CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

VETERANS ENGAGING IN TREATMENT SERVICES (VETS): AN 8 WEEK
PSYCHOEDUCATION GROUP FOR VETERANS AND THEIR WIVES

A graduate project in partial fulfillment of the requirements
For the degree of Masters of Science in
Counseling, Marriage and Family Therapy

By
Meara Lynch-Hockensmith

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This graduate project of Meara Lynch-Hockensmith is approved by:

__________________________________________  ______________________
Cecile Schwedes, M.A.,  Date:

__________________________________________  ______________________
Bridget Earl, L.M.F.T.  Date:

__________________________________________  ______________________
Dana Stone-Harris, Ph.D., Committee Chair  Date:

California State University, Northridge
DEDICATION

I would like to first take the time to thank my wonderful dad, Richard Hockenmsith, for all of his support. Ever since I was a little girl he encouraged me to be whatever I wanted to when I grew up, with one stipulation, that I got my degree first. I could have chosen any path and I know in my heart that he would have fully supported my decision. He took the time to instill morals, goals and dreams within me. My biggest fear growing up was that I would disappoint him. Throughout my journey in graduate school he has been my cheerleader, helping calm me down, loaning me money when I would tell him jokingly that I was a broke grad student, and always reassuring me that things would work out and that I was on the right path for me. I love you dad, thank you for always being there for me.

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ABSTRACT

VETERANS ENGAGING IN TREATMENT SERVICES (VETS): AN 8 WEEK PSYCHOEDUCATION GROUP FOR VETERANS AND THEIR WIVES

By

Meara Lynch-Hockensmith

Master of Science in Counseling,

Marriage and Family Therapy

Getting veterans into treatment is a first and most crucial task. Second would be prompting veterans to stay in treatment in order to fully experience the effects of proper mental health programs. The purpose of this project is to include wives of veterans in treatment as a way to educate both of them on how symptoms present themselves as well as ways to cope with symptoms and new ideas for solving problems. By decreasing negative feeling in regards to the couple’s relationship and increasing positive interactions between them hopefully their bond will begin to strengthen. In getting this couple bond stronger, the veteran’s closest source of social support is increased which may decrease symptoms and create a ripple effect for other people close to the veteran. Through the ripple effect of positive results and individual psychotherapy the goal is to increase the veteran’s functioning in civilian life and decrease their symptoms to a manageable or almost null level.
Chapter I: Introduction

Introduction

According to Lieutenant Colonel Dave Grossman, the author of *On Killing: The Psychological Cost of Learning to Kill in War and Society*, 98% of the veterans returning home from war in Iraq and Afghanistan will suffer from becoming a psychiatric causality. The other 2% it is said will be predisposed to an “aggressive psychopathic personality” (Grossman, 2009, p. 44). This statistic shows the dramatic psychological change happening to soldiers returning home from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) during the Iraq and Afghanistan wars. Of these veterans, 6-12% are returning home with symptoms of Post Traumatic Stress Disorder (PTSD) (Garcia, Kelley, Rentz & Lee, 2011). These numbers show the high volume of veterans returning from war with severe psychological issues. Stappenbeck, Hellmuth, Simpson and Jakupcak (2013) have also found that 70-75% of the veterans returning home from OIF and OEF who are diagnosed with PTSD report acts of physical aggression in the past year. These acts of physical aggression may be due in part to veteran’s difficulty dealing with irritability, as well as difficulty tolerating and regulating negative emotions while trying acclimate to civilian life in conjunction with dealing with psychological issues (Stappenbeck, Hellmuth, Simpson, & Jakupcak, 2013).

Statement of the Problem

Services are needed to aid our veterans with the transition to civilian life in both their personal and professional lives since many have marriage troubles as well as difficulty finding and keeping work. Specialized treatments are needed since veterans returning from OIE and OIF are often younger (29.8 years old versus 58.6 for Vietnam
veterans currently in the VA system) and have experienced more acute trauma than veterans of past wars (Erbes, Curry & Leskela, 2009). Sharpless and Barber (2011) have pointed out that PTSD usually runs a chronic course with 40% of patients continuing to show symptoms after 10 years, raising the risk for suicide as well as other health problems. Co-morbidity of PTSD with other issues such as depression is also a problem for this population (Bryan & Corso, 2011). Only 17% of those veterans diagnosed with PTSD have PTSD as their only diagnosis making the complexity of their return much more difficult to manage (Sharpless & Barber, 2011).

Specialized treatment programs are needed not only for our veterans returning home but also for their spouses or significant others that are dealing with the transition as well. Getting the veterans linked into treatment and comfortable seeking treatment is the first step in getting this population and their support networks help. Ouimette et al. (2011) have found that often veterans do not seek treatment due to the negative stigma (ie: not liking being told what to do, not wanting to get emotional, not wanting to talk about feelings) associated with mental health services and concerns with the social consequences of seeking help.

For this population there are very low rates of treatment compliance (high dropout rates) and high rates of alcohol abuse, which leads to a lack of effective treatment for veterans (Erbes, Curry & Lesekela, 2009). Possible reasons for this are that those veterans with PTSD or other disorders may not be knowledgeable of the services available to them or their eligibility for treatment (Ouimette et al., 2011). Garcia, Kelley, Rentz and Lee (2011) have also found that OIF and OEF veterans are more likely than Vietnam veterans to drop out of treatment and also have more problematic alcohol use for
reasons such as resistance to treatment and symptom severity (Erbes, Curry & Lesekela, 2009). High drop out rates and substance use lead to poor treatment retention, 38% for veterans with PTSD and only 24% attended for at least eight sessions, showing that many do not stay long enough to receive proper treatment (Tsan et al., 2012). These statistics show that there is a need for a specialized treatment for a younger cohort of veterans with more acute trauma/combat experiences (Erbes, Curry & Lesekela, 2009). Another trend noted by Erbes, Curry and Lesekela (2009) is that veterans are withdrawing from treatment and returning later during a time of crisis when symptoms have worsened or their life has become dramatically affected by consequences of substance use or other behaviors affecting their social circle. This is also supported by evidence showing that veterans who were rescreened for mental illness months after returning home from war showed higher rates of symptomology than when they were first screened (Erbes, Curry & Lesekela, 2009). Lastly, it is important to take the family system into account and the marital problems that can occur as a result of PTSD or other disorders (problems sleeping, emotional dissociation, sexual problems) and tailor treatments to address these issues (Goff, Crow, Reisbig & Hamilton, 2007).

**Purpose of the Project**

The purpose of Veterans Engaging in Treatment Service (VETS) is to develop a specialized treatment program for veterans of the wars in Iraq and Afghanistan, as well as for their spouses or significant others. As noted previously, many veterans are returning home and having difficulty returning to a civilian life with their friends and family. By reaching out to the veterans and also to their support system, clinicians may be able to create a treatment modality that will have a higher compliance rate. In order to create a
meaningful treatment intervention program, research was explored to assess the most prominent psychological issues faced by OIF/OEF veterans. Next, the issues faced by veterans in a relationship were examined to see what symptoms cause discord with their significant other. It is crucial to help veterans learn to transition into their family life due to the dissatisfaction endured in relationships and the impact these issues have on an entire family system. Usually a return from deployment is a joyous time, but when a veteran returns with a myriad of psychological problems their spouse, children, and extended family all feel the effects. This project will combine group psychotherapy techniques for veterans alone as well as an educational support group for spouses/significant others who may need help learning to cope with their veteran’s mental illness or symptoms.

**Terminology**

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are military reactions to the threat of weapons of mass destruction in Iraq and Afghanistan as well as the overthrow of Saddam Hussein (Gardner, 2004). The US has occupied and has been overseeing areas of Iraq and Afghanistan since the events of September 11, 2001 as well as Operation Desert Storm (Gardner, 2004). For the past 12 years the US has been working with British and other forces in the Middle East to control Al Qaeda fighters and institute a new political regime (Gardner, 2004).

PTSD (Post Traumatic Stress Disorder) is one of the most common anxiety disorders over lifetime and 12-month prevalence (Seedat, 2013). This disorder is characterized by a maladaptive response to a trauma in which an individual suffers from repetitive and intrusive memories or flashbacks related to the trauma (Seedat, 2013).
Individuals often experience nightmares, flashbacks, avoidance of trauma related stimuli, increased arousal, and loss of interest in activities or estrangement from family members (Seedat, 2013). All of these symptoms together can be formed into three clusters: re-experiencing, numbing and hyperarousal (Seedat, 2013). Other than PTSD, one of the most common injuries that veterans are showing symptoms of is TBI (traumatic brain injury). Perlick et al. (2011) define TBI as a temporary loss of consciousness or “altered mental state” (page 71). At least 22% of veterans returning home from OEF/OIF are returning home with TBI but the actual incidence may be higher since it often goes undiagnosed (Perlick et al., 2011).

Summary

A review of literature is provided which examines the specific OIF and OEF veteran population in question, group therapy techniques shown to be beneficial for this population, and specific issues related couple systems in this population. After a review of pertinent literature, the intended audience and development of the project is reviewed. Personal qualifications of those administering the treatment and the environment where the treatment may take place will follow as well as an outline for the content of the treatment. Lastly, the treatment itself will be presented in a workshop or group therapy outline. Weekly topics will be presented as well as a rationale for the topics and ways to integrate the veterans and spouses at the end of a session. At the end of the weekly topics there will be an ending activity to close out the group as well as a discussion of the treatment process.
Chapter II: Literature Review

There are many ways in which veterans of our armed forces serve our country, but their transition back to civilian life after combat is often stressful and complicated by mental illness. Whether a veteran is married or not does not change the struggles they face but those with significant others and families face an even greater challenge (Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011). Integrating oneself back into family life while struggling with Post Traumatic Stress Disorder (PTSD), anxiety, depression, and alcohol or substance abuse often needs the help of a mental health counselor as well as the veterans’ loved ones. This literature review will examine common mental health symptoms that veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) often return home with as well as how these symptoms impact the family’s reintegration process. Lastly an overview of literature and treatment for veterans of OEF and OIF will be provided.

Characteristics of Veterans of OIF and OEF

Changes in warfare in the Middle East have led our soldiers to enduring guerilla war type scenarios and many are returning home with symptoms of mental illness (Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011). It has been estimated that somewhere between 20% and 30% of combat veterans of OIF and OEF show signs of PTSD (Forbes, Lloyd, Nixon, Elliot, Varker, Perry et al., 2012). The war in the Middle East has introduced the use of civilians as combatants, which may lead to a higher incidence of non-combatant deaths as well as body recovery of civilians and an increase in direct combat with the enemy (Forbes et al., 2012). These traumatic experiences have also been shown to lead to an increase in guilt, substance abuse, and interpersonal issues.
in soldiers of OIF and OEF (Forbes, et al., 2012). One of the culprits behind the high rate of veterans with PTSD or depression is the idea of emotional toughness. Emotional toughness occurs when a soldier is not able to display vulnerable emotions (such as fear, anxiety or worry) and when soldiers cannot rely on others in times of duress (Jacupak, Blair, Grossbard, Garcia, & Okiishi, 2013). Emotional toughness may be beneficial for resiliency of physical injuries but worsens emotional distress and leads to depression and a reluctance to seek help (Jacupak et al., 2013). The complexity of symptoms, including PTSD, depression, and anxiety make it increasingly difficult to treat combat veterans returning from war in the Middle East.

Veterans with PTSD are more likely to have interpersonal problems, to isolate themselves from others, experience more physical confrontations, and have impaired occupational roles (Pukay-Martin, Pontoski, Maxwell, et al., 2012). A combination of these symptoms from depression, anxiety and PTSD may also leave veterans at a higher risk of substance abuse and suicide. Renshaw and Campbell (2011) have shown that PTSD combined with relationship distress and interpersonal conflict predicts a poor prognosis for recovery and a higher risk of suicide. Veterans who are divorced or separated from their significant other also show higher rates of PTSD than those who are single, cohabitating, or married (Jacupak et al., 2013). Which branch of the military the soldier was enlisted in also affects rates of PTSD. Army veterans were found to have the highest rates of PTSD over Marines, Air Force, and Navy but USMC veterans had the highest rates of alcohol abuse (Jacupak et al., 2013). Fredman, Monson, and Adair (2011) found that veterans who have recently returned home tend to underreport their use of alcohol (and other substances) as coping mechanisms for dealing with their PTSD.
Jacupak et al., (2013) have found that veterans use alcohol to deal with depression as well. Veterans with PTSD as well as Alcohol Use Disorder (AUD) show lower over functioning than someone with either diagnosis alone (McDevitt-Murphy, 2011).

Vinokur, Pierce, Lewandowski-Romps, Hobfoll, and Galea (2011) have shown that veterans who are better able to replenish their resources (financial as well as emotional aspects of their lives) have a better prognosis for recovering from PTSD symptoms following trauma. On the other hand, lack of social support has been shown to be the highest predictive factor of a veteran having PTSD (McDevitt-Murphy, 2011). Anger, emotional numbing, and withdrawal from one’s social support network interfere with the emotional intimacy a veteran has with their significant other, which leads to a decrease in social support and an increase in PTSD symptoms, such as emotional numbing, anger, and social avoidance (McDevitt-Murphy, 2011). Thus, allowing veterans to find a way of expressing their emotions and processing their traumatic experience is necessary to facilitate emotional intimacy with their partner which in turn leads to greater social support.

**PTSD in OEF and OIF Veterans**

According to Garcia, Finley, Lorber and Jakupcak (2011) approximately 9.5% of OIE and OIF veterans recently diagnosed with PTSD do not receive the recommended amount of treatment in the first year of their diagnosis. Garcia et al. (2011) have found PTSD rates for veterans of OIE and OIF to be as high as 11-22% upon their return home while another study found PTSD rates to be between 6-12% upon leaving Afghanistan and Iraq (Garcia, Kelley, Rentz & Lee, 2011). Although these figures have a large discrepancy in their prevalence rates, they show that many of the soldiers coming home
from war in the Middle East are showing signs associated with PTSD. One reason why clinicians should keep an eye on this population is that PTSD is likely to run a chronic course with 40% of those diagnosed showing symptoms after 10 years as well as a higher risk of suicide, substance abuse, and other health problems (Sharpless & Barber, 2011). To help serve this population clinicians also need to keep in mind what types of trauma the veteran is likely to have witnessed, ie: friends being killed, killing enemies, witnessing rape, as well as other things they may have done in combat (Sharpless & Barber, 2011). With such high rates of PTSD in soldiers returning home there is also a low percentage of soldiers utilizing treatment for their symptoms (Garcia, Finley, Lorber, & Jakupcak, 2011).

Garcia, Finley, Lorber and Jakupcak (2011) have reviewed how traditional masculine roles for men may interfere with the likelihood that they will seek treatment. Military training tends to emphasize a traditionally masculine role, and those who enlist in the military may already be predisposed to this masculine gender role (Garcia et al., 2011). It is this masculine role which emphasizes self-reliance, discourages emotional expression (fear of emotionality and emotional restrictiveness), as well as the idea that seeking treatment is seen as weak (Garcia, Finley, Lorber, & Jakupcak, 2011). Garcia, Finley, Lorber and Jakupcak (2011) have also found that these masculinity norms have been linked to anxiety and depression in civilian populations as well. Within the veteran population the avoidance symptom cluster is likely to prevent soldiers from seeking treatment but may also be exacerbating current PTSD as well (Garcia, Finley, Lorber, & Jakupcak, 2011).
Depression and avoidance with PTSD

Avoidance of emotion is likely to lead the veteran to avoid emotional processing of traumatic events, decrease the ability to cope with symptoms or seek treatment, and also leads to avoiding memories or thinking of psychological trauma causing their avoidance/numbing symptoms to worsen (Garcia, Finley, Lorber, & Jakupcak, 2011). Erbes, Curry and Leskela (2009) estimate that of 1.6 million service members that have served in Iraq and Afghanistan, 15% will report PTSD, depression, generalized anxiety or substance use. Of the veterans who have been diagnosed with PTSD, those who also experience intense depressive symptoms are likely to experience suicidal ideation (Pukay-Martin et al., 2012). Bryan and Corso (2011) have found that depression is one of the links between PTSD and suicidality and that the more PTSD symptoms that are experienced the higher the prevalence of comorbid depression. These statistics show the complex relationship that depression and PTSD have and how it is both important and relevant it is to treat veterans for both simultaneously.

Owens, Steger, Whitesell and Herrera (2009) also note that the more depressed an individual is the more symptoms of PTSD they report. Feelings of guilt and depression are often present after stressful combat missions and may be a result of not being able to make sense of the traumatic events they have witnessed or being able to find meaning in their life after such incidences. Being able to make meaning in their life is a key buffer to both PTSD and depression symptoms and those capable of cognitive restructuring are better able to complete this task (Owens, Steger, Whitesell, & Herrera, 2009).
Avoidance is another common symptom of PTSD partly because combat survivors often feel a deep sense of responsibility and accountability for that goes on around him (Grossman, 2009). Lieutenant Colonel Dave Grossman has noted that it is often easier to keep painful memories out of one’s mind while young but often these memories will come back to haunt one at night later on in life (Grossman, 2009). The avoidance symptom cluster also has a huge effect on marriages for those returning from Iraq and Afghanistan. Those who escape through emotional detachment (or anhedonia) often isolate themselves socially which leaves their spouse to socialize alone or become resentful of living an isolated existence (Sherman, Zanotti, & Jones, 2005). Sherman, Zanotti, and Jones (2005) have also found that this avoidance leads to emotional distance in relationships causing a decrease in emotional intimacy (which is a prime indicator in marital satisfaction). When avoidance is present, soldiers may lose interest in sex with their spouse, have a hard time showing care for their spouse, and often have low levels of self-disclosure. Such avoidance may lead to an emotional distance between spouse that results in infidelity as a way of making connection with someone new (Sherman, Zanotti, & Jones, 2005).

This article showcases the mixture of relationship problems result due to the emotional avoidance cluster of PTSD symptoms. Depression, PTSD and traumatic brain injury have also been found to be closely linked to marriage dissolution and divorce rates for OIF and OEF have increased for US Army personnel according to Makin-Byrd, Gifford, McCutcheon, and Glynn (2011). In treating PTSD, veterans with emotional numbing and avoidance have been found not to respond well to treatment but Cognitive
Processing Therapy (CPT) has been shown to produce a decline of these symptoms (Monson et al., 2006).

**Traumatic Brain Injury (TBI) in combination with PTSD**

Guerilla warfare (improvised explosive devices (IEDs), car bombs, suicide bombers, civilian casualties) is having a huge impact on our veteran’s mental health with 75% of injuries caused by explosions of IEDs and suicide/car bombs (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). TBI, which is an injury associated with brief loss of consciousness or “altered mental state” has been coined the signature injury of the wars in Iraq and Afghanistan (Perlick et al., 2011). An estimated 22% of veterans returning from OIF/OEF have experienced TBI but the true incidence may be higher due to difficulty with diagnosis (TBI is often comorbid with PTSD) (Perlick et al., 2011). It is estimated that 80% of those with TBI also have a comorbid psychiatric diagnosis (Morissette, Woodward, Kimbrel, Meyer, Krause, Dolan, & Gulliver, 2011). TBI may cause physical pain/impairment, cognitive deficits, mental health problems (depression or PTSD), dizziness, irritability, memory problems, balance issues, and headaches (Morissette et al., 2011). Makin-Byrd et al. (2011) also note that veterans are surviving more serious physical trauma, which may have previously been fatal, due to better armor protection, improved medical care, and evacuation services, but are suffering more intense physical impairments (more amputations) and psychological impairments. Traumatic brain injury is an example of how soldiers are surviving intense explosions but suffering the mental repercussions of such incidences. Morissette et al., (2011) have also found that TBI predicts higher rates of major depression among those who lost consciousness (as opposed to entering an alternate mental state) and that this risk for
depression is present for decades after the injury. Lastly, the presence of even mild TBI is associated with lower recovery levels from PTSD (Morissette et al., 2011).

**Alcohol abuse in combination with PTSD**

Alcohol and substance dependence is becoming a growing issue with as many as 11.5-35% of veterans returning from OIF/OEF reporting high rates of alcohol misuse (Jakupcak, Tull, McDermott, Kaysen, Hunt, & Simpson, 2012). The tendency to self-medicate to manage PTSD or other psychological issues with alcohol or other drugs is leading to a high correlation between diagnosis of PTSD and Alcohol Use Disorder (AUD) (Seal, Cohen, Waldrop, Cohen, Maguen, & Ren, 2011). Clinicians also need to take into account the idea that drinking has become a part of military culture, especially for those under the age of 25 who have the highest rates of AUD for veterans of the Army and US Marine Corps (USMC) (Jakupcak et al., 2012). Veterans may be using alcohol or other drugs to regulate both their positive and negative emotions by drinking in order to make social interactions easier or more pleasurable as well as to detach and blunt negative emotions (Jakupcak et al., 2012). Alcohol misuse has been linked to spousal abuse, occupational impairment, and legal problems for the veterans adding to the complexity of their return to civilian life and reuniting with their families (Jakupcak et al., 2012). Seal, Cohen, Waldrop, Cohen, Maguen, and Ren, (2011) found that veterans who are separated, divorced, or widowed have a 1.5-3 times higher likelihood to be diagnosed with AUD or drug use disorder (DUD). This raises the issue of whether it is a lack of social support or a proper support system that leads to veteran’s overuse of alcohol, especially if they are alone.
The number of veterans experiencing AUD or DUD with at least one co-morbid psychological disorder is a staggering 82-93% (Seal et al., 2011). PTSD, depression, anxiety, and adjustment disorder have high correlations with co-morbid diagnosis of AUD or DUD with PTSD increasing an AUD diagnosis by four times (Seal et al., 2011). When looking at the effects of PTSD or depression on AUD diagnosis, clinicians should evaluate how symptoms are interacting with the alcohol use and which symptoms are likely to lead to alcohol abuse (emotional numbing and hyperarousal are most closely linked with alcohol abuse) in order to decide on a plan for treatment (Jakupcak et al., 2012). Between the high incidence rates and the myriad of problems alcohol abuse adds to the lives of veterans, it is important for clinicians to screen for AUD or DUD and also to prepare treatment for these issues.

*Anger in combination with PTSD*

Often veterans use anger and dissociation as ways of “active avoidance” to cope with PTSD and its various co-morbid disorders (Kulkarni, Porter, & Rauch, 2012). Anger gives the veteran a false sense of control, which is perpetuated by male gender roles and the idea that men cannot show their vulnerability (Kulkarni, Porter, & Rauch, 2012). Kulkarni, Porter, and Rauch (2012) also found that anger is a serious of unprocessed emotions, which create triggers connected to the traumatic events that eventually increase in intensity. Younger veterans show more anger than veterans from older war eras due to the proximity of their traumatic experiences to the present time and an increased difficulty integrating into civilian life (Kulkarni, Porter, & Rauch, 2012). Dissociation is a form of “active avoidance” allowing the veteran to withdraw from the distressing moment and avoiding a series of traumatic memories that have not been dealt with
Kulkarni, Porter, and Rauch (2012) found that an open discussion of a veteran’s anger and dissociative symptoms in conjunction with processing the trauma and emotional reactions show positive trends for recovery.

Anger management skills for veterans with PTSD may be a key role in maintaining successful marriages. Many young veterans are likely to perpetrate nonphysical aggression, with there being a positive correlation between combat exposure and PTSD symptom severity, with the presence of physical aggression in relationships at home after the war (Stappenbeck, Hellmuth, Simpson, & Jakupcak, 2013). It is estimated that 70-75% of veterans diagnosed with PTSD report acts of physical aggression in the past year compared with 17-29% of veterans not diagnosed with PTSD (Stappenbeck, Hellmuth, Simpson, & Jakupcak, 2013). Reasons for such high incidence of physical aggression reported relates to soldiers issues with feeling irritable or difficulty regulating their negative emotions (Stappenbeck et al., 2013). Stappenbeck, et al. (2013) have also found a link between those veterans reporting acts of aggression (physical or nonphysical) also having problems with alcohol.

**Treatment for Veterans of OEF and OIF**

Sharpless and Barber (2011) have outline 9 treatment modules to use with veterans individually but caution to take into account the client’s readiness to deal with the trauma, the funds they have available for treatment, as well as the severity of their symptoms, possible co-morbid diagnosis, any cognitive limitations they may be experiencing due to brain injuries, or any medications the veteran may be taking. The researchers also point out that only 17% of veterans are diagnosed solely with PTSD with many having a comorbid diagnosis (Sharpless, & Barber, 2011).
**Prolonged Exposure Therapy**

Prolonged Exposure (PE) therapy is a treatment that reduces PTSD through modifying the memory structures causing emotions such as fear (Sharpless, & Barber, 2011). PE is a manualized treatment lasting 8-15 weeks with 90 minute sessions using imaginal revisiting of traumatic memories (recounting memories out loud and then immediately discussing the memories with the clinician) (Sharpless, & Barber, 2011). PE also uses in vivo exposure to safe trauma related situations that the client avoids, as well as psychoeducation and the practice of slow breathing techniques (Sharpless, & Barber, 2011). The slow breathing techniques have had the most evidence for efficacy in the treatment of PTSD out of the previous two practices (Sharpless, & Barber, 2011).

**Cognitive Processing Therapy**

Cognitive Processing Therapy (CPT) is also used with OIE and OIF veteran populations focusing on challenging problematic thoughts and self blame (Sharpless & Barber, 2011). There are normally 12 sessions and the exposure component of having the veteran write about traumatic events in detail and then reading it aloud during sessions allows the clinician to guide veterans when they become “stuck” (Sharpless & Barber, 2011). Sharpless and Barber (2011) have noted with this technique that both the cognitive and written components have been proven to be useful but the cognitive component shows more benefit to the veteran.

Another type of group therapy that has been used with veterans of OIE and OIF is CBT group therapy. Techniques used in this group therapy format showed improvements in client functioning (numbing and avoidance were decreased) but differences between control groups were not present (Sharpless & Barber, 2011).
Eye Movement Desensitization and Reprocessing (EMDR)

EMDR, which is a combination of Cognitive Behavioral Therapy, mindfulness, body based approaches, and person centered therapies has also been found by Sharpless and Barber (2011) to be an effective treatment modality for OIE and OIF veterans. EMDR has a specific, manualized treatment process which implements desensitization, reprocessing, rhythmic finger movements, practicing positive cognitions, and journaling (Sharpless & Barber, 2011).

Stress Inoculation Training (SIT)

Stress Inoculation Training (SIT) has been shown to help veterans manage the anxiety component of PTSD by teaching thought stopping and processing in vivo exposure to feared situations (Sharpless & Barber, 2011). Sharpless and Barber (2011) have found relaxation training to be effective for treating PTSD. This treatment teaches a client the successive tensing and relaxing of muscles reduces fear and anxiety responses to traumatic experiences. SIT can be used alone or as part of a broader treatment package (it has been found to be more effective when part of a larger treatment package) (Sharpless & Barber 2011).

Interpersonal Psychotherapy (IPT)

Sharpless and Barber (2011) found Interpersonal Psychotherapy (IPT) to improve symptoms of anger and depression through reframing the trauma as an impairment to one’s ability to trust that damages interpersonal relationships. IPT is time limited and although it was initially created to treat major depression with this population, the aim is to increase social skills, reduce feelings of helplessness and demoralization, and to
facilitate emotional expression. Additionally, IPT assists veterans in generating adaptive coping strategies (Sharpless & Barber, 2011).

*Dialectical Behavioral Therapy (DBT)*

Dialectical Behavioral Therapy (DBT) has been used with the OIF and OEF population and combines CBT techniques with mindfulness training to facilitate coping mechanisms for affect regulation and dealing with interpersonal relationships (Sharpless & Barber, 2011). Clients attend individual sessions as well as DBT group sessions where the clinician works with clients toward accepting and changing their problematic behavior (Sharpless & Barber, 2011).

**Issues for Veterans of OEF/OIF and their Partners**

Symptoms of trauma and PTSD not only affect the veteran but also the spouse or partner of the veteran and their satisfaction as a couple. Goff, Crow, Reisbig and Hamilton (2007) have found that sleep problems, dissociation, and severe sexual problems were the biggest factors leading to martial dissatisfaction for male OIF/OEF veterans and their female spouses. This is in part due to the fact that high levels of trauma can interfere with the daily activities of a veteran’s life causing them to be less emotionally attuned to their spouse; leading to decreased marital satisfaction (Goff, Crow, Reisbig, & Hamilton, 2007). General trauma symptoms have been found to have a greater impact of martial satisfaction than symptoms specific to PTSD (Goff, Crow, Reisbig, & Hamilton, 2007). This may be due to the fact that soldiers are acutely trained to detect symptoms of PTSD and that they then deflect these symptoms to avoid the consequences of such a diagnosis and show more problems related to general trauma (Goff, Crow, Reisbig, & Hamilton, 2007).
Marital Dissatisfaction

Sherman, Zanotti, and Jones (2005) looked at including spouses in the treatment of PTSD in OIF/OEF veterans because it has been found that partners of veterans experience more marital dissatisfaction and are often unhappier than their male counterparts. Female partners experience high levels of care-giver burden because of relationship problems such as poor relationship adjustment, poor communication with partners, and difficulties with intimacy which may be chronic for veterans diagnosed with PTSD (Sherman, Zanotti & Jones, 2005). These primary chronic issues for veterans are due to three symptom clusters: re-experiencing, avoidance, and increased arousal (Sherman, Zanotti & Jones, 2005). The researchers found that high levels of expressed emotion (usually anger) as well as high levels of stress in the family (especially tension and hostility) will worsen symptoms of PTSD (Sherman, Zanotti & Jones, 2005). These symptoms act in a cycle by emotionally hurting the veteran’s spouse causing her to be hesitant to seek help, which lessens the social support and intimacy available to the veteran (Sherman, Zanotti & Jones, 2005). This cycle of emotional pain and withdrawal exacerbates PTSD symptoms for the veteran (Sherman, Zanotti, & Jones, 2005). Working with the family unit has been successful in changing the maladaptive relationship patterns between veteran and spouse through creating a balance of the needs of both individuals and increasing understanding and sensitivity to each other’s experience (Sherman, Zanotti, & Jones, 2005).
Creating Positive Marital Interactions

Sherman, Zanotti, & Jones (2005) report that relational interventions for veterans with PTSD have had negative outcomes, which raises the question of how to create a specialized treatment for this population. Couple therapy should be used in conjunction with the veteran’s personal therapy to address the three main symptom clusters (re-experiencing, avoidance, and increased arousal) unless the strengths of the couple system could withstand intensive relational treatment (Sherman, Zanotti, & Jones, 2005). One way the couple relationship can be balanced is to change the perception that the partner is not married to a man with PTSD but instead to a man dealing with wartime challenges and the partner is dealing with a different set of chronic difficulties (Sherman, Zanotti, & Jones, 2005). Early on in therapy the couple should also decide how to deal with certain phenomena (flashbacks, nightmares, etc.) instead of focusing on symptom management for the veteran (which puts blame onto the veteran for marital dissatisfaction) (Sherman, Zanotti, & Jones, 2005). Another way to promote positive behavioral change is to encourage acceptance of tolerating relational differences in the couple instead of trying to eliminate a chronic problem (Sherman, Zanotti, & Jones, 2005).

Re-experiencing Symptoms

Sherman, Zanotti, & Jones (2005) have demonstrated working with combat veteran couple systems by dividing treatment based on the three main symptom clusters (re-experiencing, avoidance, and increased arousal. Re-experiencing is a symptom involving flashbacks or nightmares which often cause a veteran to feel confused, ashamed or anxious after coming to. Often, after a re-experiencing episode, the veteran is reluctant to talk about what happened leaving their spouse feeling alone, afraid, or
helpless (Sherman, Zanotti, & Jones, 2005). Ultimately the couple may end up sleeping in separate beds or rooms causing a decrease in physical intimacy and emotional closeness (Sherman, Zanotti, & Jones, 2005). Caregiver burden may also be increased for the veteran’s spouse if he is having trouble finding work due to his PTSD symptoms leaving his partner to provide for the family (Sherman, Zanotti, & Jones, 2005). Sherman, Zanotti, and Jones (2005) provide steps for treating re-experiencing by helping the veteran explain the symptom from his perspective and explaining to his spouse how to support him during a re-experiencing episode, teaching the couple coping skills to manage the episode, and using the experience as a way to learn more about the veteran’s symptoms.

Avoidance Symptoms

Avoidance, the second of the cluster symptoms of PTSD, is especially detrimental to the marital relationship. Often, a veteran using avoidance pulls away from their relationships using emotional detachment or by experiencing anhedonia, leading to social isolation, leaving his spouse to either socialize alone or become resentful of her isolated existence (Sherman, Zanotti, & Jones, 2005). Anhedonia may lead to a veteran doing very little except watching TV, sleeping, or doing other menial activities, which lead to a feeling of living a meaningless existence, worsening their already distant relationship with their spouse (Sherman, Zanotti, & Jones, 2005). Emotional intimacy is a prime indicator of marital satisfaction and stability, and symptoms of avoidance such as low sexual desire on behalf of either spouse and low levels of self-disclosure from the veteran put a further strain on the couple. Low sexual desire and low levels of self-disclosure have led to infidelity as a means of making a connection with another (Sherman, Zanotti,
The experience of emotional closeness between veteran and spouse may trigger negative feelings due survivor’s guilt from losing close friends or comrades during combat, leading to further avoidance behaviors with their spouse (Sherman, Zanotti, & Jones, 2005).

**Increased Arousal Symptoms**

Sherman, Zanotti, and Jones (2005) provide an overview of the increased arousal symptom cluster which they have found to lead to a lack of sleep causing increased social withdrawal and interpersonal stress. Long periods of low tension can also decrease the overall positive feelings associated with a relationship causing partners of veterans to “walk on eggshells” in order to avoid upsetting their husband and thus causing them to act critically or disengage from the relationship (Sherman, Zanotti, & Jones, 2005). The increased arousal cluster has also been linked to increases in violent acts by veterans on their spouses. These displays of anger have been linked to a decrease in offers for social support by those close to the veteran (Sherman, Zanotti, & Jones, 2005). Sherman, Zanotti, and Jones (2005) have found that this increase in domestic violence (DV) is often heightened by the likelihood that PTSD symptoms will be comorbid with diagnosis such as substance abuse, depression, relationship distress, and a lowered ability to solve problems.

Treatment with these couples in which a veteran is struggling with increased arousal, begins with discussion and development of boundaries for emotional discussions (Sherman, Zanotti, and Jones (2005). When one partner is flooded with too much emotional stress it can cause them to mentally check out making communication more difficult and leaving gaps in the emotional intimacy of the relationship (Sherman, Zanotti
& Jones, 2005). The therapist aids the couple in defining their boundaries for such discussions as well as planning out when and how to have them (Sherman, Zanotti & Jones, 2005). The second step for Sherman, Zanotti, and Jones (2005) is to assess for domestic violence. If severe DV is occurring, therapy may be stopped to prevent further perpetration against the spouse and separate measures for treatment will be taken if continued domestic violence is a threat. Lastly, the therapist helps the couple deal with irritability/anger by exploring triggers for either partner and using psychoeducation to teach the couple about appropriate coping strategies (Sherman, Zanotti & Jones, 2005). Sherman, Zanotti and Jones (2005) have found that the last steps helps the veteran learn when he is displacing his anger onto his spouse and allows the spouse time to deal with the veteran’s anger and learn how to provide feedback when he has an outburst.

**Beginning Couple Treatment**

Sherman, Zanotti, and Jones (2005) suggest beginning couple’s treatment by assessing the couple’s commitment and readiness to work on emotional intimacy by outlining the potential benefits and fears associated with expressing these emotions. Second, Sherman, Zanotti, and Jones (2005) advise empowering the couple to take the risk of being open and trusting one another in order to help the veteran see that his previous methods of keeping people emotionally at bay are no longer needed. The third step in this model is assisting the couple to decide on how much of the trauma will be shared within the relationship by teaching the spouse how to support the veteran and showing the veteran how to communicate his trauma experience in a controlled manner (Sherman, Zanotti, & Jones, 2005). Lastly, the therapist helps the couple chose mutually satisfying social activities that will not interfere with the veteran’s PTSD symptoms and
also have a high likelihood of following through (participating in groups for other veterans, etc.) (Sherman, Zanotti, & Jones, 2005). All of these steps have been created by Sherman, Zanotti, and Jones (2005) in an attempt to help the couple, specifically the veteran, deal with interpersonal problems directly and decrease avoidant behaviors.

**Group Therapy Programs for Veterans and their Partners**

*SAFE (The Support and Family Education Program)*

Makin-Byrd, Gifford, McCutheson, and Glynn (2011) have outlined several family based interventions, which have shown promise with veterans of OIF and OEF. The first is SAFE (The Support and Family Education Program) from the Oklahoma City Veteran Affairs Medical Center. SAFE is an 18-session family education program. SAFE focuses on PTSD by providing psychoeducation about mental illness symptoms, as well as skill development for family members linking family members to mental health services within the VA hospital and community (Makin-Byrd, Gifford, McCutheson, & Glynn, 2011). Each group session is 90 minutes and takes place either once or twice a month depending on the needs of the participants. Sessions consist of three parts: group discussion and support, didactic presentation, and a question and answer time with a psychiatrist (Makin-Byrd, Gifford, McCutheson, & Glynn, 2011). The topics covered in these sessions include communication, creating low stress environments, problem solving, and anger management (Makin-Byrd, Gifford, McCutheson, & Glynn, 2011). Makin-Byrd, Gifford, McCutheson, and Glynn (2011) have found that the SAFE program produced an increased awareness of VA resources available, lower caregiver distress, better understanding of mental illness, and higher probability of caregivers engaging in self care.
FFEP (Family-to Family Education Program)

FFEP (Family-to Family Education Program) is a partnership between the VA system and NAMI (National Alliance on Mental Illness), which provides information on mental illness, medications, treatment, problem solving and communication techniques, caring for the caregiver, and access to community services (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). FFEP is a manualized 12-week course with 2-3-hour sessions lead by trained family members who volunteer (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). The FFEP provides information on mental illness, medications, problem solving and communication techniques, taking care of the caregiver, and community services available (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). Outcomes of this treatment program include decreased caregiver burden and increased caregiver empowerment, increased understanding of severe mental illness and mental health services, and increases in caregiver self care (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). To close out this program veterans and their family members get together to create a “shared story” in which they list the strengths they have used to deal with deployment, things that have changed since deployment, and what has stayed the same (Makin-Byrd, Gifford, McCutcheson, & Glynn, 2011). Makin-Byrd, Gifford, McCutcheson, and Glynn, (2011) found that having the veteran and family members create this shared experience story helps all those involved make sense of the deployment and reintegration of the veteran and allows the family to move forward.

MFG-TBI (Multifamily Group Therapy for TBI)

The MFG-TBI model created by Perlick et al. (2011) emphasizes education for mental illness and problem solving skills for veterans and their family members. The
MFG-TBI model consists of 6-8 veterans and their family members who meet for an introduction for the first 2-3 sessions to become familiar with each other (Perlick et al., 2011). The remaining sessions are educational workshops for problem solving techniques for frequently encountered issues as well as mental illness (Perlick et al., 2011). The final meetings are two times a month for all members for 12 months (Perlick et al., 2011). MFG adapted for TBI facilitates decreased burden for family members, lower rates of depression and anger expression, and increased satisfaction with life for the veteran (Perlick et al., 2011). Since the goal of MFG-TBI is psychoeducation and not focused on trauma, it may be more enticing for those hesitant to seek treatment (Perlick et al., 2011).

Some of the issues worked on include: difficulty remembering appointments, fitting appointments into a schedule while dealing with memory and organizational issues, and reducing the stigma of seeking treatment (Perlick et al., 2011). Stigma reduction was done by addressing pros and cons of seeking treatment using motivational interviewing by the therapist with the veteran (Perlick et al., 2011). During the first few sessions where the group members and therapist are building rapport, genograms are used to look at the multi-generational patterns of mental illness and stressors within the veteran’s family (Perlick et al., 2011). This process helps normalize the issues the veterans are having by seeing that others also deal with similar issues and how those they have grown up with have influenced their mental health over many years. Perlick et al. (2011) continues to facilitate this process by building ecomaps with the group members. An ecomap is a way for the veteran to view the relationship between them and their family, the resources available to them, as well as their family’s size and diversity (Perlick et al., 2011). Ecomaps help the veteran identify strengths and challenges, which
the veteran may be facing or that can be addressed in treatment (Perlick et al., 2011). Using visual aids, veterans can see which ties have been broken in their own families due to their PTSD symptoms and the therapist can educate group members about how avoidance/emotional numbing can have an especially detrimental impact on their relationships (Perlick et al., 2011). By helping veterans see relationship patterns and the impact their symptoms have had, treatment can take a specific direction for symptom and relationship distress.

*MFG-TBI Skills Training*

At the beginning of MFG-TBI three key areas of treatment are introduced, addressing strengths and weaknesses, areas of major conflict for the couple, and the benefits of treatment (Perlick et al., 2011). Therapists work with veterans with the MFG-TBI model on communication skills by teaching how to make positive requests, give positive feedback, and express negative feelings (Perlick et al., 2011). By increasing positive communication between couples, marital distress should decrease as incidences of positive feelings increase between veteran and spouse. Next, Perlick et al. (2011) introduce emotional acceptance, the idea that instead of demanding behavioral change (which one partner may not be ready or unable to make) that partners should move toward relationship goals by understanding and taking the perspective of their partner. The goal is to help both partners see the impact that symptoms have on the relationship (Perlick et al., 2011). Psychoeducation about TBI is also included to help family members learn about the disorder since a lack of knowledge has lead to personalization of negative symptoms by veteran’s family members (Perlick et al., 2011). Since organization, attention and memory can be affected by TBI, Perlick et al. (2011) created
workshop slides for the skills training portion of treatment that were not overly wordy, had bright contrasting colors and images which helped to hold attention. Pamphlets were also distributed summarizing each workshop and the treatment program as a whole as well as resources available to veterans to keep for reference later (Perlick et al., 2011).

*MFG-TBI Group Meetings*

Each group session started with a brief socialization period for group members, then a check-in for each family was conducted followed by problem formulation, problem solving, planning for the next meeting, and a second brief socialization period before dismissal (Perlick et al., 2011). The problem formulation was lumped into three categories for discussion: relationship difficulties, veteran’s difficulties with memory, organization, taking medications, etc., and helping veterans accept and acknowledge their limitations and difficulties (Perlick et al., 2011). Perlick et al. (2011) found it helpful to use a whiteboard to conduct a summary at the end of each session so members can actively participate what they recall from the session and provide feedback to facilitators.

*Limitations and Difficulties*

Group facilitators of MFG-TBI noticed that there was a low carry over of information from the educational segments into later group meetings (Perlick et al., 2011). Possible reasons for this may be the very symptoms of TBI that veterans are learning to deal with, low attention, poor short-term memory and lowered organizational skills. Difficulty with keeping group meeting format and emotional regulation was also encountered (Perlick et al., 2011). These issues stem from group members getting agitated or losing focus, having poor attention to the topic and problems with attendance due to problems scheduling group meetings into their time (Perlick et al., 2011). One-way
Perlick et al. (2011) dealt with these issues was to offer individual or couple sessions for those needing extra help outside of group meetings.

Summary

PTSD is the most commonly diagnosed mental illness being seen in veterans of Operation Iraqi Freedom and Operation Enduring Freedom with prevalence statistics ranging from 20%-30% (Makin-Byrd, Gifford, McCutcheon & Glynn, 2011). Veterans also often have comorbid diagnosis of depression, traumatic brain injury, alcohol abuse and face many interpersonal problems. There are many new treatment options being developed for this cohort of veterans including: Prolonged Exposure Therapy, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, Stress Inoculation Training, Cognitive Behavioral Therapy, Interpersonal Psychotherapy, Dialectical Behavioral Therapy, The Support and Family Education Program, Family to Family Education Program, and Multifamily Group Therapy for TBI. Many of these therapy models are lacking something, veterans often drop out of treatment early or decide not to seek treatment, and the group therapy treatment below will hopefully work to fulfill some of the challenges faced by previous models to keep veterans engaged in treatment.

For the group therapy treatment outlined below VETS (Veterans Engaging in Treatment Services) the Perlick et al. (2011) MFG-TBI will be the main source of inspiration as far as formatting and structure for sessions. Using psychoeducation instead of trauma focused sessions and finding ways for veterans to work together with their spouses is the main direction of the VETS system. Lowering marital distress and veteran’s symptoms as well as educating both parties about mental illness and its impact on relationships is the main goal of VETS. Hopefully by reducing the stigma of seeking treatment and engaging
those closet to our veteran’s returning home there will be a higher rate of treatment compliance and veterans will be more aware of the services available to them in order to ease their transition back into civilian life and back into their family.
Chapter III: Project Audience and Implementation Factors

With the high rates of soldiers returning home from the Iraq and Afghanistan wars diagnosed with PTSD or other mental illnesses, a treatment tailored specifically for this population is needed. Veterans who are married will be targeted and treatment will include their spouses in an 8-week group therapy workshop. High rates of treatment dropout are common for veterans with more acute trauma and combat experience than previous generations (Erbes, Curry, & Leskela, 2009). The development process creating the treatment program is first described and then the audience for which the program is intended to be used is reviewed. Next credentials and personal qualifications for those providing the program will be reviewed followed by the environment needed to hold the sessions in and any special attributes needed. Lastly the content and procedures to follow for the treatment will be provided.

Development of the Project

This project was for me a way to help and reach out to those I have personally seen struggle after returning home from deployments in the Middle East. I began the process by reading the book *On Killing: The Psychological Cost of Killing In War and Society* that was recommended to me by a friend deployed to Afghanistan in the US Air Force. After reading the book, I decided to do a review of literature starting with the most common psychological symptoms experienced by those individuals returning from OIF and OEF. After speaking with my faculty chair I decided to focus on the family structure that is affected by deployment as well as the veteran. Next I began reviewing and increasing my understanding of the symptoms that caused the most distress in marriages for both the veteran and their spouse. Last, in my review of literature, was an exploration
of the types of treatments known to work best for the OIF and OEF population, since there are many challenges in getting these veterans to first seek and regularly attend treatment for mental health concerns. After reading many articles and looking over notes I had written from *On Killing* I had a better understanding of how veterans were dealing with their transition to civilian life and what types of treatment would likely be most successful.

**Intended Audience**

The population that this group treatment intervention is designed for is veterans of the wars in Iraq and Afghanistan, Operation Iraqi Freedom and Operation Enduring Freedom. There is not a specified age range this group treatment intervention but it is intended for veterans either married or in a serious long-term relationship. The main diagnosis addressed in this treatment format is PTSD; although there will be topics related to other common diagnosis as well. This group may not be the proper fit for someone enduring extremely severe symptoms, which may require more intensive treatment, or for those with a primary diagnosis, which is more severe than their PTSD symptoms.

**Personal Qualifications**

Those in charge of administering the treatment program would preferably be a licensed marriage and family therapist, licensed psychologist, or licensed professional counselor. Training in counseling and therapeutic interventions specifically related to PTSD and working with veterans would be most helpful. Having a working knowledge of military culture and experience with veterans would also be desirable. A PTSD focused training would be ideal since there are different modalities for treating this diagnosis,
which can be tailored depending on the group. Depending on the area where the
treatment group is conducted, proficiency in Spanish may be necessary, but only if all
group members preferred treatment in Spanish. Ideally, there will be two facilitators for
the implementation of the group, one to work directly with the veterans and one to work
with the spouses during the group and both therapists working together at the beginning
and end of session each session.

Environment and Equipment

The ideal facility for the groups to be implemented will have two separate rooms
in close proximity to each other. Rooms should be in a quiet area where conversations
can be held privately and in confidence. Ideally the treatment should take place either on
the grounds of a VA hospital, a medical hospital that routinely treats large numbers of
veterans, or on an actual military base. The use of whiteboards and markers will be useful
for engaging group members and encouraging participation with certain topics.

Formative Evaluation

As a way of collecting constructive feedback on the outlined treatment
intervention, professionals in the field will be asked for their opinions on how to most
effectively work with veterans. Looking into areas that are working as well as those that
have room for improvement will be the main focus. Psychologists that have previous
experience working with veterans as well as military personnel who have worked with
veterans returning from the wars in Iraq and Afghanistan will be sought out. In addition
to professional input, anonymous surveys could be distributed to group members at the
end of treatment, either using Likert scales or open ended questions to get general
feedback from participants for areas that they feel they benefit from and areas which could be improved for future sessions.

**Project Outline**

The proposed group treatment intervention will be called Veterans Engaging in Treatment Services (VETS) and will be comprised of eight 90-minute sessions held twice a month. Each session will start with a 15-minute introduction time where couples can check in on how the past two weeks have been and the weekly topic will be introduced. Next will come a 45-minute psychoeducation component, some weeks veterans and spouses will be together and certain weeks they will discuss topics separately. The last 30-minutes of the session will include a closing discussion of the week’s topic as well as comments about the session and general questions. Pamphlets giving an overview of the week’s topic will be available to those who wish to take them home for further review.

A brief outline for the group treatment intervention by week is as follows: week one is an introduction session where guidelines, rules and expectations for treatment are reviewed and group members can get to know each other as well as the therapists. Weeks two and three will separate the couples for psychoeducation on PTSD and TBI, and then a session for depression and alcohol abuse. The weeks of 4-8 will keep the couples together; week four will provide psychoeducation on communication techniques for the couples and problem solving skills. Week five will be comprised of anger management techniques and coping skills for dealing with negative emotions. Week six will be unique in that group facilitators will get feedback from group members for problems they face in their everyday lives and then act as a team to form solutions to these problems; in week seven resources available to the veteran and their spouse for physical and mental health
will be provided. The final week of treatment will be a closing session for veterans and their spouses to recount their experience in treatment and together they will create a “shared story” of the deployment and reunification process as a way to make sense of the many changes they have experienced and form a point from which they can move forward with their lives as a family unit.
Chapter IV

Summary of Project

Veterans returning home from war in Iraq and Afghanistan right now are facing very different circumstances than our veterans of previous wars. Due to the tactics of guerilla warfare, veterans are dealing with suicide bombings, high rates of civilian casualties and are surviving serious injuries due to combat trauma (Sharpless & Barber, 2011). These conditions put veterans at a high risk for PTSD as well as TBI and substance abuse. Treatment specified for this population as the course for PTSD is usually chronic with 40% of patients showing symptoms 10 years after the trauma occurred and the high rates of comorbidity for PTSD and other mental and physical illnesses (Sharpless & Barber, 2011). Often veterans avoid seeking treatment due to the stigmatization of seeming weak, or crazy, but as Erbes, Curry, and Leskela (2009) have found, it is important to intervene early upon the veteran’s return home before symptoms become increasingly chronic or severe. The proposed treatment intervention is tailored specifically to veterans of Iraq and Afghanistan, it was also created to include the veteran’s spouse as a way to increase social support and focuses primarily on psychoeducation and processing of information to increase the likelihood that participants will return to treatment since the focus is not on their personal trauma experience.

Recommendations for Implementation

Full implementation of this project with the specific population requires patience for repetition and increased time for processing of information. Those with TBI may have trouble understanding or concentrating, and those that are resistant to treatment may be reluctant to participate at first. Spouses may also present a challenge if they are enabling
their husbands’ symptoms which may present a new set of issues to be worked through. Overall, in implementing this treatment intervention knowledge of the experiences this population has endured as well as best practice for working with veterans would benefit instructors.

**Recommendations for Future Research**

Future research on the benefits of different treatment modalities for veterans would be advised. Veterans often drop out of treatment prematurely or do not seek treatment at all, looking into these factors is also highly advised to learn what can be done to provide treatment to this population and keep them coming back for sessions. There is scant information on both of these topics and continuing to look into these areas would provide a wider breadth for clinicians as to how to properly work with veterans as well as their families.

**Conclusion**

It seems as though getting veterans into treatment is the first and most crucial task at hand. Second would be prompting veterans to stay in treatment in order to fully experience the effects of proper mental health programs. Part of the purpose of this project is including wives of veterans in treatment as a way to educate both of them on how symptoms present themselves as well as ways to cope with symptoms and new ideas for solving problems. If we can decrease negative feeling in regards to the couple’s relationship and increase positive interactions between them then hopefully their bond will begin to strengthen. In getting this couple bond stronger, the veteran’s closest source of social support is increased which may decrease symptoms and create a ripple effect for other people close to the veteran. Through the ripple effect of positive results and
individual psychotherapy the goal is to increase the veteran’s functioning in civilian life and decrease their symptoms to a manageable or almost null level.
REFERENCES


APPENDIX

Introduction

Veterans that are currently coming home from the wars in Iraq and Afghanistan are dealing with a new crop of comorbid issues that have not been seen in previous wars. Guerilla warfare is leaving veterans with combat traumas such as suicide bombers, civilian militia members, car bombings, and IEDs among other things. Our veterans now are also equipped with better armor and have more advanced medical training than previous wars. This means that our soldiers and marines are surviving combat more so now than in the past but are dealing with more gruesome physical injuries (amputations, potential paralysis, etc.) and are also dealing with the psychological consequences of surviving such violent attacks. Treatment models of the past are not adequately prepared for these types of physical and psychological injuries leaving our veterans under served. Getting veterans to seek treatment is the first step since many may be resistant to the stigma of seeming weak or crazy, but these issues often go hand in hand with substance abuse and there is potential for domestic violence if these symptoms are left untreated. It is my goal to create a psychoeducation based group therapy format in which veterans will be comfortable with learning about how to cope with their experiences and hold a sacred space where they can work through marital issues with their partner. My goal is also to enlist the support of the veteran’s closet ally, their mate, as a way to engage them in treatment and most important, keep them coming back each week.

Target Population

This treatment plan is targeted specifically for veterans of the recent wars in Iraq and Afghanistan. Due to changes in military warfare and the types of injuries that are
now being incurred, a specialized treatment format is needed for this population. Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) are two of the most common psychological casualties seen in this cohort of veterans, there are also high rates of alcohol abuse and issues coping with depression and anger.

**Group Type**

This group has been designed to serve veterans and their spouses or partners in a multi-couple group therapy format. For most of the group sessions, couples will be together for the duration of the session but when presenting psychoeducation sections for PTSD and TBI the couples will be separated into two groups: veterans and partners. This will be done so that veterans have adequate space for processing their experience dealing with PTSD and TBI and so that information for dealing with these symptoms can be presented in two ways- one specifically for the veterans and also for the partners to help them learn ways of dealing with their veteran’s symptoms. This treatment is designed for 5-7 couples at one time.

**General Overview**

This group therapy format covers 8 weeks with each session being 90 minutes. The breakdown for each session is as follows: weekly check-in for 15 minutes, topic of the week discussions for 45 minutes, closing discussions for 15 minutes, and a final 15 minutes of questions, wrap up and preparing for the next session. Specifics for each session are in the guidebook along with a schedule, goals for each session, as well as recommendations for any materials needed. Suggested process questions are listed for interaction with group members and to facilitate an understanding of material and so you as the instructor can get a feel for where each group member is emotionally and
cognitively. A power point presentation with notes for the instructor is also included for each group meeting.

VETS
Veterans Engaging in Treatment Services
Treatment Guidelines

• 8-90 minute sessions
  • Topic discussions, closing, questions, wrap up

• Commitment to your relationship & the program

• Confidentiality

• No cell phone use while attending group

• Individual appointments can be made as needed

• WEEK ONE:
  • For the first session of treatment, the focus is to introduce group members to each other as well as for the facilitators to introduce themselves to the group members.
    • Allow group members to ask questions of the facilitators to create an environment as comfortable as possible for the group members
  • Ice breaker activities can be used to ease tension and facilitate group members’ interaction with one another
  • Provide a brief overview of the topics that will be discussed in treatment and allow for any questions or concerns
  • Commitment- Ask group members to make a commitment to keep their relationship together (no divorce, separations, etc.) during the course of treatment, and ask couples to sign a commitment to the program, allowing for any concerns about treatment to be brought up when issues may arise
  • Confidentiality- Ask group members to keep what is said in group to stay in group- Cover mandated reporting guidelines (child/dependent adult abuse, homicide, suicide)
  • Let group members know that if significant issues arise with an individual or the couple system that individual appointments can be made in order to work through issues and allow for further progress to be made in group
Expectations of Members

- **Group members are allowed to participate at their comfort level- participation is not mandatory, but recommended**
- **Respect the experiences other group members and facilitators**
  - no cross-talk or advice giving
- **Please arrive on time**
- **Conflict will be addressed and dealt with individually and on a case by case basis**
  - please be honest with facilitators about things bothering you

**WEEK ONE:**
- Participation- Although group members are not forced to participate, for the most beneficial experience members are encouraged to participate at least minimally
- Respecting others’ experiences- group is not a place for judgment but instead for learning, listening, and sharing
  - Cross-talk is group members having side conversations, or monopolizing time by giving advice or suggestions to one group member in particular
- Stress the importance of showing up on time, not only so information is not missed, but also as a sign of respect to other group members
- Conflict between group members should be addressed outside of group to ensure that the group is not affected and if a resolution cannot be reached, then facilitators and the members involved can create an individualized plan for treatment, or review other options
Overview of Treatment

- Each 90-minute session will be broken down as follows:
  - Weekly check-in with each couple (15-minutes)
  - Topic discussions- new topic each week (45-minutes)
  - Closing discussion- (15-minutes)
    - What did you learn? Was there something you did or did not like?
  - Questions/ Wrap up- (15- minutes)
    - Concerns/ comments about the program or any other areas

- WEEK ONE:
  - Provide group members with an outline of how treatment will proceed, may help ease nervousness about what to expect out of the program, and allows for questions and concerns about treatment to be brought up
  - One of the main goals of the first session is to hook the participants into treatment by creating an environment that is as comfortable as possible and by showing them exactly what treatment is and hopefully by having a finite set of topics and sessions, which may decrease the dropout level of members
  - This is the end of the first session, allow for members to ask questions as a group, but also announce that facilitators will be around after dismissal in case anyone has questions they would like to be addressed on a one on one basis
GENOGRAMS

• Genograms are a way to look at our families in a broad context

• It is easier to see difficult relationships and those who struggle with mental illness

WEEK ONE:

• Help couples construct genograms for both group members
• A genogram is a way of creating a visual map of someone’s family tree. Depending on why the genogram is being created, it can go back one, two, or three generations and may include the participant’s children as well. Usually genograms use squares for males and circles for females. Each person is connected by a single line (dashed lines may indicate divorce, squiggles may indicate conflict, double lines for those that are enmeshed) and dates of birth and date are written underneath. A key may be created for issues such as substance abuse (usually a shaded box), medical issues, death (an X going through the symbol), patterns of physical or sexual abuse, etc.
• Participants may begin with their parents, connecting themselves and their siblings, then adding in children, grand parents, and extended family.
• The emphasis is not on creating the perfect genogram, but on helping the couples see patterns in familial relationships and those dealing with mental illness (and if there are patterns of mental illness)
• Use white boards or something that is easily erased to reduce frustrations from mistakes low Help couples see how their upbringing and other relevant issues are relating to their current struggles. Is there a lack of resources? Are symptoms from a diagnosis causing relationship issues? Are there broken family ties somewhere? How are the spouses currently interacting?
POST TRAUMATIC STRESS DISORDER

- 6-12% of veterans are returning home from Iraq and Afghanistan with PTSD (Garcia, Kelley, Rentz & Lee, 2011)

- 70-75% have reported acts of physical aggression in the last year (Stappenbeck, Hellmuth, Simpson & Jakupcak, 2013)

- Difficulty with irritability, issues tolerating/regulating negative emotions

- 40% of those with PTSD show symptoms 10 years later (Sharpless and Barber, 2011).

- What do you think of these statistics? Do they seem realistic? What comments do you have?

WEEK TWO: VETERANS AND SPOUSES ARE SEPARATED FOR DISCUSSION TOPICS

- Veterans and their wives will be split apart for the psychoeducation portion of the session so that veterans have a chance to process their PTSD/TBI experiences with other veterans before sharing those experiences with their significant others, the couple will be reunited for the closing discussion and wrap up portions of the session

- Allow participants to discuss their feelings related to the statements presented.
  - Ask if anyone has had difficulties in this area (the veterans, or the spouses have experienced these issues with their husbands)
TRAUMATIC BRAIN INJURY

- TBI= injury associated with brief loss of consciousness (or “altered mental state”) (Perlick et al., 2011)

- 22% of vets may have experienced TBI
  - Higher incidences of TBI due to guerilla warfare
  - IEDs, car bombs, suicide bombers

- Better medical training and response to injuries than past wars, better armor protection

- TBI may cause physical pain/impairments, difficulty following and remembering conversations or interpreting nonverbal cues, balance issues, headaches

WEEK TWO: VETERANS AND SPOUSES ARE SEPARATED FOR DISCUSSION TOPICS

- TBI may predict higher rates of depression among those who lost consciousness, this risk may even be present for decades after the injury has occurred (Morrissette et al., 2011) Presence of TBI is associated with lower recovery levels from PTSD (Morrissette et al., 2011)
- What do you think of these statistics? Do they seem realistic/correct from your experience? How have symptoms of PTSD interfered with your life? Do you have any additional comments?
PTSD

• Depression:
  • More PTSD symptoms= more depression symptoms (Owens, Steger, Whitesell & Herrera, 2009)

  • Difficult memories may lead to depression
    • Witnessing the death of comrades, civilian deaths, dealing with the stress of combat missions
    • Feeling accountable or responsible= guilt

  • Depression may lead to suicidal thoughts
    • Not being able to make sense of traumatic events

WEEK THREE: VETERANS AND SPOUSES ARE SEPARATED FOR DISCUSSION TOPICS

• The link between symptoms of PTSD and those of depression is significant due to the high co-morbidity rate between the two diagnosis
• Emotional toughness for male veterans is a product of military training (much like the idea of self-reliance) leading the soldier to not display vulnerable emotions (fear, anxiety, worry) and to not rely on others in times of duress
  • Emotional toughness can be beneficial for resiliency of physical injuries but worsens emotional distress and leads to depression and a reluctance to seek help
PTSD

• Avoidance:
  • Avoiding painful memories through emotional detachment or anhedonia

• Often leads to isolation and emotional distance between spouses and decreased emotional intimacy

• No interest in sex, hard time showing affection, low levels of self-disclosure, can lead to infidelity

WEEK THREE: VETERANS AND SPOUSES ARE SEPARATED FOR DISCUSSION TOPICS

• Emotional detachment: avoiding painful memories by detaching from them emotionally, thus pushing them to the side- can cause a lack of emotionality in other parts of one’s life and/or relationships

• Anhedonia- a psychological condition characterized by inability to experience pleasure in normally pleasurable activities

• Avoidance causes a lot of relationship problems as emotional intimacy decreases and spouses begin to feel disconnected to one another
  • Infidelity may result as a way to make a connection with someone new

→ Allow group members to process these two symptoms and share experiences they have had as well as questions regarding the information presented
COMMUNICATION TECHNIQUES

• MAKING POSITIVE REQUESTS
  • “I would really appreciate it if you can try to...”

• GIVING POSITIVE FEEDBACK
  • “It was really awesome the way you....”

• EXPRESSING NEGATIVE FEELINGS
  • Refrain from accusations and criticisms

WEEK 4: FROM THIS POINT ON VETERANS AND THEIR SPOUSES REMAIN TOGETHER FOR THE DURATION OF THE SESSION
• MAKING POSITIVE REQUESTS
  • This is important once couples begin working on problem solving techniques
  • Keeping requests positive takes away criticism from the partner placing the requests and shifts blame away from the partner fulfilling the request
• GIVING POSITIVE FEEDBACK
  • Helps couples shift from negative to positive interactions
• EXPRESSING NEGATIVE FEELINGS
  • This may be difficult for those with difficulty regulating emotions
  • This is the option that keeps partners from emotional avoidance and bottling up emotions
  • Writing down difficult feelings before verbalizing them may help the partner organize their thoughts and refrain from becoming accusatory or critical
COMMUNICATION TECHNIQUES

- **EMOTIONAL ACCEPTANCE**
  - Not demanding behavioral changes
  - Taking your partner’s perspective

- **REROMANTICIZING ACTIVITY**
  - Make a list of small gestures your partner can do for you
  - Which of these seem do-able?
  - Is there something that you won’t do?

- **COUPLE’S DIALOGUE**
  - Mirroring: Repeat back what your partner has expressed
  - Validation: Understanding your partner’s perspective
  - Empathy: Feeling the way your partner feels

WEEK 4: FROM THIS POINT ON VETERANS AND THEIR SPOUSES REMAIN TOGETHER FOR THE DURATION OF THE SESSION

- **EMOTIONAL ACCEPTANCE**
  - This helps couples move away from demanding behavioral changes that one party may not be ready to make and instead helps each partner look at the perspective of the other
  - Taking small steps towards reaching relationship goals

- **REROMANTICIZING**
  - Helps put positive interactions back into the relationship
  - This is not tit for tat, but instead encourages members to produce the acts despite what their partner has done for them
  - Start with small actions and move towards the more difficult ones

- **COUPLE’S DIAGLOUGE**
  - One partner expresses an issue that is troubling them
  - The other partner mirrors the message until they have it correct (and without defenses or criticisms), have the first partner add in more detail until they feel they have been thoroughly heard
  - Validation comes from the second partner understanding the perspective of the first partner (ie: I may not agree with you, but I can see why you feel that way)
  - Empathy can be expressed once the second partner understands the perspective and emotion of the first
ANGER MANAGEMENT

• What is anger?
  • Emotion that ranges from irritation to fury and rage
  • Not the same as aggression
  • Aggression is behavior intended to hurt or harm someone

• When is anger a problem?
  When it is too intense, too frequent or expressed inappropriately
  • There may be positive or negative consequences

WEEK 5: (INFORMATION COURTESY OR SAMSHA ANGER MANAGEMENT PDF)
• PROCESS ANGER WITH GROUP MEMBERS:
• DO YOU EVER CONFUSE ANGER WITH AGGRESSION?
• WHAT ARE SOME WAYS YOUR ANGER HAS AFFECTED YOU PHYSICALLY? WHAT ARE SOME OF THE NEGATIVE CONSEQUENCES OF YOUR ANGER?
• ARE THERE ANY POSITIVE OUTCOMES FROM ANGER?
ANGER MANAGEMENT

- Myths about anger:
  - Anger is inherited
    - Expression of anger is a learned behavior
  - Anger automatically leads to aggression
    - Aggression can be controlled, being assertive without being aggressive, changing our “self-talk”
  - You must be aggressive to get what you want
    - Being assertive without blaming or being disrespectful
  - Venting anger is always desirable
    - This shows us how to be better at being angry instead of how to control and express anger

WEEK 5: (SAMSHA ANGER MANAGEMENT PDF)
PROCESS WITH GROUP MEMBERS:
  • DO YOU BELIEVE ANY OF THESE TO BE TRUE?
  • WHY OR WHY NOT?
  • HAVE YOUR THOUGHTS CHANGED AFTER DISCUSSING ANGER?
  • WHAT ARE SOME OF YOUR TRIGGERS FOR ANGER?
ANGER MANAGEMENT

• Ways to work through anger:
  • Identify triggers
  • Timeouts
  • Relaxation breathing exercises
  • Thought stopping
  • “I don’t need these thoughts”
    • “Don’t go there”
    • “I will only get myself into trouble
    • “I need to stop thinking these thoughts”
• Anger in our family
  • How was anger expressed in your family?

• WHAT ARE SOME OF YOUR WAYS FOR COPING WITH ANGER?
• Timeouts: Provides a time for de-escalation of anger, either person involved in the conflict can call timeout.
  • Take time to leave the situation and come back to it at later time when feelings have decreased
  • Go for a walk, write in a journal, call someone you trust
• Breathing exercises: instructors may chose a breathing exercise that they have experience with or feel comfortable with
• Walk participants through shortened relaxation breathing exercise, watch for those that feel uncomfortable or cannot perform the exercise
• Thought Stopping: review the thought stopping statements. Use these as a way to track anger and see how thoughts are causing more anger
  • Stopping angry thoughts help de-escalate the situation/feelings of anger
• Process with group members how anger was expressed in their family, what behaviors did they learn? What consequences do those behaviors have?
  • How were other emotions expressed? Happiness, sadness?
PROBLEM SOLVING TECHNIQUES

• Family and relationship issues:
  • Poor communication
  • Parenting conflicts

• Partner frustration related to veterans’
  • cognitive troubles
  • PTSD symptoms
  • Depression

WEEK 6: (TAKEN FROM PERLICK, ET AL.)
• Family and relationship issues
  • Communication problems: How can group members relate to having communication problems? Have techniques from previous sessions helped with these issues? Help group members brainstorm ideas for new techniques, or discuss ones that have worked, what about ones that did not work? What happened?
  • Parenting conflicts: what issues are couples facing? Discipline? Is the veteran having difficulty enforcing rules or being listened to by the children?
  • Partner frustration: help partners take the perspective of the veteran to better understand their mental illness/ symptoms they are experiencing. Refer back to emotional acceptance exercise. Did this work for them? Why or why not?
PROBLEM SOLVING TECHNIQUES

• Veteran’s problems related to cognitive deficits or symptoms
  • Losing or misplacing important items
  • Forgetting to take medications
  • Trouble setting goals
  • Difficulty making realistic plans

WEEK 6:
• Veterans’ problems related to cognitive deficits or symptoms
  • How can group members resolve some of these issues?
  • Using reminders on cell phones, writing reminders on white boards, using pill boxes, writing schedules down, etc.
OUR SHARED STORY

• What does deployment look like for your family?

• What relationships exist after deployment?

• What strengths did you use to deal with deployment?

• What changed during deployment?
  • What stayed the same?

• What ways can we move forward as a family?

• What new goals do you have as a family?

WEEK 7: Makin-Byrd, Gifford, McCutcheon & Glynn (2011)
• creating a “shared story” can help family members make sense of the deployment and reintegration and allows the family to move forward
• family members get together and list:
  • strengths that they used to deal with the deployment
  • things that have changed since the deployment
  • things that stayed the same
• Provide either large sheets of paper or white boards to couples with colored markers
• Encourage couples to write down their shared story in any way that makes sense to them, can be creative, have pictures, be bulleted lists, etc. Help couples use this exercise to make sense of their experience, process what has changed, and look forward to the future
RESOURCES

- Assessment Tools
  * My HealtheVet: Brief assessment measures; Myhealth.va.gov

- Education
  * National Center for PTSD Returning from the War Zone: A Guide for
  * Military Personnel and Returning from the War Zone: A Guide for
  * Families of Military Members; www.ptsd.va.gov

- The National Online Resource Center on Violence Against Women:

- Online resources on domestic and sexual violence. www.vawnet.org

- Military One Source: Free 24-hour information and referral service; www.militaryonesource.com; 1–800–342–9647; En español llame al: 1–877–888–0727

- Sesame Street Talk, Listen, Connect: Offers bilingual

- (English/Spanish) materials for children and families related to deployments, homecomings, changes and grief; http://www.sesamестreet.org/tlc

- Real Warriors Website: Offers resources for active duty service members and their families to promote resilience and access to resources, and reduce stigma; http://www.realwarriors.net/

- Emergency Contacts
  * Veterans Suicide Prevention Hotline: 1–800–273–TALK (8255) National

- 422–4453)

WEEK 8:

- Taken from Makin- Byrd, Gifford, McCutcheon & Glynn (2011)
INDEX

Week By Week Guidebook for VETS

WEEK 1

TOPIC: Overview of Treatment & Create Genograms for the Couple

GOALS:
- Introduce group members to one another
- Facilitators introduce themselves to group members
- Ice breaker activity
- Overview of rules & expectations for group members
- Review topics to be covered for the next 8 weeks
- Review confidentiality policy
- Review commitment policy
- Inform group members of when/how/why to make individual session appointments
- Each couple creates a genogram for their family of origin
- Closing- Questions, preparation for next week

MATERIALS
- Power Point Presentation slides of Week 1 (Slides 1-5)
- Ice Breaker of your choice (a sample ice breaker will be provided)
- White boards, and appropriate markers (for making genograms)

PROCEDURE
- Introductions: Ask group members to go around and identify the following characteristics:
- For veterans:
  - Which branch of military they are serving/have served
  - Where they were deployed and for how long
- For partners:
  - Where they are from
  - How long have they been a military spouse/partner
- Introduction for facilitators: Facilitators may introduce themselves to the group with as much information as they feel comfortable sharing and what they feel is relevant (education/ experience/ personal experience with combat, etc.)
- Example ice breaker activity: Cut sheets of paper into slips with the following characteristics:
  - Only child
  - Someone with the same birthday month as you
  - Has gone on vacation in the past year
  - Has 3 children

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• Speaks another language
• Plays a sport
• Was born in the same state as you
• Has the same favorite food as you
• Wants to travel to the same vacation destination as you
• Is from the same branch of the service as you/your spouse
• Have members go around the room and find someone who fits one of the
characteristics on the sheet and write their name down until all slots all
filled- If facilitators have a stand by ice breaker they prefer then that one
can be used
• (Slide 2 on Power Point)
  ▪ Explain the treatment process to group members
  ▪ The layout of each week’s session
  ▪ Why we ask for their commitment to the group and to their relationship
  ▪ Limits of confidentiality
    ▪ Confidentiality: Let group members know that what is said in
group stays in group, except for limits for mandated reporting:
child or dependent adult abuse, homicide or suicide
• No cell phone use during group
• Individual appointments can be made as needed and at the therapist’s
discretion
• (Slide 3)
  ▪ Expectations of group members:
    ▪ Group members participate at their comfort level, participation is
not mandatory but it is encouraged
    ▪ Respecting the experiences of other group members and of
facilitators
      ▪ No cross-talk or advice giving
    ▪ Please arrive on time
    ▪ Conflict with other group members will be addressed and dealt
with individually and on a case by case basis
      ▪ Please be honest with facilitators if something is bothering
you
• (Slide 4) Overview of treatment
  ▪ Each week will be a 90 minutes session as follows:
    ▪ Weekly check-in (15 minutes)
    ▪ Topic discussion for the week (45 minutes)
    ▪ Closing discussion (15 minutes)
      ▪ What did you learn? Was there something you did or did
not like about today’s session?
    ▪ Questions/Wrap-up (15 minutes)
      ▪ Concerns/Comments, preparation for next week
• (Slide 5) Genograms:
  ▪ Main topic for the first week is making a genogram for both partners
• This should be a tool to look at patterns within families of mental illness, substance abuse, conflict and other family related issues (abandonment, physical or sexual abuse, etc.)
• Help couples construct genograms for both group members
• A genogram is a way of creating a visual map of someone’s family tree. Depending on why the genogram is being created, it can go back one, two, or three generations and may include the participant’s children as well. Usually genograms use squares for males and circles for females. Each person is connected by a single line (dashed lines may indicate divorce, squiggle lines may indicate conflict, double lines for those that are enmeshed) and dates of birth (or death) are written underneath. A key may be created for issues such as substance abuse (usually a shaded box), medical issues, death (an X going through the symbol), patterns or a symbol can be designed for physical or sexual abuse, etc.
• Participants may begin with their parents, connecting themselves and their siblings, then adding in children, grand parents, and extended family.
• The emphasis is not on creating the perfect genogram, but on helping the couples see patterns in familial relationships and those dealing with mental illness (and if there are patterns of mental illness)
• Use white boards or something that is easily erased to reduce frustrations from mistakes. Help couples see how their upbringing and other relevant issues are relating to their current struggles. Is there a lack of resources? Are symptoms from a diagnosis causing relationship issues? Are there broken family ties somewhere? How are the spouses currently interacting?
  • Process Questions to ask: are symptoms from a mental illness playing a role in marital or parental roles, are either partner struggling with broken family ties, how are the veteran and the spouse interacting in their relationships?

• Closing: Do you notice any patterns in your genogram? Did you find this exercise helpful? Why or why not? Any general questions about today’s session, or next week?

WEEK 2

TOPIC: Post Traumatic Stress Disorder & Traumatic Brain Injury

GOALS: Provide an overview of information to veterans and their spouses on Post Traumatic Stress Disorder and Traumatic Brain Injury, process with group members how PTSD and TBI may be interfering in their lives

MATERIALS: Slides 6 & 7 from Power Point Presentation

PROCEDURE: Split group members into two groups (veterans and spouses) for the main portion of this group. The purpose of this is to allow veterans to process
their symptoms with others who are experiencing the same issues, and the same for spouses. The information presented will be the same but process questions for each population will listed separately. For the remaining portion of the group, reunite veterans and spouses and allow them to perform the closing portions of the session together to process what they learned during group and raise any additional questions with their partner or group facilitators.

• (Slide 6):
  o PTSD: A common anxiety disorder characterized by a maladaptive response to trauma in which an individual suffers from repetitive intrusive memories or flashbacks related to the trauma.
    ▪ Common symptoms: nightmares, flashbacks, avoidance of trauma related stimuli, increased arousal and loss of interest in activities (may also look like estrangement from family members or friends)
    ▪ There are three main symptom clusters for PTSD: re-experiencing, numbing (avoidance) and hyperarousal.
  o There are a large percentage of veterans returning home from war with PTSD
    ▪ Estimates of 6%-12% of veterans return home with PTSD
  o PTSD can lead to issues with irritability, inability to tolerate and regulate negative emotions
    ▪ Avoiding negative emotions can lead to emotional buildup which causes tension between veterans and their partners. This is happening while the veteran is trying to fit back into their family life after deployment.
  o 70-75% of those diagnosed with PTSD have reported acts of physical aggression within the past year
  o Of those diagnosed with PTSD, only 17% have that as their only diagnosis- the rates of comorbidity with PTSD are extremely high
    ▪ Substance use and abuse is a common way to treat symptoms
      • As many as 11-35% of veterans returning from Iraq and Afghanistan report high rates of alcohol misuse
      • Drinking is often a common theme in military culture which decreases the stigma of drinking regularly
      • Individuals may use alcohol or other drugs to regulate positive or negative emotions, to facilitate social interactions or to detach or blunt their negative emotions
      • Individuals who are separated from their spouse, divorced or widowed have a 1.5-3 times higher likelihood of over using alcohol or other drugs
    ▪ Depression is also highly correlated with PTSD
  o Veterans of OIF/OEF have very high drop out rates for treatment, many that begin services do not get the amount of services they need
• PTSD is chronic with 40% of those diagnosed showing symptoms 10 years later
• **Process Questions for Veterans:** What do you think of these statistics? Do they seem realistic/correct from your experience? How have symptoms of PTSD interfered with your life? Do you have any additional comments?

• **Process Questions for Spouses:** How has your partner’s symptoms affected you or your family? Is there anything you have or your partner has done to help alleviate these symptoms? How do you personally deal when your partner’s symptoms are too intense?

• (Slide 7)

• High rates of TBI have been linked to the guerilla style warfare common in the wars in Iraq and Afghanistan
  - Improvised explosive devices (bombs along the side of the road), car bombs, suicide bombers are examples of guerilla warfare tactics
  - Service members are surviving more of these attacks due to advances in armor, medical services and specialized training
    - This leads to higher rates of TBI, and surviving serious attacks with wounds leading to amputation and prolonged hospital stays

• Traumatic Brain Injury is an injury associated with brief loss of consciousness or entered into an “altered mental state”
  - 22% of veterans of OIF/OEF may have experienced TBI
  - High rates of TBI are due to guerilla warfare tactics (IEDs, car bombings, suicide bombers, etc.)

• Veterans with TBI may experience: physical pain or impairments, difficulty following and remembering conversations or interpreting nonverbal cues, balance issues, headaches

• TBI is associated with lower recovery rates from PTSD, may cause higher rates of depression for those who lost consciousness (i.e.: more serious cases of TBI)
  - Depression may be present for decades after the initial injury

• **Process Questions for Veterans:** Why do you think TBI makes it harder to recover from symptoms of PTSD? Have you noticed changes in your memory or ability to organize thoughts or plans? Has “forgetfulness” caused problems within your marriage? Have you (or your partner) been experiencing headaches or unexplained problems with balance? How else may symptoms such as these interfere in your life?

• **Process Questions for Spouses:** What changes have you noticed in your husband due to TBI? Have either of you worked to deal with these challenges? What have you done or what do you see as being helpful? Has anything been especially helpful for dealing with issues related to TBI?

• **Closing:** (Veterans and spouses are reunited) How has this information been helpful for looking at your current relationship? In what ways have any of these symptoms caused problems in your relationship? Are there ways of coping you have found to be helpful for dealing with these issues? Any general questions about today’s topic or next week?
WEEK 3

TOPIC: Dealing with PTSD in conjunction with depression and avoidance

GOALS: Provide an overview of information to veterans and their spouses on issues manifested from dealing with PTSD as well as depression or symptoms of avoidance, process with group members how PTSD/depression/avoidance may be interfering in their lives

MATERIALS: Slides 8 & 9 from Power Point Presentation

PROCEDURE Split group members into two groups (veterans and spouses) for the main portion of this group. The purpose of this is to allow veterans to process their symptoms with others who are experiencing the same issues and the same for spouses. For the remaining portion of the group, reunite veterans and spouses and allow them to perform the closing portions of the session together to process what they learned during group and raise any additional questions with their partner or group facilitators.

- (Slide 8)
- The more symptoms of PTSD one is experiencing leads to a higher likelihood that more symptoms of depression will be present
- Dealing with difficult combat memories may lead to depression
  - Witnessing the deaths of comrades or civilians, dealing with the stress of combat missions
- Depression may lead to suicidal thoughts
  - One may be having a tough time making sense of traumatic events
    - Guilt is often high after stressful missions
  - One may be having a tough time making sense of traumatic events in their life is a key buffer to symptoms of PTSD and depression since the individual is able to restructure events
- Emotional toughness is a product of military training (self reliance, resistance to expressing fear or sadness) which leads to an inability to display vulnerable emotions (fear, anxiety, worry) or rely on others in times of duress
  - Emotional toughness may be beneficial for recovery from physical injuries but worsens emotional distress and leads to depression and a reluctance to seek help
- Information for Spousal Group Only: Rates of domestic violence is much higher for those diagnosed with combat related PTSD and depression compared to veterans diagnosed with anxiety or other low level disorders. A lowered ability to regulate emotions, dealing with psychological problems and substance abuse all account for part of the reason there is a potential for violence to be perpetrated against the spouse of a service member. If you ever feel you are in danger or have
experiences with domestic violence, it is important to have a plan ready for the safety of yourself (and children in the house). Have someone you can call if you need to leave the situation, let someone know where you are going if you do not stay with a friend/relative, or in a hotel. There are domestic violence hotlines you can call if you need to talk to someone, as well as shelters. If you have a counselor or therapist, talking with them can help you see your options, establish safety for everyone involved, and work through issues with your partner.

- **Process Questions for Veterans:** Has depression been a factor in your PTSD symptoms? What experiences have you had with these feelings? Do you feel like you are able to talk openly about these feelings?
- **Process Questions for Spouses:** Have you noticed a change in your feelings since your partner’s return? Have you noticed changes in your partner’s feelings since his return? In what ways have you dealt with these changes? What has been helpful to you for dealing with your own feelings?

- (Slide 9)
- Avoidance is a common symptom in PTSD when survivors of trauma feel a deep sense of responsibility or accountability for traumatic events
- Avoidance of painful memories is often accomplished through emotional detachment or anhedonia
  - Emotional detachment is avoiding painful memories by detaching from them emotionally, thus pushing them to the side—this can cause a lack of emotionality in other parts of one’s life/relationship
  - Anhedonia is a psychological inability to experience pleasure in normally pleasurable activities
- This often leads to isolation and emotional distance between a veteran and their spouse as well as decreased emotional intimacy
  - No interest in sex, hard time showing affection, low levels of self disclosure— all of these factors can lead to infidelity
  - Infidelity is a result of one partner trying to form a connection with someone else (creating emotional closeness/intimacy)
- **Process Questions for Veterans:** What experiences have you had with avoidance? Has emotional detachment been a factor in your relationship? Or a lack of experiencing pleasure in activities?
- **Process Questions for Spouses:** Has your partner been emotionally distant? How do you cope with distance in your relationship? Are there activities or times when emotional distance does not seem like it is an issue?

- **Closing:** (Veterans and spouses are reunited) How has this information been helpful looking at your current relationship? In what ways have any of these symptoms caused problems in your relationship? Are there ways of coping you have found to be helpful for dealing with these issues? Any general questions about today’s topic or next week?
WEEK 4

TOPIC: Communication Techniques

GOALS: Help couples learn ways of communicating to decrease conflict and express their emotions in appropriate ways

MATERIALS: Slides 10 & 11 from Power Point Presentation

PROCEDURE: Couples are no longer separated into two groups at this point. Keeping the couples together, discuss and practice some of the techniques listed. Take time to process questions and issues group members may have with information presented.

• (Slide 10)
• Some communication techniques will be covered, these activities help couples shift away from blaming their partner, acknowledge positive aspects of their partner’s behavior or in interactions with their partner, and express negative feelings in a regulated and appropriate way

• Making Positive Requests
  o This is a first step for couples beginning to work on problem solving techniques. It essentially is asking participants to ask for what they need in a positive and controlled manner rather than making judgments about their partner or blaming them.
    ▪ Keeping requests positive takes criticism away from the partner placing the request and shifts blame away from the partner fulfilling the request
    ▪ Since a request can be fulfilled, it gives the second partner a chance to correct the situation rather than feeling defensive for their actions in the past.
    ▪ Ask couples to frame an issue in their relationship as a positive request, ie: “I would really appreciate it if you can try to…” rather than “I really hate it when you..” or “You always do…”

• Giving Positive Feedback
  o This step helps couples shift away from negative interactions to positive ones and also helps take judgments blame away from the situation.
  o Couples that acknowledge the small things their partner does have what is called positive sentiment override which can be equated to having money in the emotional bank of the relationship. When stressful events occur or a couple argues, it is likely that they will refrain from blaming and judging
if they have positive emotional interactions stored up in their “emotional bank account”.

- Ask couples to jot down a list of small things that they have praised their partner for in the past week, i.e.: “It was really awesome the way you…” or “I saw how you …, and I think you handled it very well, thank you”

• Expressing Negative Feelings
  - Caution: This step may be more difficult for those that experience difficulty with emotional regulation
    - For those with intense anger management issues this activity may be too intense and should be forfeited
  - This step helps steer partners away from emotional avoidance and bottling up their feelings
  - Writing down difficult feelings before verbalizing them may help partners organize their thoughts and refrain from becoming accusatory or critical

• Ask couples to take one issue that they are experiencing in their relationship and reframe it using the first two techniques, or work on expressing their negative feelings related to the issue without accusing or being critical

• Process Questions: Do these exercises feel like something you can practice? Why or why not? Is there anything that can make these exercises easier for you to practice?

• (Slide 11)
• Emotional Acceptance
  - Essentially this is asking each individual to take the perspective of their partner when asking for changes in the relationship
  - This helps couples move away from demanding behavioral changes of their partner (the partner may not be ready to make such changes) and instead moves them towards taking their partners perspective
  - Seeing their partner’s perspective helps couples understand the changes they are asking to be done

• Reromanticizing Activity
  - Reromanticizing is a way to bring positive interactions back into the relationship by asking couples to complete small activities for their partner
  - Help couples make a short list of small gestures that would like their partner to do for them
    - I.e.: a back massage for 20 minutes, taking turns going to the grocery store, taking the trash out on a particular day, attending an event, bringing home flowers, cooking dinner, etc.
  - This activity helps bring positive interactions back into the relationship
  - Encourage couples to start with small actions and move towards bigger ones
    - Ask which ones seem do-able? Is there something one partner will not do?
IMPORTANT: The idea is not that partners do nice things quid pro quo, but that each positive gesture is done solely to pleasure their partner despite what their partner may or may not do for them

• Couple’s Dialogue
  o The couple’s dialogue helps each partner express an issue that is troubling them in a space where their partner is solely listening and reflecting back what they hear. This helps clarify problems for couples and allows each person a time to voice something that is bothering them in a controlled manner free of blaming or judgments.
  o One partner expresses an issue that is troubling them
  o The other partner mirrors the message until they have it correct- and without any defenses or criticisms, have the first partner add more detail until they feel as if they have been thoroughly heard
  o Validation comes from the second partner understanding the perspective of the first partner (i.e.: “I may not agree with you, but I can see that you feel that way)

• Have each couple practice with one of the exercises listed above

• Process Questions: Have any of the above exercises been helpful to you? Was there anything that was particularly difficult for you tonight?

• Closing Questions: Has this information been helpful looking at your current relationship? In what ways have any of these symptoms caused problems in your relationship? Are there ways of coping you have found to be helpful for dealing with these issues? Any general questions about today’s topic or next week?

WEEK 5

TOPIC: Anger Management
GOALS: Identify what anger is, provide psychoeducation on myths surrounding anger as well as how anger is processed in ones family, and coping skills

MATERIALS: Slides 12, 13, & 14 from Power Point Presentation

PROCEDURE: Couples are no longer separated into two groups at this point. Keeping the couples together, discuss and practice some of the techniques listed. Take time to process questions and issues group members may have with information presented.

• (Slide 12)
  • What is anger?
    o An emotion that ranges from irritation to fur and rage
    o It is not the same as aggression
      ▪ Aggression is a behavior intended to hurt or harm someone else
  • When is anger a problem?
    o When it becomes too intense, too frequent, or expressed inappropriately
    o There may be positive or negative (usually negative) consequences
• **Process Questions:** Do you ever confuse anger with aggression? What are some ways your anger has affected you physically? What are some of the negative consequences of your anger? Have there been any positive outcomes?

• (Slide 13)
• Myths about anger:
  o Anger is inherited
    ▪ Expression of anger is a learned behavior
  o Anger automatically leads to aggression
    ▪ Aggression can be controlled, being assertive without being aggressive, we can change our “self-talk” to avoid escalation of anger
  o You must be aggressive to get what you want
    ▪ There are ways to be assertive without being blaming or being disrespectful
  o Venting anger is always desirable
    ▪ Venting shows us how to be better at being angry instead of how to control and express anger

• **Process Questions:** Do you believe any of these myths to be true? Why or why not? Have any of your previous thoughts about anger changed after this discussion? Why or why not?

• (Slide 14)
• Ways to work through anger:
  o Timeouts provide a time for de-escalation of anger. Essentially a timeout means taking a moment to take a few deep breaths and make the choice not to react. Either person involved in the conflict may call a timeout.
    ▪ Take time to leave the situation and come back to it at a later time when feelings have decreased. Part of calling a timeout is agreeing to finish the discussion when the timeout has ended or deciding to postpone it when both partners feel they can successfully resolve the problem.
    ▪ → Go for a walk, write in a journal, call someone you trust
    ▪ → Ask participants how they would use a timeout plan. What strategies would work to decrease their anger and give them time or space to calm down?
  o Breathing exercises: Chose a breathing exercise you feel comfortable with or have experience performing, i.e.: progressive relaxation of muscles, or practicing diaphragmatic breathing
    ▪ Walk participants through a shortened version of the breathing or relaxation exercise, be mindful of those who feel uncomfortable (some may not want to close their eyes, etc.) or those who cannot perform the exercise
    ▪ Have participants get comfortable in their chairs, allowing them to close their eyes or keep them open. Here is an example script:
I would like you to take a moment to feel your weight as you sit in your chair. Your feet on the floor, the back of your legs on the seat, the pressure of your spine on the back of the chair, your hands resting comfortably, your head and your eyes. Now I would like you to squeeze the muscles in your toes and feet until they are tense, hold it for a few seconds and release, take a moment to feel how relaxed your feet feel now resting on the floor. Next, squeeze your calf muscle, hold, and release, feel the tension in your calves floating away. Next squeeze your thigh muscles, front and back and feel the tension in your thighs, hold this, and now release. Feel the tension floating out of your legs. Now squeeze your abdominal muscles, hold the tension, and release. Feel the tension float away from your abdomen. Next squeeze the muscles in your buttocks and feel the tension there as you sit in your chair, hold, and release. Feel the tension float away from your buttocks. Next squeeze the muscles in your back and shoulders. Feel the tension in your back and shoulders, hold this, and release. Feel the tension float away from your back and shoulders. Next, tighten your facial muscles, feel the tension in your face, and release. Feel the tension float away from your body. Now take a moment to take note of how your body feels again. You may be feeling more relaxed and less tense. Remember what the relaxation of your muscles feels like. Open your eyes when you are ready.

- Thought stopping is used to de-escalate the situation or feelings of anger
  - Review thought stopping statements:
    - “I don’t need these thoughts”, “Don’t go there”, “I will only get myself into trouble”, “I need to stop thinking these thoughts”
  - Next, help clients track how their anger escalates and which statements make sense to them to help stop their anger from increasing

- **Process Questions**: How was anger expressed in your family? What behaviors have you learned? What consequences do those behaviors have? How were emotions such as happiness or sadness expressed?

- **Closing Questions**: Has this information been helpful looking at your current relationship? In what ways have any of these symptoms caused problems in your relationship? Are there ways of coping you have found to be helpful for dealing with these issues? Any general questions about today’s topic or next week?

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**WEEK 6**

**TOPIC**: Problem Solving Techniques
GOALS: Help couples process family and relationship issues and brainstorm ideas for solving problems within their own relationship

MATERIALS: Slides 15 & 16 from Power Point Presentation, white board + markers

PROCEDURE: Couples are no longer separated into two groups at this point. Keeping the couples together, discuss and practice some of the techniques listed. Take time to process questions and issues group members may have with information presented.

• (Slide 15)- Process Group
• Family and relationship issues:
  o Poor communication- What problems are you currently experiencing with communication? Have techniques from previous sessions been helpful?
  o Parenting Conflicts: What parenting conflicts are you currently facing? Discipline? Is the veteran having a hard time enforcing rules or being listened to by children upon return home?
• Partner frustration related to veteran’s:
  o Cognitive troubles
  o PTSD symptoms
  o Depression
  ➔ Help partners take the perspective of the veteran and then of the civilian partner in discussing the above symptoms/issues. Refer back to emotional acceptance exercise, how is this working for the couples? What is or is not working?

• (Slide 16)
• Veterans’ problems related to cognitive deficits or PTSD symptoms
  o Losing or misplacing important items
  o Forgetting to take medications
  o Having trouble setting goals
  o Difficulty making realistic plans/schedules
• How can group members resolve some of these issues? Use white boards and markers to make a list of possible solutions to these issues
  o Using reminders on cell phones for taking medications
  o Using white boards at home to write down reminders for schedules
  o Using pill boxes to keep track of medications
  o Making a list of goals/chores to be done, etc.

• Closing Questions: Has this information been helpful looking at your current relationship? In what ways have any of these symptoms caused problems in your relationship? Are there ways of coping you have found to be helpful for dealing with these issues? Any general questions about today’s topic or next week?
WEEK 7

TOPIC: Creating “Our Shared Story”

GOALS: To help couples create a document to look at the deployment process, recognize strengths, and create a point to move forward from

MATERIALS: Slide 17 from Power Point Presentation, white boards + markers, or large pieces of white paper and markers

PROCEDURE

• Creating a shared story helps couples make sense of the deployment reintegration process and allows the family to move forward from this point
  o Couples get together and make a list of: Strengths that they used to deal with the deployment, things that have changed, things that have stayed the same, what ways they can move forward as a family, any new goals for the family
  o Couples can use white boards or paper, and either draw or write down the items listed above (encourage couples to be creative and express themselves however they feel comfortable)

• Closing Questions: Has this information been helpful looking at your current relationship? Any general questions about today’s topic or next week?

WEEK 8

TOPIC: Resources

GOALS: Provide an overview of resources available to veterans and their families

MATERIALS: Slide 18 from Power Point Presentation

PROCEDURE: The last session of the 8 week group is mainly to provide couples with information they can use later; mental health resources, aids for talking with children dealing deployment, domestic violence hotline information, etc. Provide this time to couples for closing any last issues they may want to talk about. Make sure to process what couples have learned as well any final concerns they may have. This session is similar to the very first session in that it is not extremely structured and is focused mainly on closing out the group and assuring that
participants are comfortable ending treatment, and that accommodations and referrals are made anyone seeking further treatment.