

**PTSD 101**

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**COURSE TRANSCRIPT FOR:**

**PTSD & Families:**

**Supporting Veterans, Recent Returnees, Active Duty Personnel & Their Families**

**Course Instructor: Erika Curran, LCSW**

**Slide 1: PTSD and Families: Supporting Veterans, Recent Returnees, Active Duty Personnel and Their Families**

My name is Erika Curran. I'm a social worker and family treatment specialist with the National Center for PTSD. I'm going to talk about PTSD in families supporting veterans, recent returnees, and active duty personnel and their families.

**Slide 2: This presentation will cover:**

In this presentation I'm going to cover how the structural and strategic models of family therapy can inform family assessment and treatment, ways a family member's problems related to PTSD can impact on the family, ways the clinician can support the family in identifying goals in making changes, and ways the clinician can support family reunification following deployment in part in hopes of reducing any potential impact of PTSD if it does emerge.

**Slide 3: Families in Treatment**

There is a great variety in who might come to your office as a family. I have worked with couples in long-term stable relationships in marriages that have continued for twenty, thirty, forty years, sometimes more, couples in more recent relationships, so it might be a first, second, third relationship or marriage for the partners. I've worked with parents of young children, teenagers, parents of adult children, and now many of the Vietnam veterans are, are grandparents. I've worked with single parents and children and that might or might not include the children's other parent. If the child is a minor child, I would like to invite the participation of the other parent, or at least have that parent's blessing in proceeding with work. Families might be the veteran and their parents and/or siblings.

**Slide 4: Structural/Strategic Family Therapy**

Models that have informed my observation and interventions with families are those developed by the schools of structural and strategic family therapy. There is a great deal of overlap between these two schools. The Structural School was developed by Salvador Minuchin at the Philadelphia Child Guidance Clinic. And, when I talk about the Strategic School, I'm talking about the school that was developed by Jay Haley and Cleo Madanes at the Family Therapy

Institute. What is common to the two schools is that the therapist's attention is on what is happening between people in the family. Or, as Paul Watzlawick at MRI has said, "You can't study hydrogen and oxygen separately and understand the properties of water." Likewise, just hearing about a family from any particular family member does not give you information that you need to know about how the family members interact with each other that's going to help you to plan the intervention. The interventions for both of the schools have the intent to change the accustomed interaction patterns between the family members.

### **Slide 5: Structural School**

The Structural School offers a model for looking at the organization of a family. There's an underlying premise that changing a family's structure is the vehicle for helping a family to achieve their goal-- such as changes in proximity, hierarchy, boundaries, and coalition. The clinician can help a family change through joining and challenging. Joining allows the clinician to almost assume a temporary family membership through demonstrating likeness, understanding, and respect for the family. The joining also provides the clinician with the mobility within the family system that can help the family to make changes. Once joined, the challenging prompts the family to interact in a new way. Either joining or challenging without the other isn't going to be sufficient to help the family make changes.

### **Slide 6: Strategic School**

The Strategic School draws attention to strategizing the therapy and planning the intervention. Another contribution is seeing family members' intentions as usually being benevolent or protective, which is particularly relevant in understanding how PTSD can work in a family.

The Strategic School gives attention to correcting and maintaining hierarchy. They use metaphor as a language to understand and facilitate change. When I started working with veterans and their families, I came to thinking of the trauma experience as having a similar power as does the metaphor to influence thinking and behaviors that can mobilize families in certain ways or keep them "stuck".

### **Slide 7: When a Partner/Parent has PTSD (1)**

When a partner or parent has PTSD, there might be different ways that that impacts on the family. When I get to know a family I will want to know something about the degree of family tension. A comment that would be an indicator of family tension is, "We all have to be careful what we say." I want to know if there are opportunities for open communication within the family. If someone says, "I don't want to tell my wife what I'm thinking because I don't want to upset her." Or someone says, "He's easily upset so I don't want to worry him"--this would be an indication that communication is shut down in some way. Is the veteran participating in family life? Comments such as, "She doesn't want to do anything with us," or "He doesn't go with us to family functions," would indicate less participation on the part of that family member. Is the family interacting with others outside of the family? Or, comments such as, "We moved away to live out in the country and now we don't see anyone anymore," or "We don't go to our son's track meet because we assume that he wouldn't want us to be there."

### **Slide 8: When a Partner/Parent has PTSD (2)**

Are parents working together as a team? Sometimes a family member might say, “I feel I have to handle everything on my own since he gets so upset,” which would be an indication that there was not teamwork among the parents. If decision making is shared the veteran says, “Everything needs to be just right.” Or might say, “I’m more comfortable with him or her making all of the decisions for now.”

The next thing to look for would be: are family members needs being met? Comments such as, “I can’t even take care of myself, how can I take care of my kids?” or an adult daughter who says to her father, “I thought all of those years that you didn’t love us.”

### **Slide 9: When a Partner/Parent has PTSD (3)**

Has the veteran been overly protective or intrusive in the family? For instance an extreme situation might be a veteran who says, “I didn’t send my kids to school I was afraid they would get killed.” Or a veteran who says, “My wife is late getting home-- I worry.” Another thing to look for is how trauma has lingered in the life in the family. “If I get close to anyone I might lose them.” It can be a belief that comes from being in a life-endangering situation that can carry on and linger in a family life. “When he or she touches me I remember the sexual assault.” “When my wife was pregnant with our baby I put baby room monitors around the perimeter of my property thinking that’s what parents do.” So the impact of the trauma can be very explicit or it can be implicit in how it’s lived in the family.

### **Slide 10: When a Partner/Parent has PTSD (4)**

How has the family accommodated to the veteran’s PTSD? Comments that would indicate accommodation would be, “I always have to mediate between my husband and our kids.” “I make sure our grandchildren are quiet.” “We don’t do things as a family anymore since she is so anxious about going out.” “I have to do things for him since he gets frustrated so easily.”

### **Slide 11: Inviting a Family into Treatment**

In the residential program I work in, veterans are encouraged to invite their families to participate in their treatment. In the program manual is a section on families, and it starts by saying, “If you are living with a family you have not struggled alone with the problems and concerns that brought you into treatment for PTSD. As you look to make changes in yourself these changes will impact on your family life. If you have a spouse or partner we encourage the two of you to work together to identify family goals and put into action changes you want to make in your home life.”

### **Slide 12: Family Goals**

In the residential rehab program I ask every family the same questions as we get started in our work together. When men or women come into a program it’s usually about making changes

and I suggest of the partners that they talk together about what they want that to mean for their family. I will ask them, “What do you want, as the family, to come from the veteran being in treatment?” “How will you know when this is happening? And, “Is there anything you’re already noticing in the direction of the changes that you want?” Once they, talk about, and answer these questions, this provides the content of the treatment that we’re going to do together-- and also gives the momentum, a forward momentum to changes that they want to make.

For a family that’s seeing you in outpatient treatment, questions you can ask include, “How will you know when things are going better for you as a family?” “Can you think of a time that this was happening?” And, if they can tell you a time that things were better for them, “What were you doing at the time?” “What would you be noticing if this was happening again in your family?”

### **Slide 13: Therapeutic Goals**

When the family has told me the changes that they want to work on and see, I’ll want to help them to organize their family life around the life stage needs of the family as the whole, and the age-appropriate needs of the individual family members ---rather than in response to the PTSD of a family member, or the implicit or explicit impact of the trauma. I want to help the family experience, in the session with me, changes that they want to make. For instance, if where communication has been a problem, I want to help the family to experience improved communication while they are with me. And when I notice when that happens, I want to notice and comment on it and increase their awareness of it.

### **Slide 14: A father who was estranged from his daughters (Example 1)**

Some examples of ways that the family members’ problems with PTSD can impact on a family and how families have made these changes.

The first example is the father who is estranged from his daughters. The mother was a very involved parent as their daughters were growing up, father worked, stayed uninvolved emotionally with the children-- did not spend much time at home. He talked about, in the program, feeling very embarrassed about what happened in Vietnam and he didn’t want his daughters to ever know what happened to him in the war.

When the father and mother talked about wanting the father to be more involved he started to share with his daughters information about that he struggled with PTSD. At one point, one of his adult daughters shared with him that she had thought that he didn’t love them during the whole time they were growing up. After the father talked with the three daughters who were present about PTSD, we did a conference call with the fourth daughter who was on the East Coast, and the father shared with her what the family had been talking about.

### **Slide 15: A father who was estranged from his daughters (Example 1 cont.)**

The outcome of that increased openness in the family included the daughter who was on the East Coast sending an email to her mother the next day apologizing for having been angry at her (the

mother) for having “kept us away from our father.” And also saying, “I now know that it was dad who distanced himself from his daughters.” The daughters, together, prepared a Christmas gift for their father by framing his medals from the war, and the family talked about a plan that the grandchildren would walk with him in their community’s next Fourth of July parade.

#### **Slide 16: Parent who were not co-parenting (Example 2)**

In the next example, I want to talk about parents who are not co-parenting together for many years at the time that I met them. The father talked about being very troubled with problems that he had with anger. The mother had responded to her husband’s concern and concern about her husband by protecting her husband in trying to handle things on her own, and protecting her sons from the father’s anger by not telling the husband when things were happening. Eventually, the mother would become very overwhelmed, would tell her husband what the sons had been doing, and ask for her husband’s help. Father then would get the message that he needed to do something-- hear a lot of misbehaviors at one time. He would become upset and would become angry and come down hard on the boys. The mother would say to herself, “I knew I should not have told him,” and would resume withholding.

#### **Slide 17: Changing the repeating pattern so parents can co-parent**

In this family, the father worked very hard in treatment on learning anger management skills, while the mother worked on increasing her confidence in her husband’s ability to manage anger and also worked on her own comfort with disclosure. When the couple could do these things together, then they could discuss and agree upon reasonable consequences for their son’s misbehaviors and move towards becoming a fuller co-parenting team. I had occasion to talk to this family a year later and at that time the father was telling the mother what was happening with her sons as often as she was telling him and they were making decisions together. As a matter of fact, when I called them, the mother answered the phone and said, “It’s funny you would have called today because John and I just got back from taking a walk to figure out how we wanted to handle.....” what had come up with one of their sons on that day.

#### **Slide 18: Veteran who put baby room monitors around the perimeter of his property (Example 3)**

The veteran who put the baby room monitors around the perimeter of his property when his wife was pregnant, ironically, was in a situation where his family actually was at risk because of their neighbors. They had neighbors who were unable to manage their own resources and would regularly come to the veteran and his wife asking for food for their children-- towards the end of the month. The veteran and his wife were very generous people and would give food to their neighbors, but this would lead to their needing to go to their own parents to ask for food for their own children. The couple worked together in therapy on how to be appropriately protective of their children, which included being assertive with their neighbors. Until he was in treatment, it did not occur to the veteran that his placing the baby room monitors had anything to do with his responsibilities for perimeter guard duty in Vietnam.

#### **Slide 19: Communication Breakdown (Example 4)**

Another example of PTSD in families involves communication breakdown between a husband and wife. After the Persian Gulf War a veteran of the war in Vietnam found that he was becoming more and more preoccupied by his memories of what had happened in Vietnam and did not want to share this with his wife. Wife was noticing that he was troubled and preoccupied so she didn't want to worry him. Eventually the husband became extremely withdrawn and the wife was sometimes giving misinformation about what was happening in the family--all in an effort to spare him and so that he would not be upset.

**Slide 20: Improving their communication (Example 4 continued)**

Their communication actually improved very rapidly when the husband was able to say to his wife, "What I've been thinking about is Vietnam, and since I saw those videos of the events that were happening in the Persian Gulf War, I started to see almost like a movie reel going over and over again-- things that happened to me in Vietnam. And I didn't want to tell you because I was worried about you. It was upsetting to me. I didn't want it to be upsetting to you." The wife says to him, "I didn't want to upset you, so I've not been telling you some of what's been happening in our family." When the husband says, "I need to know. It would help me to know," then the wife can start to share more often and openly about family matters leading to the veteran less withdrawn and isolated and being more involved in the everyday life of this family.

**Slide 21: Clinician can help by:**

Ways clinicians can help families to come in for some help include: facilitating the veteran or returnee achieving greater competence as a family member, and highlighting competencies and strengths of all family members. Discouraged individuals and families often need to have their attention drawn to ways they have done and are doing what is good for them and for their families. Helping the couple as parents-- identify and prioritize current day needs of family members. Increasing family member's awareness of subtle or explicit lingering thoughts and behaviors coming from trauma experiences. Facilitating the veteran being the expert in his or her own PTSD. The therapist can encourage this by saying, "Everyone experiences PTSD a little bit differently. Have you shared with your family what it's like for you to have problems with PTSD?" And often, this kind of communication does not happen within a family, and when the veteran is invited to share this with the family, they can speak directly to their family members. Or when it happens between a husband and wife or two partners, it greatly increases the communication between the two of them and empowers the veteran, who then becomes the teacher rather than the clinician. The communication is happening then between the husband and wife, rather than between the family member who is not experiencing the PTSD and others while the person with the PTSD sits aside and just listens.

**Slide 22: Talking about trauma**

Talking about trauma in the family. A lot of my work has to do with helping the couple decide together how much they will talk about the trauma between them. I have seen a great variation, a great variety in how much couples have or want to discuss trauma. A wife has said, "I'm glad that you have a place to talk about what happened in the war. I don't think it would be comfortable for me to hear about." Then there's a wife who is very hurt and offended that her

husband can talk to strangers, when all along she has been there and wanting to listen and support her partner. A husband might say, "I can never tell my wife what happened." Another couple I worked with told me that they talked about Vietnam ninety-five percent of their time together. When I asked them how much they wanted to be talking about Vietnam they said seventy-five percent of the time. And the therapy became identifying things that they could talk about in the other twenty-five percent of their time when they weren't talking about Vietnam. Couples will often need help negotiating how much they want to talk about or how much would be helpful to talk about the trauma, and most of the time they are able to reach a compromise in that.

### **Slide 23: Talking about trauma, cont**

A few more comments about talking about trauma. I think it's important to facilitate and support enough discussion about trauma so that the partner at home has a context for understanding changed behaviors, and so that disclosure is not left in a vacuum. Some examples about changes in behavior that are important to understand. One example is a couple who were experiencing the result of the returnee having and expressing anger rather than sharing with his wife that he was feeling fearful. The couple went to an IKEA (very busy and very large department and home furnishings store) to do some shopping and the veteran felt very overwhelmed, became angry with his wife, "Why did we have to go here, come here? What, why did we have to do this?" And they left the store. Only later, in the family session did he explain to his wife that he was actually feeling scared and overwhelmed. He told her a little bit about what it was like to be out in a public place in Iraq, what the fears were, what the dangers were, how vigilant he needed to be. Once he said to his wife that I was scared and overwhelmed she said to him, "Let's talk about some steps we can take. We can take baby steps. We don't need to go to an IKEA." And the returnee said, "We could have gone to a K-Mart. We could have gone to a Target. Because the aisles were more open, I could see the exit." And this is the kind of planning that couples can then do together once they're communicating more about what happened.

Another example is of a need to communicate in order to understand. An active duty soldier who has been to Iraq and comes home and is no longer able to go out with their three young children, something he had previously enjoyed doing. His wife saw him as being withdrawn, staying at home, not engaging in family life, and the man then talked to her about the dangers that he experienced in Iraq-- how when he went out with his children he felt fearful for their safety, how he was vigilant, was constantly scanning the environment, and felt ill at ease out with his children. Then he shared with her that what he was learning in treatment was how to become more mindful of what was happening within himself and actually before he went out with his kids-- planning for how he was going to be and how he could be more comfortable with them and how his attention could be on them and what they were all doing rather than being preoccupied with their safety.

Another reason to facilitate some discussion of trauma is so that disclosure within a family is not left in a vacuum. One husband talked about having shared with his wife that he was responsible for the death of a child in Iraq and his wife was silent and made no response to him. The wife tells me that she didn't know what to say and then went on and on for about four or five minutes about all of the thoughts that she had as he was sharing this with her. She ends this by saying, "See I didn't know what to say." And I said to her, "You did know what to say. What you had

to say was what you were thinking. And turn to him right now and tell him what you just told me.” And she did that. She turned to him. She shared with him all of the thoughts that she had just shared with me, with a lot more feeling in her voice and with a lot more connection with her husband. The husband was very relieved, had been previously fearful, had told himself I shouldn’t have told her, and now was glad that he had told her and that they could both have some understanding. So, the point, couples need some help in understanding sometimes--it is not a matter of having or knowing the right thing to say, but just to begin to talk about and share their feelings and thoughts with each other.

**Slide 24: For recent returnees...**

For recent returnees, the family is likely to be a primary source of sustained support for the returnee. The clinician can be available as a support for everyone in the family through the reunification process. Support for the returnee and the family can increase the potential for the returnee to have a smooth transition home and decrease the potential for estrangement that some veterans with PTSD have experienced from their family of origin after returning from Vietnam. Keep in mind when working with young couples, these couples have sometimes been apart for longer than they’ve been together, and if so, it would be helpful to use words that support their identity as a family when talking with them such as using the terms, “husband”, “wife”, “family”, and “couple”.

**Slide 25: Families of recent returnees are in transition and can be supported in**

Families of recent returnees are in transition and can be supported in just sharing their day to day life together again, parents resuming co-parenting together, adult children maintaining relationships with their parents and siblings. Or if the veteran is in treatment, talking about how the veteran is learning about managing PTSD, which can contribute to the well-being of the veteran and the family.

**Slide 26: If there could be further deployment, families can be supported in**

If there is, or can be, further deployment, families can be supported in making the most of the time that they do have together, planning together for how they will handle future separations, and parents helping children anticipate further absence from the parent.

**Slide 27: What to assess in families of recent returnees (1)**

What to assess in families of recent returnees in looking at their reunification and possible emergence of PTSD in the returnee? I will want to know from the family: have they been able to resume routines together or develop new equally satisfying ones, and if not, what is still missing, How will they know when routines are back in place? Did the returning family member miss any significant family events? If so, how can those events be recognized and honored. The veteran I talked about earlier with the three young children had missed all of his children’s birthdays when he was in Iraq and one of the things he and his wife planned to do together is to go out to a local establishment with all three children in honor of their birthday to celebrate their birthday. Did the family put anything on hold during the family member’s absence that now

needs attention? For instance. Or were there any decisions that were postponed or changes or moods that the family now wants to happen? Have partners, parents eased back into making decisions together? Does the returning partner have a voice in decisions? Has the partner parent at home invited the returning family member to be included? Has there been times when the returning family member gets the impression that he or she wants to be left alone?

**Slide 28: What to assess in families of recent returnees (2)**

Is the returnee feeling like a bit of an outsider to the family? If so what would help him or her to feel more recognized and included? What would help him or her feel more at ease in being more involved? As a couple, are partners closer or more distant than before? Do they want more closeness than they have? Or, has either been uncomfortable due to excessive closeness that can come from hypervigilance? Has there been more tension, disagreement or conflict between a couple? Do they need help with making some decisions? With resolving conflict? With reducing tension? These concerns can indicate that a first priority for the couple might be to decrease tension. If tension, disagreement, conflict is severe, the clinician will need to assess for safety and help the family develop a safety plan.

**Slide 29: What to assess in families of recent returnees (3)**

Has anyone who “helped the family out” still feel like more a part of the family than the couple would ordinarily want them to be? If so, the couple could benefit from coaching about how to un-invite a helper from their family. For instance, they could say the helper, “We sure appreciate your having helped us out while so and so was away. We’re really glad and relieved to be back together again so we can take care of our family ourselves. It feels great that we know that we can always turn to you if we need help again.” This is so the couple can feel okay about once again establishing the boundary for their own family and also express appreciation for the person or people who have helped them. Is the returning parent feeling or acting more protective? If so, this could represent hypervigilance that might indicate PTSD. It could also lead to intrusiveness in family member’s lives more than would be good for them all.

**Slide 30: What to assess in families of recent returnees (4)**

Has the family had a chance to talk about their worries while the family member was in the War? Parents can model for children that it’s okay to talk about it, and talk about their own worries. Sometimes, children might be shy about talking and need to be asked, and need to be encouraged to talk about what it was like for them. Has the returning family member been able to talk with others and answer questions about their work experiences? It’s important that some discussion be supported, otherwise, it can contribute to estrangement within the family-- both within the immediate family or the returnee or members of his family of origin. If returning home for good, the clinician can , “How will you all know that the returning family member is really home?” It’s useful for adults and children to talk about ways that they already know that the family member is home and to identify what still needs to happen for the union to feel more complete.

**Slide 31: Goal of the Clinician**

Regardless of whether the family is experiencing problems related to long term PTSD or recent onset of PTSD, or is even just at risk of developing PTSD, the goal of the clinician who is working with the family is to work toward everyone in the family feeling included and cared for, all family members resuming or establishing satisfying interactions with one another, agreed upon balance in the couple relationship and parenting team, privacy in their marriage, parents together sharing responsibility for leadership and nurturance of their children (which might at times include continued co-parenting between couples who are no longer together, who are divorced), and ability of the family to maintain relationships with extended family and with their community.

### **Slide 32: Way clinicians can care for themselves while doing family work**

Ways clinicians can care for themselves while doing family work, which of course is an important part of any clinician's well-being and being able to bring the most they can to families and clients they work with. When working with families, it's important to see couples only when you're not the individual therapist for one of the partners. If you're in an office with two staff people and each person is seeing individual, I would encourage you to consider swapping those people for the purpose of the family work so the family member who is coming in for treatment might see one clinician but as a family they're seeing a second clinician.

It's important to talk with your team or with your colleagues about your work with your families. It's important to let a fellow clinician know if you're feeling stuck with a family. When appropriate it's part of taking care of yourself and the family would be to include metaphors and interventions that can be playful for the family and fun for you. Many families come to us with very difficult, challenging problems, a lot of sadness, a lot of loss that they talk about. And if there's a way that you can respectfully acknowledge, validate that and help them to lighten things, that can go a long way to taking care of yourself as well as taking care of them. It's important of course, to attend to having balance in your own life. And also as clinicians, we are also family member. And it's important to remain aware that you cannot be a family therapist within your own family-- that you can bring skills and talents to working with families in your office as a clinician-- but that does not mean that you would take or use those same skills to your own family. At home, you're a husband, wife, a son or a daughter, a parent, and uncle-- and that's a different way of being with a family than to be a clinician to a family.