It’s Like Walking on Eggshells: The Impact of PTSD and SUDs on Veterans’ Families

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Disclaimers

• This presentation is NOT sponsored by the Veterans Affairs Medical Center.
• This presentation will attempt to condense a great deal of information into three hours.
• Due to the topic of the presentation, there may be triggers related to combat and/or substance use for Veterans and/or their family members. Please refrain from sharing details of combat-related experiences or detailed stories of past substance use for the safety of other attendees.
Objectives of the Presentation

• Upon completion of this presentation, participants will be able to:
  • Identify DSM 5 Criteria for Posttraumatic Stress Disorder and Substance Use Disorders.
  
  • Identify three hypotheses about the connection between PTSD and Substance Use Disorders among Veterans.
  
  • Discuss four ways that PTSD and Substance Use Disorders impact families.
  
  • Discuss the concept of Posttraumatic Growth and identify five (PTG) common areas of growth following exposure to trauma.
How Many Veterans Have a PTSD Diagnosis?

PTSD and the Military

The majority of U.S. soldiers serving in Iraq and Afghanistan who have encountered traumatic experiences have high rates of Post-Traumatic Stress Disorder (PTSD) and other difficulties.

PTSD Among U.S. Veterans:

Other factors in a combat situation may contribute to PTSD and other mental health problems. These factors include a veteran's role in the war, the politics around the war, location and the type of enemy faced. Occurrence of PTSD among veterans of recent wars:

- Iraq and Afghanistan: 11-20%
- Gulf War (Desert Storm): 10%
- Vietnam: 30%

Length of Deployment

- 12-15 months*
- 210 days**
- 12 months

*Serves multiple deployments
**Operation Desert Storm lasted 210 days

Sources: U.S. Department of Veterans Affairs, Department of Defense, R. Toro / LiveScience.com
Epidemiology of PTSD and Substance Use Disorders Among Veterans

A Veteran’s Worst Wounds May Be the Ones You Can’t See.

- More military deaths by suicide than in combat in 2012
- Military suicides are at their highest rate in 10 years
- 8% to 20% of military personnel deployed in Iraq and Afghanistan experienced a traumatic brain injury
- 20% of national suicides are completed by veterans
- 300,000 veterans of the wars in Iraq and Afghanistan have been diagnosed with PTSD
- Traumatic brain injuries can increase suicidal thoughts and behavior

Recognizing mental illness is the first step toward recovery. Show returning soldiers that seeking help is a sign of strength. Learn more at psychiatry.org/mentalhealth
DSM 5 Criteria for PTSD

- Posttraumatic Stress Disorder and Acute Stress Disorder used to be categorized as anxiety disorders in DSM IV-TR.
- PTSD and ASD are now categorized under new classification, “Trauma and Stressor-related Disorders,” in DSM 5.
What is Trauma?

TRAUMA:

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.”

(SAMHSA’s working definition of Trauma)

Types of Traumatic Events Experienced by Combat Veterans:

- Witnessing the death of others (including fellow Service Members, enemy combatants, civilians, women, children, and others)
- Having one’s life threatened by firefights, IED blasts, mortar and RPG attacks
- Engaging in duties of war that may have led to the serious injury of death of others
- Sustaining physical injury related to combat
- Witnessing and/or handling dead bodies
DSM 5 Criteria for PTSD

• Criterion A: Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following areas:
  • Directly experiencing the event
  • Seeing it, in person, happen to someone else
  • Learning that an event happened to a loved one
  • Experiencing repeated or extreme exposure to aversive details of the traumatic event (first responders, police officers, etc.)

(APA, 2013)
DSM 5 Criteria for PTSD

• Criterion B: Re-experiencing (At least one symptom):
  • Recurrent distressing memories of the event
  • Nightmares
  • Flashbacks
  • Trauma-related triggers that produce physical and/or psychological distress

• Criterion C: Avoidance (At least one symptom):
  • Attempts to avoid trauma-related thoughts, memories, thoughts, or feelings
  • Attempts to avoid external trauma-related reminders (people, places, conversations, activities, or objects)

(American Psychiatric Association, 2013)
What the Symptoms May Look/Sound Like Among Veterans

- Triggers to PTSD may include past memories of combat, sights, sounds, smells, tastes, and physiological sensations that remind Veterans of past combat experiences.

Examples:
- Trash in road
- Smell of gasoline
- Driving in traffic
- Smell of freshly cut grass
- Types of food/smells of food
- Songs
- Funerals
- War-related movies
- Hot days, rainy days
- Beaches, sand
What the Symptoms May Look/Sound Like Among Veterans

Common avoidance behaviors among Combat Veterans include:

- Trying to not talk about, think about, or feel emotions related to past combat experiences
  - “I don’t want to talk about it.”
  - “Please don’t ask me about it.”
  - “Talking about it hurts too much.”
  - “I would rather just forget about it.”
  - “If I don’t talk about it or think about it, I will just go away.”
  - “I don’t want to feel those emotions.”

- Avoiding external trauma-related stimuli (people, places, things, situations):
  - Not going to restaurants, movies, malls, crowded places
  - Not spending time with family, friends, or withdrawing socially
  - Feeling uncomfortable with leaving the house or familiar places
DSM 5 Diagnosis for PTSD

• Criterion D: Negative cognitions and moods (At least two of the following):
  • Can’t remember important details of traumatic event
  • Negative beliefs about oneself, others, and the world
  • Negative beliefs about the cause and/or consequences that lead person to blame oneself or others
  • Chronic negative emotional states (fear, horror, anger, guilt, or shame)
  • Lack of enjoyment in previously enjoyed activities
  • Emotional numbing
  • Feeling detached from others

(APA, 2013)
What the Symptoms May Look/Sound Like Among Veterans

Common thoughts:
“I can’t trust other people.”
“The world is unsafe.”
“Other people will hurt me or take advantage of me.”
“I have to be control at all times.”
“If I leave the house, something bad will happen.”
“I cannot handle things that are stressful (or unexpected).”
“The trauma was my fault.”
“I should have _____ (known, intervened, stopped), so that the event would not have happened.”

Common Emotions:
Frequent Anger or Irritability
Anxiety, Fear, or Helplessness
Emotional Numbness
Lack of pleasure in activities
Depression
Guilt, Shame
DSM 5 Diagnosis for PTSD

- Criterion E-hyperarousal (at least two of the following)
  - Irritable behavior and angry outbursts
  - Reckless or self-destructive behavior
  - Hypervigilance (watching people, scanning the environment, checking/rechecking locks)
  - Exaggerated startle response (bothered by loud noises)
  - Problems with concentration
  - Sleep disturbances (difficulties falling and/or staying asleep)
- Criterion F-symptoms last longer than one month
- Criterion G-Functional impairment
- Criterion H-Symptoms are not result of another issue (substance or another medical problem)

(APA, 2013)
What the Symptoms May Look/Sound Like Among Veterans

- Reckless, fast driving or road rage
- Keeping weapons close
- Repeatedly checking locks, particularly several times during the night
- Scanning the environment, watching people closely
- Planning escape routes and being aware of exits
- Thinking that the “worst case scenario” will happen
- Feeling more comfortable with sleeping during the day
- Having anger outbursts with little provocation
- Feeling bothered by loud noises
- Strategically picking seating to ensure ability to monitor environment and/or escape quickly
- Discomfort with people walking behind
DSM 5 Criteria for Substance Use Disorders

- A problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12 month-period:
  - 1. Substance is often taken in larger amounts or over a longer period than was intended.
  - 2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
  - 3. A great deal of time is spent in activities necessary to obtain substance, use alcohol, or recovery from the effects.
  - 4. Craving or a strong desire to use substance.

(APA, 2013)
DSM 5 Criteria for Substance Use Disorders

• 5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

• 6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance.

• 7. Important social, occupational, or recreational activities are given up or reduced because of substance use.

• 8. Recurrent substance use in situations in which it is physically hazardous.

• 9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance.

(APA, 2013)
10. Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of substance to achieve intoxication or desired effect.
   - A markedly diminished effect with continued use of the same amount of substance.

11. Withdrawal as manifested by either of the following:
   - The characteristic withdrawal syndrome for substance.
   - Substance (or closely related substance) is taken to relieve or avoid withdrawal symptoms.

(APA, 2013)
How are PTSD and Substance Use Disorders Connected?
Co-Occurrence of PTSD/SUD with other Disorders

Figure II-14: Overlapping of Multiple Health Issues
Theories related to PTSD and SUD Connection

• Self-medication hypothesis: PTSD increases the risk for SUDs as people attempt to cope with symptoms.

• Substance-Induced Anxiety Enhancement Hypothesis: SUDs leads to the development of PTSD symptoms (following a trauma) because of how the SUDs impact the body’s stress response system.

• Shared vulnerability hypothesis: PTSD and SUD onset may happen near same time because of a “shared vulnerability” for the development of both disorders.

(Ouimette & Read, 2013)
How PTSD and Substance Use Disorders Impacts Families

• PTSD and Substance Use Disorders affect the whole family.
  Spouses: PTSD severity is related with negative outcomes for one’s intimate partner.

  Common Reactions from Spouses/Intimate Partners:
  • Sympathy
  • Conflict
  • Anger
  • Disconnection and detachment
  • Depression
  • Fear and Anxiety
  • Avoidance
  • Guilt and Shame

(Carlson & Ruzek, 2014; Lambert et al, 2012)
How PTSD and Substance Use Disorders Impacts Families

Common Reactions from Spouses/Intimate Partners (cont.)

- Negative feelings
- Drug and Alcohol Abuse
- Sleep Problems
- Health Problems
- Grief and Loss
  - Loss of identity
  - Loss of partner
  - Loss of dreams about future
  - Loss of connection

(Carlson & Ruzek, 2014; Calhoun, Beckham, & Bosworth, 2002)
The Impact of PTSD and Substance Use Disorders on Families

• Families are at risk for caregiver burden, role strain, and secondary traumatization.

• Veterans’ mood shifts may confuse family members.

• Families may feel that Veteran tries to run the family like the military.

• Veteran’s avoidance behaviors may limit Veteran’s participation in family activities.

• Veteran’s emotional numbing may reduce emotional connectedness, intimacy, affection, and desire for sex.

• Veteran’s nightmares may negatively impact sleep patterns for spouse.

• Families may feel they are “suffering in silence.”

(Lambert et al, 2012; Dinshtein, Dekel, & Polliack, 2011)
The Impact of PTSD and Substance Use Disorders on Families

Children of a Parent with PTSD:

• Child may display PTSD symptoms to connect with parent.
• Child may have increase in negative emotions: anger, depression, irritability, and anxiety.
• Child may begin to predict parent’s triggers for PTSD and SUD.
• Child could be trigger for PTSD symptoms (could remind Veteran of combat experiences).
• Child may take on parental responsibilities.

(Price, 2014)
Suggestions for Treating Family Members

• Provide psychoeducation about both disorders
• Build trust and rapport with all family members
• Learn about military culture
• Suggest Al-Anon and Ala-teen attendance
• Teach effective communication skills
• Assist family member in identifying and expressing emotions
• Encourage use of relaxation and stress reduction skills
• Encourage regular engagement in pleasurable activities
• Assist the family member in aligning with the Veteran to be angry with the illness, rather than the person
• Support the family member in telling and/or writing their story.
• Encourage family member to keep gratitude journal.
Suggestions for Treating Family Members

• 6 S’s to Support Families affected by SUDs
  • Separate self from problem (Stay out of PTSD/SUD bubble)
  • Set limits, roles, and boundaries
  • Solidify position-know where you stand
  • Support sobriety (and recovery)
  • Simplify approach by setting small goals
  • Sustain physical, mental and physical health

(Ligon, 2004)
Posttraumatic Growth

• Family Therapy Interventions
• Increase community involvement
• Help families to find opportunities to make meaning from experiences
• Facilitate Posttraumatic Growth Principles
  • New Possibilities
  • Improved Relationships with Others
  • Enhanced Spirituality
  • Increased Personal Strength
  • Greater Appreciation for Life

(Tedeshi & Calhoun, 2004)
References


