protecting the children from his angry outbursts (Glynn, 1997).
 6. The rage exhibited publicly may further alienate the family from their social network.
 7. May comment about cycle of physical abuse by male/verbal abuse by female.



Discussion Questions:

- Do you feel emotionally connected to your family member who is struggling with PTSD, or do you have an emotionally distant relationship?
- Besides your family, how else do you get your needs for emotional intimacy met?
 1. Emotional withdrawal and emotional numbing are ways that people with PTSD try to protect themselves from overwhelming emotion.
 2. Patients 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 veteran may be reluctant or unwilling to share his feelings with his wife 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 may be unavailable to his children and unable to meet their emotional needs (Curran, 1997).



Discussion Question:

- What kind of sleep disturbances does your family member experience?
- How do they affect you and the rest of your family?
 1. Given the difficulties many veterans with PTSD have with sleep (including insomnia, frequent wakings, nightmares, etc.), many couples choose to sleep in separate beds (and rooms). This physical separation can parallel the emotional distance experienced in the relationship. Physical intimacy can also be adversely affected by this sleeping arrangement.
 2. In addition, the veteran's behavior during a nightmare can be very frightening for the family. In the midst of a nightmare or flashback, some patients become physically aggressive, thinking that their wife/partner is 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.



Discussion Question:

- What challenges have you faced in negotiating family roles and responsibilities with your loved one?

1. Given the veteran's emotional instability, the roles that each spouse assumed before the deployment or stressor 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 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 familial responsibilities (Peterson, 1997).
2. If the wife has taken over many of the veteran's tasks, she may be unable to pursue her own goals, which can breed further bitterness (Matsakis, 1989).
3. Children may acquire adult responsibilities at an earlier age, resulting in their maturing quickly and sometimes taking on the role of a "parentified child" (Catherall, 1997).
4. Individuals with PTSD often have difficulty keeping their jobs, thereby creating financial duress on the family.
5. Given these potentially difficult family issues, the fact that Vietnam veterans with PTSD and their partners experience greater levels of marital conflict (Riggs, 1998) and less marital satisfaction (Jordan, 1992) than do comparison families without PTSD is not surprising. Veterans with PTSD are twice as likely to have been divorced (in comparison to veterans without PTSD) and almost three times as likely to have had multiple divorces (Jordan, 1992).

A. "More of the Same" Cycles

Leader's Guide: *Illustrate these cycles on the board and use a discussion format. Israeli research found that many couples struggling to cope with PTSD develop dysfunctional, self-perpetuating, downward spirals. These spirals are also known as "more of the same" cycles of interaction (material gathered from Rabin, C. and Nardi, C. "Treating PTSD Couples: A Psychoeducational Program." *Community Mental Health Journal* 27 (1991): 209-224).*

1. Nag and Withdrawal—"More of the Same" Cycle
 - Nagging on the part of the family interacts with withdrawal on the part of the veteran so the family nags more, so the veteran withdraws more, and the cycle perpetuates.
2. Under-Function/Over-Function—"More of the Same" Cycle
 - The family over-functions to avoid conflict or stress (i.e., "Let me do all I can to not 'rock the boat' and keep things calm") and the veteran under-functions (because of PTSD symptoms); this leads to more over-functioning by the family, which leads to more veteran under-functioning, and the cycle perpetuates.

3. Passiveness and Aggressiveness—“More of the Same” Cycle
 - The veteran’s aggression leads to guilt, which leads to passive avoidance of conflict (don’t “rock the boat”), which results in frustration in all parties, which leads to aggressiveness, which leads to guilt, and the cycle perpetuates.
4. Stress, Dysfunction, and Isolation—“More of the Same” Cycle
 - Stress and dysfunction increase in the family due to isolation and secrecy, which leads to more stress and dysfunction, which leads to more isolation and secrecy, and the cycle perpetuates.
5. Dysfunctional Coping and Self-Blame—“More of the Same” Cycle
 - Increased use of dysfunctional coping patterns reinforces the veteran’s sense of failure and guilt (“This clearly is not working; I must be an idiot!”), which results in more self-blame, which hampers sound coping strategies, which increases dysfunctional coping patterns, and the cycle perpetuates.

IV. Treatment Options for PTSD

- A. Participating in treatment for PTSD can be challenging, as patients are invited to directly face memories and feelings that they may have avoided for many years. Patients are much more likely to succeed in treatment if the following pre-requisites are in place:
 1. Patient is not abusing alcohol or using any street drugs. As stated earlier, substance abuse is often an issue for patients with PTSD. Patients need to learn skills (such as through a substance abuse treatment program) to cope with strong emotions such that they can directly face the traumatic memories without numbing themselves with substances.
 2. Patient has adequate coping skills (patient is not suicidal or homicidal).
 3. Patient has sufficient social support.
 4. Patient has a safe living situation (not homeless or in an abusive environment).
- B. Although each patient’s individualized treatment plan is 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 intense.

3. Discover ways to relax (possibly including physical exercise).
 4. Increase the frequency of patient's pleasant activities.
 5. Re-invest energy in positive relationships with family and/or friends.
 6. Enhance sense of personal power and control in his/her environment.
- C. Most PTSD treatment programs involve a comprehensive approach, including several components of treatment: psychiatric medications; education for patient and family; group therapy; cognitive behavioral therapy; and writing exercises.
1. Psychiatric medications
 - Choice of medication(s) depends on the patient's specific symptoms and any co-morbid difficulties (e.g., depression, panic attacks)
 - In general, medications can decrease the severity of the depression, anxiety and insomnia. However, there is no "cure" for PTSD.
 - Medications may be prescribed by the patient's primary care provider or psychiatrist.
 2. Education for patient and family about PTSD
 - Education is very important, both for the patient and the family. It typically addresses the nature of PTSD (e.g., symptoms, course, and triggers), communication skills, problem-solving skills, and anger management.
 - The education may occur in a variety of modalities, such as couples or family therapy, psycho-educational programs, support groups, etc.
 3. Group therapy
 - In general, groups "counter the profound sense of isolation, social withdrawal, mistrust, and loss of control [experienced by people suffering from PTSD]. 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).
 - 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 psycho-educational (e.g., anger management).
 4. Cognitive behavioral therapy
 - Cognitive therapy involves inviting patients to examine their thinking processes and replace irrational thoughts with more realistic thoughts. This form of therapy has received strong research support. Cognitive restructuring is a cognitive therapy approach used with PTSD.

- Behavioral therapy involves inviting patients 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.
- Anger management training may involve both cognitive and behavioral skills.
- Exposure-based therapy (e.g., flooding, desensitization) involves helping the patient 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 for some people in decreasing symptoms of PTSD.

5. Writing exercises

- Psychologist James Pennebaker, Ph.D., at the University of Texas at Austin has performed extensive research over the past 20 years on the power of writing. He has studied many survivors of trauma and discovered interesting results about the healing potential of writing.
- Dr. Pennebaker reports that people who write about traumatic events have many positive outcomes (e.g., fewer calls for doctor’s appointments, decreased pain for arthritic patients, lower blood pressure, happier moods, increased lung capacity for asthmatics, etc.) (Pennebaker, 1997).
- Why might writing be associated with such positive outcomes? Pennebaker suggests that writing helps people to:
 1. Feel a greater sense of control over their lives
 2. Gain greater understanding of their feelings
 3. Break the situation into smaller pieces
 4. Pay more attention to their feelings

Leader’s Guide: *For the “Get in Touch with Our Strengths” Exercise, have each member of the group state one word that describes a strength that has helped him/her cope with traumatic or stressful experiences. Go around the room until ideas/descriptors are exhausted. You as the group leader should feel free to add descriptors as well.*

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

Leader’s Guide: *Distribute Handout 12: “PTSD and Its Impact on the Family” and discuss resources related to OIF/OEF soldiers & their families. Encourage family members to abide by the following guidelines for interacting with their loved one:*

- 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 to 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. Patients may try to rationalize their behavior by stating that they were “not themselves” or “not in control” or “in another world.” However, patients 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.

Books, Resources, and Articles

Good Books on PTSD:

- *Courage After Fire: Coping Strategies for Returning Soldiers and Their Families* (2006).
—K. Armstrong, S. Best, & P. Domenici.
- *Down Range: To Iraq and Back* (2005). WordSmith Publishing.
—B. Cantrell & C. Dean
- *Back from the Brink: A Family Guide to Overcoming Traumatic Stress* (1992).
—D. Catherall

- *Recovering After the War* (1990).
—P. Mason
- *Why Is Daddy Like He Is? A Book for Kids about PTSD* (1990).
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- *Vietnam Wives*, 2nd ed. (1996).
—A. Matsakis
- *Trust After Trauma: A Guide for Relationships for Survivors and Those Who Love Them* (1998).
—A. Matsakis
- *Post-Trauma Stress* (2000).
—F. Parkinson
- *Finding My Way: A Teen’s Guide to Living with a Parent Who Has Experienced Trauma* (2005).
—M.D. Sherman & D.M. Sherman (Available at www.seedsofhopebooks.com).

Interesting Movies About PTSD and Its Effects on the Family:

Leader’s Note: Warn group members that some of these movies are quite disturbing, so they should be prepared to see traumatic events if you choose to watch them.

“The Great Santini” “Ordinary People” “Saving Private Ryan”
 “Born on the 4th of July” “In Country” “Fearless”
 “Prince of Tides” “Copy Cat” “We Were Soldiers”
 “Coming Home” “The Accused”

Relevant Web Sites:

- www.patiencepress.com (site with examples of the “Post-Traumatic Gazette”)
- www.adaa.org (“Anxiety Disorders Association of America”)
- www.ncptsd.org (“National Center for PTSD”)
- www.sidran.org (“Sidran Traumatic Stress Foundation”)
- www.trauma-pages.com (David Baldwin’s “Trauma Information Pages”)

Recent Journal Articles of Interest:

- Hoge, C.W., Auchterlonie, J.L. & Milliken C.S. “Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service after Returning from Deployment to Iraq or Afghanistan.” *JAMA: Journal of the American Medical Association* 295.9 (March 2006): 1023-1032.
- Hoge, C.W., Castro, C.A., Messer S.C., McGurk, D. Cotting, D.I. & Koffman, R.L. “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care.” *New England Journal of Medicine* 351 (2004): 13-22.

VI. Local Treatment Options for Veterans with Symptoms of PTSD

Example: Oklahoma City VA Medical Center

A. OIF/OEF Readjustment Program

- This ongoing program offers individual assessment and treatment for readjustment problems like depression and PTSD. They also offer medication evaluations. A one day “brief” PTSD treatment program is offered monthly, along with a weekly support group.

B. Post Traumatic Stress Recovery Program

- This six-week intensive outpatient program focuses on unresolved feelings about combat experiences as well as present day coping skills. Specific groups address issues of anger management, communication skills, dealing with emotions, insomnia management, etc.

C. “Women/Men of Courage” Programs

- This 12-week, weekly 90-minute psychotherapy group focuses on healing from a sexual trauma (experienced in childhood and/or in the military). Specific sessions address issues of safety, self-esteem, telling one’s story, and empowerment.

D. Some VA facilities (including ones in Little Rock, AK; and 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.

“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 patient 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 patient experienced or witnessed an event that involved actual or threatened death or serious injury, and the patient felt very afraid or helpless.
- C. Patients may RE-EXPERIENCE the event in a variety of ways (e.g., distressing dreams).
- D. Patients may experience INCREASED AROUSAL (e.g., anger, sleep problems).
- E. Patients may AVOID certain reminders of the event.
- F. Patients 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 to 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.
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- 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. 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.
- J. Learn as much as you can about PTSD.

Good Books on PTSD

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“Coming Home”	“The Accused”	

Relevant Web Sites

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- www.ncptsd.org (National Center for PTSD)
- www.sidran.org (Sidran Traumatic Stress Foundation)
- www.trauma-pages.com (David Baldwin’s Trauma Information Pages)

Local Treatment Options for Veterans with Symptoms of PTSD:

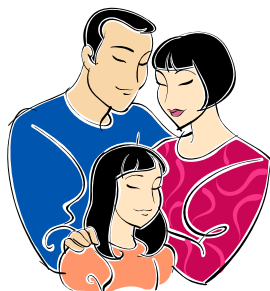
- OEF/OIF Readjustment Program
- PTSD Recovery Program
- “Men/Women of Courage” sexual trauma groups
- Time-limited inpatient programs for veterans with PTSD (only at some sites)

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

“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 patients 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

“What to Do When a Family Member Is Depressed”

Materials Needed:

- Handout 15: “What to Do When a Loved One Is Depressed”
- Handout 16: “Tips for Managing Depression”
- Video: *When You Love Someone Who Is Depressed: Depression and Its Impact on Marriage and the Family*
- Brochures on local treatment options for patients with depression

I. Symptoms of Depression

Leader’s Guide: *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).
- 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 approximately 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 $\frac{3}{4}$ 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.

Leader’s Guide: *Show and discuss Video: “When You Love Someone Who Is Depressed: Depression and Its Impact on Marriage and the Family” (University of Notre Dame Alumni Association, 1998).*

II. What Causes Depression?

- A. No one single factor causes depression. Doctors often cannot determine the specific cause of a patient’s illness. The constellation of causes is unique to each individual.
- B. Family members and friends need to remember that depression is not the person’s fault.
- C. Several causes are common:
 1. Certain life events may trigger a depressive episode (e.g., death of loved one, retirement). Deployment and a return from service can also trigger depression (**Leader’s Note:** *Ask the group to discuss why they think this is the case.*)

2. A strong genetic factor is present in many cases of depression:
 - If one identical twin has major depression, the other twin has an approximately 50% chance of developing depressive symptoms sometime in his/her life.
3. Depression may be caused by an imbalance in the level of chemicals in the brain. Many antidepressants work by regulating the levels of these chemicals (neurotransmitters).
4. Medical illness may be a causative factor in depression.
5. Use of certain medications may cause depressive symptoms.
6. Excessive use of alcohol and other illicit drugs may contribute to depression, as alcohol acts as a depressant on the central nervous system. Further, substance abuse complicates the diagnosis and treatment of the underlying psychiatric disorder(s).

III. The Impact of Depression on Relationships



Discussion Questions:

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

Leader's Guide: *As you discuss group members' responses to these questions, distribute Handout 15 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 patient 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 patient is no longer physically attracted to them, which can increase the tension in the relationship.

IV. Important Issues Surrounding Suicide

Leader's Note: *As these issues may be difficult to discuss, the facilitator may wish to normalize any anxiety when talking about these issues. Coping skills will be addressed in the next section (material adapted from Woolis, 1992).*

- A. Many family members worry a great deal that their loved ones may try to kill themselves.
- B. Over 90% of suicides are associated with a mental disorder (Clark & Fawcett, 1992). The U.S. Army reports that suicides are at a record high.
- C. More specifically, one-third of all clinically depressed patients attempt suicide, and approximately 15,000 people with mood disorders kill themselves each year (Adamec, 1996).
- D. Men are 4 to 5 times more likely to complete suicide than women. Women are 3 times more likely to attempt (but not complete) suicide than men (Moscicki, 1995).
- E. Many reasons exist for why people consider and attempt suicide:
 - 1. Some make a decision to end their lives - they are very unhappy with their lives and feel hopeless that the situation will improve.
 - 2. Some engage in reckless behavior because they don't think they will die (e.g., driving recklessly, drinking excessively, engaging in thrill-seeking behaviors). Their judgment is impaired, and they may not understand the consequences of their behavior.
 - 3. Some do not know how to ask for help more directly, but kill themselves unintentionally (e.g., take too much pain medicine; cut wrists, etc.)
- F. Red flags that warrant further exploration are often accompanied by changes in the level of depression (more depressed or happier than usual), especially if your family member:
 - 1. Has a specific plan for how they would kill themselves
 - 2. Has access to lethal means (such as weapons, pills, etc.)
 - 3. Feels worthless
 - 4. Talks about having done an unforgivable behavior
 - 5. Feels hopeless about the future
 - 6. Hears voices telling them to harm themselves

7. Begins to get their affairs in order (e.g., writes a will, gives things away, systematically contacts old friends or relatives)
8. Has experienced a recent significant loss (or perceived loss)
9. Lives with chronic medical illness and/or chronic pain
10. Has previously attempted suicide OR has a history of being impulsive
11. Talks about killing him/herself (e.g., “everyone would be better off without me”)
12. Makes suicidal gestures (takes too many pills, cuts wrists, etc.)
13. Increases use of alcohol or other drugs. These substances may increase the level of depression AND may lower inhibitions, both of which are dangerous with suicidal patients.

V. What Can I Do if My Family Member Is Suicidal?

Leader’s Guide: *Use this session to encourage family members to TALK ABOUT IT! Reassure them that asking about suicide will NOT put ideas in the patient’s head and will NOT make the situation worse. Suicidal family members may even feel relieved to be able to talk about it.*



Discussion Questions:

- What have you found to be helpful for yourself and for your loved one when he/she shares thoughts of suicide?
- How do you feel in these situations?

Leader’s Guide: *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, the local hospital). Make these resources available by noting the **National SUICIDE Hotline Number: 1-800-SUICIDE**, the number for the suicide hotline in your local area: **(405) 848-CARE**, and any other relevant information.*

- A. Discussing suicidal ideation can be very important, as 50-70% of people who complete suicide communicate their intent in advance, usually to a family member (Adamec, 1996).
- B. Family members can offer emotional support by:
 1. LISTENING in a nonjudgmental, compassionate manner
 2. Empathizing with their feelings (e.g. “It must be awful to feel that way.”)
 3. Reminding them of recent accomplishments
 4. Normalizing depression and thoughts of suicide

5. Expressing concern, care, and willingness to help
- C. Ask your loved ones if they have a plan about how they are thinking about killing themselves. If they describe a specific plan, then:
 1. Seek professional help immediately.
 2. Try to get them to make an agreement with you that they will not act on these plans without first talking to you, a hotline, or a mental health professional.
 3. Put away any objects that they may use to harm themselves (guns, knives, pills, razors, etc.).
 - D. Family members can benefit from discussing this issue with their loved ones when they are not actively suicidal. Together, the family members and patient can create a plan for how to cope with this inherently stressful situation if it arises again in the future (Spaniol & Zipple, 1994).

Leader's Guide: *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.*

VI. 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 three modules addressing issues of: increasing pleasant activities, modifying dysfunctional thought patterns, and improving interpersonal skills.

B. Individual Therapy through the OIF/OEF Program

C. Day Treatment Center

- The Day Treatment Center provides a structured intensive program for veterans experiencing chronic mental illness (including depression).

D. Antidepressant Medications

- The patient's primary care provider 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 patients 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 patients (Tamminga, 2002).

VII. Coping Strategies for Managing Depression

Leader’s Guide: *Explain that in the previous session we discussed strategies for managing and coping with depression in others. However, many veterans and family members struggle with depression themselves. We are now going to discuss strategies for managing and coping with depression. 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.*



Discussion Questions:

- What are some ideas you have for how people can cope with their own depression?

Leader’s Guide: *Write these answers on the board, then distribute Handout 16 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 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.
11. **Catch and Reverse Negative Thinking**

- Research shows that when people are depressed they become very pessimistic, triggering more depressed mood. Recognize the tendency to assume “the worst” and identify other ways of looking at your situation.

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

“What to Do When a Loved One Is Depressed”

DOs:

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

Some Good Books on Depression:

- *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.
- *Feeling Good* (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)

Interesting Movies on Depression:

- “Ordinary People”
- “Patch Adams”

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 patients 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.



“Tips for Managing Depression”



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