

Empowering versus Enabling PTSD

Good morning and welcome everyone my name is Tracy Croghan. The Caregiver Support Program has decided to host to this presentation today to help educate caregivers on the difference between empowering and enabling to help reduce caregiver burden. Our presenter today is Dr. Hudspeth a psychologist at the Tampa VA. So without further ado, we will turn it over to Dr. Hudspeth.

Hello everyone and thank you so much for having me, as Tracy said, my name is Dr. Amber Hudspeth. I am a psychologist, and the MST coordinator at the James A Haley Veterans Hospital in Tampa, I'm so happy to be able to talk to you today about the difference between empowering and enabling, and hopefully for our caregivers, we can actually help reduce some of the burden that you all carry with the amazing work that you're doing with helping your family and your, and the veterans in your family. So with that, let's get started with our presentation.

So these are our objectives for today. So first we're going to review PTSD and common symptoms associated with PTSD. We're going to work towards understanding how avoidance maintains PTSD and PTSD symptoms. We're going to learn how reducing avoidance can actually help with PTSD and anxiety. We're also going to review some evidence based treatments for PTSD. So you have a better understanding about what might be available for you and your veteran. We're also going to understand how VA resources can help support a family members, and to help veterans seek further help. We're going to understand the impact of PTSD on supportive family members, and how we better understand what you as a family member can do to support your veteran and understanding the difference between helping and enabling.

So first let's start with just a brief review of what PTSD is so PTSD stands for post-traumatic stress disorder. When we think about PTSD, we really think about symptoms that exist in four different categories. And these symptoms develop after experiencing a traumatic event and cause significant impairment in daily functioning. So the first category is what we call re-experiencing symptoms. These are things such as nightmares flashbacks, or intrusive thoughts. They're anything that pulls the experience from before into the present moment. Now, the next symptom cluster is what we call the arousal symptoms. This is where people will feel like they're always on edge, they have reduced sleep. They are what kind of always looking for something to happen, it just feels like they are almost humming like they're just keyed up a little bit more.

The next symptom cluster is alterations in mood and cognition. This can wear be where people have difficulty experiencing positive emotions they might be more irritable might have feelings or thoughts of guilt, and they might have difficulty connecting with other people so they kind of hold people at a distance, and they feel sometimes emotional now.

The last category is avoidance. So avoidance can take many forms that we'll discuss a little a little bit, but avoidance can be things such as not going to certain places or trying to avoid anything that reminds us of that significant traumatic event. When we think about PTSD, something important to remember is that the main emotion that underlies PTSD is anxiety.

So, even though the vast majority of the population experiences a traumatic event in their lifetime, the development of PTSD is actually rather rare. When we look at prevalence rates over the lifetime of American adults, the rate tends to be about 6.8% for men, and 9.7% for women. Now the rate of PTSD does tend to be higher in the veteran population. And part of that is because we have people that we know are exposed to more traumatic experiences.

What this means though is that if the lifetime rate is low, is that most people who experienced a traumatic event tend to recover, and don't meet criteria for PTSD.

What that means is that PTSD can really be thought of as a problem in recovery. So something got in the way a sort of the natural process that we all have for recovering from trauma.

What it also means is that even if someone has a diagnosis of PTSD at one point, it's not a lifetime diagnosis. So I do see people who are diagnosed with PTSD, and after going through treatment actually no longer make diagnosis for the client, no longer meet criteria for the diagnosis.

So let's talk about the role that anxiety and avoidance play in PTSD.

So avoidance is not only a common symptom of anxiety, but it is also the primary factor in maintaining anxiety.

So avoidance produces immediate relief. The problem is, however, is that anxiety actually gets worse over time, if we use avoidance to manage it. When we use avoidance, we never have a learning experience that the thing that we avoid is not actually dangerous. So if I feel nervous going to the grocery store, and so I avoid going to the grocery store. I don't actually have the chance to learn that going to the grocery store isn't actually dangerous. In order to learn that have to resist that avoidance, and actually go to the grocery store.

Now as I said before, avoidance can take lots of different forms. So avoidance can be of avoiding particular situations, avoiding thoughts about the event, avoiding talking about the event. It can also be things such as like keeping as busy as possible. It can be things like alcohol and substance use, it can be forgetting important parts of the event. It can also be things such as refusing to go to treatment, or dropping out of treatment. Also sometimes people will go to treatment, and not do the homework or the assignments associated with treatment or going to treatment and not talking about the worst event.

The last is one that we see sort of where irritability and anxiety come together, and this is where people will lash out in anger, when they're afraid. So anxiety feels really uncomfortable and it feels very vulnerable. But anger and irritability, feel powerful, and so if our brain gets to choose between feeling anxiety and feeling vulnerable, or feeling anger and feeling powerful, it's going to choose, anger, probably about nine times out of 10, because it just feels better. Doesn't necessarily feel good, but it feels better.

And this leads to something that we call experiential avoidance. So experiential avoidance is the process through which we avoid distressing thoughts, emotions or memories, or internal sensations. We first develop avoidance as a way to kind of deal with things that are dangerous in the external world. So things like lions, tigers and bears and avoidance for those things works, right. So if I don't go near a bear, bear can eat me. The problem is that we turn that same rule of avoiding lions, tigers and bears to internal discomfort. And where avoidance works for external things, it doesn't work for internal things.

When we avoid internal discomfort. We have this immediate relief. And then just comfort goes down, what we end up doing over time is that we avoid the things that are most important to us.

Things like running a marathon, earning a degree going to work, all of those things that are really important to us. Inherently how some sort of distress associated with them. And even when we look at sort of the practice guidelines and clinical guidelines when we think about PTSD, the continuing presence of symptoms of PTSD is not considered in itself sufficient justification for preventing return to work with GE, so we recognize that the role of avoidance in PTSD is not helpful and we need to actually work on reducing. So how do we do that? Well first we reduce persons, by reducing avoidance persons have the opportunity for new learning, and you can only learn that going to the grocery store is not dangerous by repeatedly going to the grocery store and seeing that nothing dangerous happens.

But we also have to do is stay in the grocery store until the anxiety naturally reduces on its own. If we leave before then this is actually what I call sneaky avoidance. So we went, but we didn't stay long enough for the anxiety to come down over new learning to happen. So where is anxiety reduces rewards reduces anxiety immediately, it actually prolongs again long term. So the more that we use avoidance, the smaller that circle of things that we feel comfortable doing gets so eventually we become really shut in, and we're unable to do most of the things that we need to do to lead a fulfilling life that we really enjoy. So what we're going to talk about next is ways that we can actually reduce avoidance, or we're going to talk about some evidence based treatments for PTSD.

So what I mean by evidence based treatments are treatments that have been shown to be effective and we've done this in many many studies. When we talk about effectiveness. What we use is something called an effect size. So an effect size varies from zero to 2.0. And we look at this over across many studies with called a meta-analysis so we look at research based on lots of different studies of the same type of treatment to see how effective it is. And then effect sizes are categorized into small, medium and large. So an effect size of 0.2 is considered small. So here the person might notice a difference after treating a difference after treatment, but other people might not. An effect size of 0.5 is considered to be medium. So here the person would likely notice a difference after treatment. In addition, close family and friends might notice a small difference or improvement, but other people interrupting with the veteran might not.

And effect size of 0.8 or larger is considered large. So this is not only would the person to notice a difference, and their family would notice the difference, but pretty much anybody that interact with them is a difference so I talked about it as kind of like the butcher and the baker and the candlestick maker. would all notice the difference if we have a large effect size. So when we think about treatment of PTSD, there's sort of three gold standard treatments that we consider this is not an exhaustive list of all the treatments that are available but these are kind of the gold standard evidence based treatments for PTSD.

And those are prolonged exposure cognitive processing therapy, an eye movement desensitization and reprocessing or EMDR for short. We're going to talk about each of those gold standard treatments in depth in the next few minutes, but there are other treatments that are also being studied, including things like Acceptance and Commitment Therapy Moral Injury Therapy, yoga. Mindfulness Based Stress Reduction stress inoculation training and cognitive behavioral conjoint therapy for PTSD, which is actually a couples therapy that you can do with your significant other, and then you do the treatment together and it actually focuses on PTSD and the impact of the relationship. And then also trauma

informed grief reduction therapy or trigger training, which is actually a shorter therapy it's only about six weeks long, and another one that's gaining a lot of support and a lot of research basis behind.

So first we're going to talk about prolonged exposure. Now prolonged exposure was developed by Edna Foa, she is a psychologist I'm giving you her name so if you want to look up more information after this presentation, you'll have good names. Now prolonged exposure or PE for short, is based on the emotion processing theory of PTSD. And this focuses on trauma, at the time of trauma and is based on the learning theory. What that theory states, is that things that were in the environment, at the time of trauma, get associated with danger, even if they're not really dangerous in general. So prolonged exposure base is based on four different components. So psycho education so learning about PTSD and its symptom. Breathing skills and other relaxation exercises in vivo exposure and imaginal exposure. So with in vivo exposure, the veteran and the therapist create a list of the things that they avoid doing because they make them nervous or anxious, and then they slowly work their way up that list with imaginal exposure, the person goes back through the traumatic event in detail and then listens to it. In between sessions to have more exposure and liken it to saying the word lemon 10,000 times, the more times I say it, the less emotional impact that event.

Now prolonged exposure takes somewhere between 10 to 16 weeks and those are weekly individual sessions, and the sessions tend to be 90 minutes in length. Now the effect size for prolonged exposure is 1.91, and as we said anything point over 0.8 is considered large so as you can see, there's a lot of research just for that this treatment is extremely effective.

The next trend that we're going to talk about is called cognitive processing therapy or CPT for short. Now this was developed by two psychologists Kathleen Chard and Patricia Resick again I put their names there for you to research. And this is actually a VA based treatment. This was a treatment that was developed in the VA to work with veterans specifically but it has been applied to a lot of other populations, as we found that it tends to be helpful across trauma and across populations.

So CPT is based on the cognitive processing theory of PTSD. And it really focuses on how the trauma affects how the veteran thinks about himself or herself or others in the world. and it really focuses on five major areas. So those areas are trust, safety, power and control esteem and intimacy, cognitive processing therapy is again has four components. So again we do psychoeducation on PTSD, and the role of thoughts and emotions, we also work on processing the trauma, even through CPT or CPT a which has a trauma count associate.

We challenge thoughts and we teach the patient to actually be their own therapist, and then we do cognitive restructuring. So what we try to do is better understand the trauma and fit it into what the veteran knows about the world, and see how it's changed how the veteran thinks about the world where PE focuses on how the trauma affected the veteran at the time of trauma CPT really focuses on how the trauma affects the person now in their daily life.

CPT has 12 sessions, and these can be done either individually or in a group setting the settings are going to vary then it's going to vary the treatment session length. So if you're doing individual sessions or 60, minutes. If you're going to do group sessions or 90 minutes is tends to be a little bit more writing intensive, as there's a lot of worksheets involved. That also helps the veteran then recreate the same treatment if they need to do more work after treatment presented again teaching the veteran to be their own therapist. One of the other financial benefits the kind of processing therapy is that it can be

done twice weekly. So instead of having 12 weekly sessions, you can have six weeks where you have two sessions a week.

Now what we have found from our research is that cognitive processing therapy tends to be a little bit better if people are experiencing guilt over the trauma so it tends to be a little bit better than prolonged exposure and addressing guilt. Again the effect size shows that it's really effective. It has an effect size of 1.81, which again anything over point eight is considered to be large.

The last of the evidence based gold standard treatments, we're going to talk about is eye movement desensitization and reprocessing, or EMDR. EMDR was developed by another psychologist named Francine Shapiro, and it's based on the idea of dual processing, which states that attending to two processes are recounting the trauma, well paying attention to an external stimuli helps improve processing of the trauma. So how this works is that while talking about, or thinking about the trauma. People are asked to pay attention to an external stimuli such as the therapists hand moving, or lightbar moving. And then the process, the person thinks about and processes the trauma at the same time, there is an ongoing debate about the utility of the eye movement portion of the therapy that the most effective portion tends to be the actual processing of the trauma, either by talking about it, or thinking about it.

Now the treatment length is much more variable with EMDR, so for some people treatment is completed in three sessions. For some people it's 12 some people it's more, and the session length also tends to be variable. So, it is somewhere between 50 to 90, minute sessions. Again the effect size tends to be really effective. So an effect size of 1.891 of the things that can be really helpful is hearing from other people who've been through the treatment, about what the treatment is like, and so a resource I really love is about face. So this is a VA resource that allows veterans family and commission clinicians to access resource. So the website actually allows you to hear from other veterans and other veterans families about what treatment was like for them and what their journey of PTSD has been like, I put the website here and on the next slide, I'm going to give you, I'm going to show you a screenshot of what that website looks like, so that you can see what it will be like when you go there.

Now the website is great because it allows you to actually search for different criteria so you can search for a specific branch of the military, a specific conflict specific type of trauma, a specific gender or a specific age, so you can really find a veteran story that's similar to you and your veterans. Now this is what the website looks like. So as you can see for each of the different veterans you'll be able to scroll through the different videos to look at who the veteran is how they knew they had PTSD, how PTSD affects the people they love, why they didn't ask for help right away. When they knew they needed help, what treatment was like, how treatment helps them, and any advice that they would have to you So I really encourage both veterans and family and clinicians actually to look at this website, so they can get a better understanding about what treatment is like from the patients.

So now that we've talked about PTSD and some potential treatments for PTSD, let's talk about what PTSD actually does to relationships, and to family. So when we think about the impact of PTSD, we tend to find is that when we think about the relationship, there tends to be more severe relationship problems or also tends to be parenting problems and family disruption, and sometimes even chaos.

When we look at the research what we found was that 33% of relationships reported domestic violence within the last year of veterans in a relationships with a veteran with PTSD. And this is compared to only

13.5% of relationships with veterans without PTSD. What other studies have shown to is that the severity of the aggressive behavior was related to this very sad symptoms as PTSD symptoms got worse, the severity of the aggressive behavior tend to do worse as well.

And what appears to be happening is that the severity of that aggressive behavior is actually associated with those arousal symptoms that we talked about so that feeling like you're feeling like you're keyed up. Well, we also know is that veterans with PTSD, are as likely as veterans without PTSD, to be married at some point in their life. However, the divorce rates for veterans with PTSD is significantly higher up to six times higher than veterans without PTSD.

What we also found is that the impact on intimacy is pretty significant that veterans with PTSD and their partners report a lack of intimacy and emotional connection. And this appears to be associated primarily with emotional numbing, and avoidance, that when we choose to avoid a certain emotion such as anxiety. We don't just avoid that emotion, we avoid all emotions, because we can't just pick and choose. And as we avoid emotions. It was really difficult to connect with other people on an emotional level.

What we also know is that partners of veterans with PTSD, as compared to partners of veterans without PTSD tend to report lower life satisfaction, lower happiness, and about 50% of them report is feeling as though they are on the verge of a mental breakdown. What we know is that this tends to be associated with what's called caregiver burden.

So caregiver burden refers to caring for a partner with functional and behavioral impairments associated with PTSD and caregiver burden is associated with psychological distress anxiety and depression. And it tends to be associated, this is a verity of the PTSD symptoms. So as PTSD symptoms get worse caregiver burden increases, and caregiver satisfaction decreases.

But what we also know is the reverse is true as well, is that as PTSD symptoms improve caregiver burden decreases and caregiver satisfaction, increases. So part of why I encourage people to encourage veterans to seek treatment is that treatment isn't only for the veteran It doesn't just benefit the veteran. It also benefits their significant other, their caregiver, and anyone associated with them and their family. I've put on here a brief video that's from make a connection which is another VA resource we'll talk about, but it actually talks with a veteran and his wife about what PTSD treatment was like and how its benefited their family.

So when we're thinking about caregiver burden, we really need to understand the importance of caregiver self-care. So social support is important when considering the severity of symptoms and treatment outcomes. So some of the tips that I have for caregivers as I talked about with caregivers that I meet with is get information about PTSD, understand what it is that we're dealing with and encourage your veteran to seek treatment. I also encourage you to utilize the caregiver support resources and reach out to the caregiver support program about resources that might be available.

I encourage caregivers to schedule time for themselves. In addition to caring for other people you have to take some time to take care of yourself. You have to engage in things like hobbies and pleasant activities that you enjoy to avoid burnout. Encourage caregivers to take care of their health as well, both their physical health so seeking medical attention is even as needed, eating well exercising and their emotional health as well. So spend time with supportive others like family and friends. Seek mental

health treatment if needed, and to really understand the difference between helping and enabling, so we're actually not doing more than needs to be done, or that is helpful to eat.

So let's talk about sort of the difference between helping and enabling. So helping is a process that aids progression, it helps the veteran move forward, and it encourages independence, helping the veteran do more things on their own. It lifts the person up and it gets the person moving. What it tends to do, is it adds value to the person's life who I was being helped, so it adds value to the veterans by, and it tends to be supportive and strengthening so helps move that person forward, enabling on the other hand, tends to keep people stuck, and encourages dependence on the caregiver. Enabling tends to hold the person up, instead of helping them get moving. And it keeps the caregiver moving, instead of the veteran.

What we tend to find is it actually reduces the value of life for the veteran, it makes them feel more incapable, and it tends to be more debilitating over time. This is not saying that people are enabling out of spite or to do something negative. Usually care, enabling really comes from this place of compassion and love. We feel bad when we see someone that we love struggle, and we feel bad when we don't help so when we see is needing help. So enabling is often done to protect the caregiver from a distress in the short term, and to protect the veteran from distress as well.

However, it ignores the fact that sometimes we actually have to experience distress in order to achieve our goals. Enabling can also occur because sometimes it's easier to enable saying no is difficult and it feels uncomfortable. And there are some days when fighting that battle just we don't have the energy for enabling can also be a time saver. Sometimes it takes less time for us to complete a task, than it does for the veteran that we're caring for, but we need to remember that the reasons above are primarily about the caregiver and not the person receiving care that sometimes we also have to reduce our avoidance of discomfort and caring for the people that were caring for them to be able to tolerate distress needed for them to make improvements.

So let's talk about a brief case example. So for this case example I'm going to refer to the caregiver that I worked with as Helen. So, Helen and her husband was a veteran diagnosed with PTSD and Helen was established as a caregiver through the Caregiver Support Program. Helen was referred to me for psychotherapy to address caregiver burnout, when meeting with Helen it became clear that she was burned out due to overextending of a caregiver role, so she was doing all the household tasks, and working full time as well. So here's psychotherapy really focused on shifting from enabling to healthy, and this is included, providing support during resistance to transition including instead of making meals every day, identifying meals of the veteran can make on his own, and making sure the ingredients are in the house. So the plan included collaborative menu planning as well so really involving the veteran in that process.

Instead of making phone calls for the veteran we shifted to a plan where Helen would place the call on speakerphone was held present so the veteran can speak and Helen could assist him and verify the information later. And then eventually shifted to the veteran, making calls on his own. We also worked on identifying individual time, Helen was out of the house each week, and engaging activities that she enjoyed and encourage the veteran to do the same as well so we started to encourage some independence for the veteran. Also, when we're thinking about a decision that we're going to make some of the questions we need to ask are, are my actions helping the person to feel more self-empowered, am I helping them move forward. Are the circumstances staying the same worsening or

improving. If the circumstances are saying the same or worse me. It's a good idea. It's a good tip than likely enabling instead of helping or empowering.

The next is, is the person doing his or her absolute best to help him or herself, are they doing as much as I'm doing to help them get better. Are my actions motivated by fear pity or guilt, am I helping this person take advantage of his or her full potential. So, am I being respectful and helping them be as great as I see them as being.

Number six is what good has come from my help, and the counterpart to this is number seven is what harm has come from my health is the veteran doing less now than they were when I started to intercede. Let's review some effective ways to provide care, without enabling. So here you can assist with tasks that are outside of the scope of the individual's ability, but not tasks the veteran can accomplish on his or her own. So resisting the urge to complete tasks just because it may take them longer, or maybe more difficult tasks such as making phone calls for the person or taking them to the grocery store, rather than going with them, assist with reducing avoidance, so go in with them to the grocery store instead of to the grocery store for them, right, encouraging engagement and activities outside of the home. Allow them to experience the natural increase and decrease in anxiety, while completing tasks. Just because something feels uncomfortable is not mean it is dangerous and does not mean it should be avoided.

And then encourage attendance in person out equipment, instead of VVC. So, VVC might be a good bridge initially to help people get used to the idea of treatment, and then treatment should be moved in person and possible. And then over time assistance should be decreased, so we're gradually encouraging the veteran to do activities on his or her own face, and to do them on their own without the caregiver there. So initially the caregiver might do them. Then move towards the veteran doing them with the caregiver. Then move towards the veteran doing them with less support from the caregiver, and then the veteran doing them independently.

And then the last is to really encourage engagement and treatment and recommend evidence based treatment. So the best results, and the first line recommended should really be engagement and some of those evidence based treatments that we discussed, and those again were CPT, PE, and EMDR. Now the VA, and the DOD guidelines found that supportive therapy can be effective at helping people not get worse, but it actually doesn't offer any benefit for people getting better. It really helps people stay stuck, where they are because it actually helps people get more comfortable, where they are and if somebody is not in a place that's healthy for them we actually don't necessarily want them to stay comfortable there. In some cases we need that distress, motivate for action and motivate for change.

So let's talk about some important tips for caregivers. The first is to take care of yourself. The most important thing you can do for others, and for yourself is to take care of yourself, both physically and emotionally. Take sick days and see your doctor regularly, or more often if needed. Do things that you enjoy, and things that you are passionate about and engage in them and make personal time for yourself and nonnegotiable issue. This is something that is a requirement, not a benefit bonus This is something that you all of us need in order to be the best version of ourselves and to avoid burnout.

The next is to reach out and connect with others in similar situations to reach out to the Caregiver Support Program and see about caregiver support and connection through caregiver support. Encourage

your partner to be a partner. That means division of responsibilities that benefits both people, not just one.

The next is to get more practice saying no and setting boundaries. This is not easy, and it's going to require likely some support from people in your life, but it's one of the best things that you can do, not only for yourself, but also to help move your veteran forward. People often don't change because they want to, they change because the alternative is more adverse. And so, if continuing to get that no response the veteran is getting is aversive, eventually they're going to work on changing that behavior.

Below are some resources that I really encourage caregivers to. The first is informational resources on PTSD and PTSD treatment, so I've put a few here, such as the National Center for PTSD. The National Alliance on Mental illness, some information on PTSD and couples, and then again I put the about face that we talked about above.

In addition, there is what's called Coaching into Care, and this is a VA program that works with family members who become aware that the veterans post deployment difficulties and supports their efforts to find help for the veterans to contact them by phone, by email, and I put their website here as well. The next is to make connection. Now this is a YouTube channel with videos of veterans talking about different treatment options and experiences through the VA. I put the website here for you.

The next is self-care information and this is actually from the Caregiver Support Program. And so if, after this program you're not able to access this slide, you'll be able to access this through the caregiver support program as well. Last are some resources for caregivers that are from Caregiver Support. So here's agingcare.com and helpguide.org, and then acl.gov.

I really appreciate you attending this presentation today. I'm so honored to be able to join and work with you. Having grown up in a military family, I feel like I've been in the VA a very long time on both sides of it. And I know how difficult it is to care for somebody with PTSD, and I really honor and value the work of all of you're putting in to help our veterans, and to help our family and our nation as well and I really thank you for having me today.