# posttraumatic stress disorder

NAMI

National Alliance on Mental Illness

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## What is Trauma?

How do our experiences change us? This is what scientists are asking when they attempt to understand trauma and mental illnesses like posttraumatic stress disorder (PTSD). Though it may seem like a relatively simple concept, psychiatry's understanding of trauma—a powerful experience that may have long-lasting effects—has evolved over time. This development has changed practices affecting many different people, from rape survivors to victims of natural disasters to military service men and women. Roughly 10 percent of women and 5 percent of men are diagnosed with PTSD in their lifetimes, and many others will experience some adverse effects from trauma in their lives.

Everything that is "traumatic" may not meet clinical standards for trauma. Many people find losses such as the death of a loved one or the limitations resulting from an illness to be traumatic, but being shaken by such an event is not in itself abnormal. PTSD includes both an event that threatens injury to self or others and a response to those events that involves persistent fear, helplessness or horror. Current scientific understanding is that experiencing traumatic events can change the way our brains work. Especially with severe or repeated exposure, the brain can be affected in such a way that makes a person feel like the event is happening again and again. This is one of several ways trauma can affect someone far into the future. This repeated experience of the traumatic event can prevent healing and keep a person stuck in a pattern that may induce anxiety, sleeplessness, anger or an increased possibility of substance abuse.

# Risk Factors for Developing PTSD

## Prior History of Trauma

Combat, sexual assault, surviving a natural disaster or a terrorist attack are examples of traumatic psychological events that can cause PTSD. These events can be a single occurrence in a person's lifetime or occur repeatedly, such as in the case of ongoing physical abuse or an extended or repeated tour of duty in a war zone. The severity of traumatic events and duration of exposure are critical risk factors for developing PTSD.

A severe traumatic event often has a direct physical impact and occurs within a violent context. For example, veterans who have been injured in combat are at high risk for PTSD because they have sustained a direct injury in a violent setting. Because rape involves physical and emotional trauma, it is also associated with very high rates of posttraumatic responses.

Proximity to a traumatic event can determine whether a person develops PTSD. For example, a person who was working in the Twin Towers of the World Trade Center on Sept. 11, 2001 has a much greater chance of developing PTSD than a person hearing about the attack on television.

## How Trauma Becomes PTSD

Many people exposed to life-threatening or overwhelming traumatic events have short-term responses that last for days or weeks. These responses can include:

- dissociation (feeling disconnected or cut off from one's self or one's emotions);
- nightmares;
- flashbacks;
- heightened fear;
- poor concentration;
- sleeplessness; and
- anxiety.

## Patterns of Trauma Response

- **Acute Stress Disorder** is diagnosed when responses to a traumatic event occur and last for less than a month. For many people, these acute symptoms resolve over time, often with the help of a support system or treatment.
- **PTSD** is identified when disabling symptoms persist for months or years after the traumatic event(s). These symptoms interfere with daily functioning and meet specific diagnostic criteria.
- **Acute PTSD** is diagnosed when an individual has symptoms for less than three months.

- **Chronic PTSD** is diagnosed when someone has symptoms for more than three months.
- **Delayed-onset PTSD** appears months—sometimes more than year—after the initial trauma. In many cases, the individual may have had some symptoms before, just not enough to meet the diagnostic criteria. Many people with delayed-onset PTSD demonstrate dissociation to suppress their reactions and avoid thoughts of the event. Numbing and/or avoiding symptoms are associated with a worse prognosis in the long run for many people.

## The Neurobiology of PTSD

As one researcher says, "the body keeps the score" when it comes to remembering trauma. Human beings are programmed to react to threats to their safety. Unfortunately, this set of adaptive responses in the face of terror, which are lifesaving in the moment, can leave people with ongoing, long-term psychological symptoms. The biological mechanisms that promote the powerful and protective "fight or flight" response and maximize physical safety at the time—such as enabling a woman to fight off an attacker during a sexual assault—and can create complex problems later. When faced with terror, less critical body functions (*e.g.*, the parts of the brain where memory, emotion and thinking are processed) get "turned off" in the service of immediate physical safety. As a result, the traumatic experiences are not integrated as they occur because the body is focusing entirely on immediate physical safety.

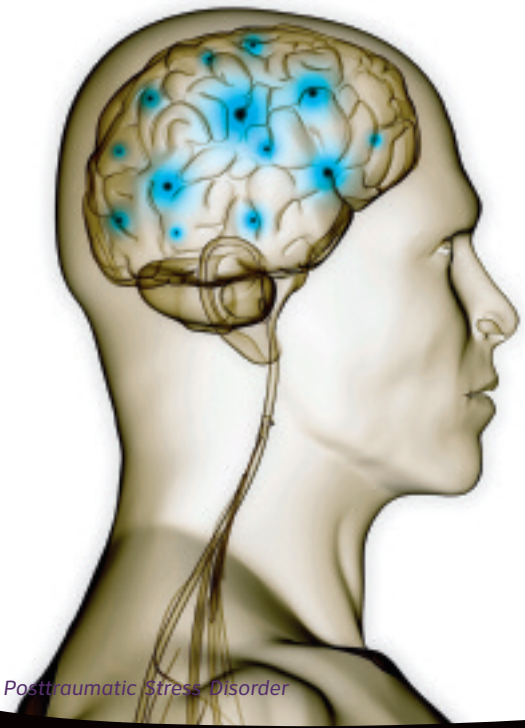
The signs of the poorly integrated traumatic experience can appear unexpectedly and unpredictably, representing unprocessed memories of the traumatic event. As long as thoughts, memories and feelings associated with the trauma remain shut off from the actual event, it is difficult for people living with PTSD to access their inner experiences because the normal flow of emotion remains deeply affected by the traumatic event. For decades, trauma survivors have described being under-responsive (hypoarousal) or over-responsive (hyperarousal) to all types of events—even if they are unrelated.

### Hypoarousal and Hyperarousal

Hypoarousal is characterized by numbness and avoidance, which represent self-protective efforts by the brain to keep overwhelming feelings under control. Hyperarousal is a heightened "startle response" to triggers seen as threatening. This shows how after surviving a trauma the body remains on alert to prevent a repeat traumatic experience. These states

demonstrate the difficulty that people living with PTSD have in regulating their emotional and physical responses. Brain imaging studies of individuals living with PTSD show that these psychological problems are biologically controlled. These studies found that the area of the brain involved in emotional processing (hippocampus) is reduced in size, the body's alarm system (amygdala) is over-reactive and the part of the brain that adjusts that alarm system (prefrontal cortex) is under-reactive.

Changes also occur in stress hormones, such as cortisol and epinephrine, and in the nervous system, which becomes more reactive. Brain scans have also shown that the functioning of people living with PTSD is more compromised by distractions than that of people without the condition. Specifically, the area of the brain that processes emotions is more likely to be triggered by stimuli, regardless of whether they have anything to do with the original trauma. These body-based changes help explain why a veteran reacts to the sound of fireworks or a helicopter flying overhead. As a result of these PTSD-related biological changes, the ability to tell the difference between a real threat and a perceived threat can be weakened.



## Diagnosing PTSD

The *DSM-IV* is the handbook for mental health professionals that categorizes mental disorders and lists the criteria for diagnosing them. PTSD is classified as an anxiety disorder in the *Diagnostic and Statistical Manual-IV (DSM-IV)* by the American Psychiatric Association. The *DSM-IV* criteria for identifying PTSD require that symptoms must be active for more than one month after the trauma and associated with a decline in social, occupational or other important areas of functioning. The three broad symptom clusters can be summarized as follows:

1. **Persistent Re-experiencing**
   A person experiences one or more of the following:
   - recurrent nightmares or flashbacks;
   - recurrent images or memories of the event—these images or memories often occur without actively thinking about the event;
   - intense distress at reminders of the trauma; and/or
   - physical reactions to triggers that symbolize or resemble the event.
2. **Avoidant/Numbness Responses**
   A person experiences three or more of the following:
   - efforts to avoid feelings or triggers associated with the trauma;
   - avoidance of activities, places or people that remind the person of the trauma;
   - inability to recall an important aspect of the trauma;
   - markedly diminished interest in activities;
   - feelings of detachment or estrangement from others;
   - restricted range of feelings; and/or
   - difficulty thinking about the long-term future—sometimes this expresses itself by a failure to plan for the future or taking risks because the person does not fully believe or consider the possibility that they will be alive for a normal life span.
3. **Increased Arousal**
   A person experiences two or more of the following:
   - difficulty falling asleep or staying asleep;
   - outbursts of anger/irritability;
   - difficulty concentrating;
   - increased vigilance that may be maladaptive; and/or
   - exaggerated startle response.

The *DSM-IV* also specifies that the person must experience, witness or be confronted with an event that involves actual or threatened death, serious injury or a threat to their physical integrity (such as rape). This trauma must be severe enough to cause intense fear, helplessness or horror. By creating this

narrow definition, the *DSM*-IV differentiates a diagnosis of PTSD from common everyday experiences that may overwhelm an individual such as feeling "traumatized" by a presentation at work or having to dance in public. The *DSM-IV* also differentiates PTSD from other conditions involving severe distress. For example, a person with a psychotic disorder may become severely distressed learning that a loved one is ill.

Though not currently included in the *DSM-IV*, some researchers have suggested that "complex PTSD" is another variant of the condition. People are thought to develop this condition, which profoundly alters thoughts, emotions and identity, when they are repeatedly subjected to trauma over a long period of time, for example when a person has experienced torture, abduction or other long-term abuse.

## PTSD and Co-Occurring Disorders

People who have been traumatized often have conditions that co-occur with PTSD. These conditions can include depression, anxiety, sleep disorders and substance abuse. These associated conditions underscore the importance of getting a comprehensive evaluation and organizing a plan that addresses the individual's specific concerns. Sleep, in particular, plays an important role in PTSD. There appear to be differences in the way a person in recovering from PTSD enters the Rapid Eye Movement (REM) phase of sleep. These differences may actually be discernible in laboratory testing and help identify the risk for developing this trauma response.

Some people living with PTSD turn to alcohol and drugs in an effort to self-medicate or control the overwhelming feelings resulting from their trauma. While alcohol and drugs can appear to help reduce overwhelming anxiety in the short term, in the long term, they contribute to worsening symptoms and make a person's recovery efforts more difficult. Research shows that among people with lifetime PTSD, approximately 21-43 percent will develop a long-term substance abuse problem, as compared with 8-25 percent of the general population. People who have been diagnosed with both PTSD and substance abuse tend to also be diagnosed with another psychiatric diagnosis as well, most commonly major depression or an anxiety disorder. It is important to treat all these conditions simultaneously to prevent a recurring cycle, and substance abuse can put someone at a greater risk for experiencing more trauma. Research has suggested that substance abuse issues within the military may be contributing to a high suicide rate.

## PTSD and Suicide

Suicidal feelings can arise in trauma survivors for many reasons. For veterans, research has found that memories and guilt about combat experiences can put someone at a greater risk of suicide. According to the Veterans Administration, between 2005 and 2007, more than 16 veterans died every day by suicide. This means nearly 6,000 veterans die by suicide each year. Rape survivors are also more likely than the general population to attempt suicide. Some of the very symptoms of PTSD—anger, poor impulse control, a tendency to isolate or hold in feelings—can also increase suicide risk. Luckily, people who are receiving some type of treatment are statistically less likely to exhibit suicidal behavior, illustrating the importance of getting help for PTSD and any associated conditions like depression.

## Combat Veterans and Trauma

Extreme psychological responses to combat have been mentioned throughout history, from Homer's writings in 800 B.C. to documents from the American Civil War and in every war that has followed. In wars prior to Vietnam, the disorder was referred to as "shell shock" or "battle fatigue." As our understanding of PTSD has grown, recent reassessments of Vietnam veterans have found higher rates of PTSD than previously reported. The return of combat veterans from Iraq and Afghanistan in recent years has highlighted the impact of psychological trauma not only for veterans but for members still in active duty. Research demonstrating that these veterans have high rates of suicide also illustrates the severity of their psychological distress. A 2007 survey of entry-level military personnel revealed that 26 percent had a history of substance abuse and nearly 16 percent reported current depressive symptoms that were "reasonable" to "severe." A survey of

troops in Iraq and Afghanistan found a correlation between PTSD symptoms and exposure to combat experiences. Of those responses met the criteria for diagnosis, only 38-45 percent expressed an interest in receiving help. Some common reasons for not seeking help include fear of being seen as weak or being treated differently by leaders and peers, as well as concerns about such an admission harming one's career.

Efforts to increase screening for trauma in primary care settings and policies that encourage the identification of troops at risk for suicide are positive developments in military culture. Similarly, policies that formerly acted as disincentives to service men and women who sought mental health services are being overturned, creating a culture allowing for earlier identification and more receptive to treatment.

## Culture and PTSD

Most of the studies that have attempted to identify differences in the way PTSD occurs among ethnic groups have been conducted on veterans, particularly Vietnam-era veterans. While the results have not established a clear pattern, it appears that most ethnic minority veteran populations have a higher incidence of PTSD than whites, although this may be due to an exposure to a higher level of combat stress or culturally different ways of reporting symptoms. Native American veterans are reported to have high levels of PTSD, though this may be related to difficulties in accessing care—especially quality, culturally competent care—in remote regions.

The issue of culturally competent care for many ethnic groups may extend to developing PTSD treatment programs tailored to the needs of specific cultures. Some of these approaches integrate an awareness of historical trauma common to an ethnic or cultural group with individual trauma experienced today.

Higher rates of PTSD would be expected in ethnic groups that have higher rates of prior traumas, major depression or substance use. In providing care for different ethnic groups, different cultural beliefs about death, the afterlife and the possibility of recovery also need to be considered. PTSD is also common among recent immigrants to the U.S., such as people who fled harsh conditions or military regimes or who endured danger, confinement or threats when entering the country.

Research has shown that people who are gay, lesbian, bisexual or transgendered are more likely to experience violence and therefore may be more likely to develop PTSD.

## Trauma during Childhood

Traumatic events have a very profound impact on a child's developing brain, body and sense of self. Children can carry these negative effects of trauma well into adulthood. More than 1 million reports of abuse or neglect are substantiated by child protective agencies every year in the U.S. Children who experience chronic physical, sexual or emotional abuse struggle in many areas of life. They are still developing the ability to process ideas, emotionally and physically, and thus express PTSD symptoms in different ways from adults. Common problems include:

- difficulty regulating their emotional reactions;
- establishing and maintaining relationships;
- controlling aggression; and/or
- low self esteem and functioning in school.

Adolescents who were abused as children are overrepresented in the juvenile justice and criminal justice system. They also have high rates of substance abuse and psychiatric illness, such as borderline personality disorder, dissociative disorder and eating disorders. Children learn how to regulate their emotions and sense of self over time through caring relationships. When these relationships are the source of trauma for the child, they can cause confusion and lead to isolation and withdrawal. This may weaken the child's ability to create trusting relationships later in life. Untreated childhood trauma can impact a person's life into adulthood. Children who experience child abuse may grow into adults with PTSD—some research has found that more than twice the number of adults with a history of child abuse go on to develop symptoms of PTSD compared to those with no history of abuse. As adults, people with a long history of childhood trauma are also at a higher risk of developing medical problems.

A large collaborative study by the Centers for Disease Control and Prevention and Kaiser Permanente focused on the impact of harmful experiences on children. The Adverse Childhood Experiences (ACE) Study found that the amount and intensity of childhood trauma had a connection with many adult health problems including obesity, alcoholism, depression, heart disease, diabetes, cancer and other serious medical problems. All of these other serious conditions that can be related to

PTSD help us understand why prevention of, and early intervention for, child abuse—whether physical, sexual or emotional—must remain a national priority.

## Women and PTSD

Studies of the general population suggest that women experience PTSD at more than twice the rate of men. This may be due to the greater likelihood of a woman experiencing a traumatic event.

In the military, women run a double risk of developing PTSD for reasons ranging from battle stress and sexual harassment to assault. In a recent study, women in the military were more than twice as likely to develop PTSD as their male counterparts. Women, however, had been denied insurance coverage for PTSD because of a former stipulation that required combat experience to qualify for the benefit. In addition, women may take longer to recover from PTSD and are four times more likely than men to experience long-lasting PTSD. Military Sexual Trauma (MST), defined by the Department of Veterans Affairs as sexual assault or repeated threatening acts of sexual harassment, is another factor women are faced with.

## Sexual Assault and PTSD

PTSD is very common among people who have experienced sexual abuse or assault. Thirty-one percent of women who have been raped develop rape-related PTSD. While this situation affects women disproportionately, PTSD can also occur in men who have been sexually assaulted.

Many people who have rape-related PTSD feel guilt about the experience and think that they should have done something to prevent the attack. They may also need to relearn good boundaries in relationships, as people who experience sexual assault-related PTSD may do so as part of a pattern of revictimization. Studies have shown that getting some type of treatment for rape early on was more important than the type of treatment in the outcomes for affected people.

## Trauma and the Mental Health System

There is now strong evidence that psychological trauma histories are quite common in psychiatric inpatient and outpatient settings. This awareness has led to a movement in the mental health community called "trauma informed care," which aims to minimize triggers and distress and increase coping strategies in mental health services for individuals affected by trauma.

The national movement to reduce the use of physical restraints in American psychiatric hospitals was driven largely by the realization that many people brought to psychiatric hospitals had been psychologically traumatized. When restrained, these individuals were often retraumatized. Increasing awareness of this problem led to a national movement to reduce the use of restraints in psychiatric hospital settings, which has become a best practice. Developing trauma-sensitive systems of care is a much-needed improvement.

While many people living with PTSD may have a difficult time discussing the traumatic event, finding trustworthy doctors and communicating openly and honestly with them can make a tremendous difference for people attempting to address trauma and its after-effects.

## Family Impact of PTSD

Having a family member who lives with PTSD can be confusing and challenging. Many feel their family member's personality has changed after the traumatic experience. A social, happy and affectionate child can become sullen, withdrawn and fearful after experiencing trauma. Likewise, troops with PTSD can return home from military service with new levels of anger and anxiety. Given the likely changes in the survivor's brain and the brain's response reactions described earlier, it makes sense that family members experience a "different" person from the one they knew before the traumatic event. Brain changes can be reversible with treatment—both medication and psychotherapy—but it can take time (months or even years) especially if PTSD is long-standing.

This change frequently creates stress in families of the trauma survivor. At times, families can feel burdened or overwhelmed living with a person who has PTSD, with many family members reporting "caregiver burnout." To cope with these issues, families need support for themselves and their affected relative. Military culture tends to emphasize self-sufficiency, which may prevent families of veterans with PTSD from publicly admitting that they need help. See the resources section for information about NAMI Family-to-Family classes designed specifically for military families.

Literature based on the experience of Holocaust survivors has led to the concept of "transmission of trauma" across generations. A related situation known as "vicarious" or "secondary traumatization" happens when clinicians or caretakers identify with traumatized individuals to the point where they begin to act and feel as if they themselves were traumatized. This explains

why individuals (especially children) can develop many of the same fears, and even some of the same symptoms, as individuals who have lived through severe traumas. In the long term, the effects of a parent's PTSD have been shown to cause higher rates of aggression and anxiety among the children of veterans with PTSD. Parents who are traumatized when they learn of their child's trauma are also classified as having PTSD.

This does not mean that PTSD is "contagious," but it does mean that it is important to pay attention to the level of stress among families and friends because PTSD can elicit a tremendous desire to help or save the person who is perceived as an "innocent victim."

## Recovery and Coping

In the aftermath of a traumatic event, individual choices can make a difference. Several common coping strategies, such as substance use, appear to yield short-term relief but create problems over time and should be discouraged. Similarly, isolation can help to reduce the number of potentially stressful emotional inputs in the short term. But over time, isolation has a negative impact on an individual's emotional health and quality of life. Sobriety efforts and connecting with other people—through one's natural support system and with individuals who have been through similar traumas—are often critical to healing. Exercise and working toward being fully functional in the workplace or school are also important.

Trauma survivors may find it easy to forget their strengths, but their resiliency may make a real difference over time in their outcomes. People who are more optimistic and have a sense of control over their environment are less likely to develop PTSD when confronted with a trauma. Many people work to find meaning in their distress. This can lead to spiritual reflection and an unselfish effort to support other trauma survivors. Support services and treatment can help, but it can take courage to seek them out. It takes determination to find the right combination of treatment and support.

Treatment strategies should be customized to the individual's needs and reflect the treatment plan of their choosing. Treatment and support options should also reflect an individual's stage of recovery—interventions that make sense immediately after a trauma may not be appropriate years later.

### Psychological First Aid

Support and compassion are critical in the immediate aftermath of a traumatic event. Some people will want to talk about the event frequently, while others will find it troubling to discuss the

trauma. It is important to provide support to the individual, help the individual maintain connections with others and encourage him or her to seek assistance in dealing with trauma. Since many people living with PTSD go to a primary care doctor first, it's important that symptoms be identified at this stage.

### Psychotherapy

There are many different kinds of psychotherapy in the field of mental health. People living with PTSD respond better to select, structured interventions than to unstructured, supportive psychotherapy. In addition to EMDR (see below), research is being conducted on dream revision therapy, also known as Imagery Rehearsal Therapy (IRT).

*I lost my stepson in a farming accident that was witnessed by my husband and two stepchildren. Since that day, life has not been the same. My husband refuses to do much. He basically goes to work, sits on the couch and watches TV. He is angry all the time and struggles with sleeping. There are times when he wakes up in a sweat; other times he simply cries in his sleep. He is easily angered. Our two-year-old daughter acts scared of him at times, because he constantly raises his voice. This is not the man I married, or the man he was before the accident. At times I try to talk to him about going to seek counseling, but he refuses. It takes a long time to get him to where he is happy. I can only imagine what he sees in his dreams. He won't take medicine, he simply says "I am fine."*

*The accident was pretty difficult. The children that were there are suffering—PTSD presents itself differently in children, as the illness is known to do. They refuse to sleep in their rooms—they sleep on our couch. They are willing to go to the place where the accident occurred, in front of my parents' home, which is surround by the farm. However, they won't sleep by themselves. They have nightmares, they struggle to make friends and have difficulty interacting with others.*

*It has been 22 months since the accident. After a lot of research on PTSD, I have been able to learn how to support from a distance. I pray each day that it will get easier, but I am only one person.*

*—Family member*

## Cognitive Behavior Therapy (CBT)

Cognitive Behavior Therapy (CBT) employs tailored exposure to the traumatic event through a memory or another form of exposure. By tolerating the exposure to the trauma, the individual's anxiety and symptoms can gradually reduce. CBT has two different parts: a behavioral component (usually referred to as "exposure therapy") and a cognitive component that aims to correct distorted thoughts that can result in shame and self-blame. There are many forms of exposure therapy that are all designed to expose the person to triggers in a safe way so that he or she can learn to tolerate them. Newer forms of CBT may involve computer simulations or other technology to create a safe form of exposure to circumstances similar to the trauma.

## Eye Movement Desensitization Reprocess (EMDR)

Developed in 1989, EMDR is a psychotherapy intervention designed for trauma that employs several strategies, including exposure to traumatic memories with alternating stimuli (eye movements are one of several options) in structured sessions with an individual certified to perform EMDR. EMDR has been shown to be effective for PTSD as it is an information-processing therapy. It is not now clear if the alternating movements of the eyes are related to the intervention's usefulness.

## Group Therapy

Joining a group of people who have been through similar experiences can uplift and support an individual who is feeling alone and isolated with upsetting and traumatic memories and symptoms. Groups can lessen shame and provide community support as well as reduce feelings of helplessness. Groups for survivors of combat and sexual assault frequently involve members living with PTSD and related symptoms. The ancient expression "pain shared is pain halved" speaks to the relief people often feel when they share their stories with others. Psychotherapy research is an active area in the PTSD field. Interest is growing in treatments that focus attention on how symptoms are experienced in the body.

## Service Dogs

The use of service dogs as forms of therapy for individuals living with PTSD, especially for veterans, is becoming increasingly common. A service dog is by a veteran's side 24 hours a day to help navigate daily stressors. Some animals come to the veteran pre-trained with a set of commands, while

others are trained by the owners themselves. Over time, an owner can rely upon the dog's instincts for a reality check, giving their brain a break from hypervigilance. The animals can also serve as a social buffer, an incentive to exercise and a de-escalation tool during times of stress. See the resources section for more information on service dogs.

## Medications

There is no one medication that will treat all cases of PTSD. Given the effectiveness of psychotherapy and medication, they should be used together to treat PTSD and reduce symptoms. Because of the common co-occurrence of depression, related anxiety disorders, aggression and impulsivity, selecting medications that address these related problems might also reduce symptoms.

- Antidepressant therapy can be useful to reduce the symptoms of PTSD. Several selective serotonin reuptake inhibitors (SSRIs) have been approved by the FDA for the treatment of PTSD in adults and are often the first line of treatment.
- Beta-blockers, a class of medications used for high blood pressure, may be helpful for some people with PTSD.
- Mood stabilizers and antipsychotic medications may have a role for individuals with aggression, mood instability or dissociation.
- Sleep restoration is important. Physicians may use off-label medications to normalize sleep patterns, a key component to supporting recovery.

Complex responses to trauma have been an element of the human condition since recorded time. In the modern era, researchers are uncovering the complicated relationship between mind, brain and body for people living with PTSD. The more that science learns about the deep level at which our experiences affect us, the more compassion, acceptance and possibilities are opening up for individuals and families living with the effects of trauma. When it comes to treating PTSD, there is much to be hopeful about once the first step of breaking through the isolation has been taken.

People living with PTSD and their families should ask their health care providers about the latest developments and treatment options that flow from recent research.

*Written by Ken Duckworth, M.D.*
*with thanks to Anand Pandya, M.D., and Bruce Dow, M.D.*

## Information Resources

**Disaster Psychiatry Outreach**
www.disasterpsych.org

**Imagery Rehearsal Therapy**
www.nightmaretreatment.com

**International Society for Traumatic Stress Studies**
www.istss.org

**NAMI'S Veterans Resource Center** includes tools such as help filing a claim for PTSD, family resources and multicultural resources.
www.nami.org/veterans

**National Center for PTSD**
www.ncptsd.va.gov

**National Center for Trauma-informed Care**
www.samhsa.gov/nctic

**National Institute of Mental Health (NIMH)**
www.nimh.nih.gov

**Psychiatric Service Dog Society (PSDS)**
www.psychdog.org

**The Trauma Center at Justice Resource Institute**
www.traumacenter.org

**Trauma-specific Interventions**
http://mentalhealth.samhsa.gov/nctic/healing.asp

**The U.S. Department of Veterans Affairs**
www.ptsd.va.gov

**www.nami.org** features the latest information on mental illnesses, medication and treatment and resources for support and advocacy. Other features include online discussion groups and fact sheets.

**StrengthofUs.org,** an online social community for teens and young adults living with mental illness, is a place where they can connect while learning about services, supports and handling the unique challenges and opportunities of transition-age years.

**The NAMI Information HelpLine** receives more than 8,000 requests each month from individuals needing support, referral and information. More than 60 fact sheets on a variety of topics are available along with referrals to NAMI State Organizations and NAMI Affiliates in communities across the country.
www.nami.org/helpline • 1 (800) 950-NAMI (6264)

**NAMI Hearts & Minds** is an online, interactive wellness educational initiative intended to promote quality of life and recovery for individuals who live with mental illness. Focuses include exercise, nutrition and smoking cessation. www.nami.org/heartsandminds

**NAMI Peer-to-Peer** is a free, 10-week education course on the topic of recovery for any person living with a serious mental illness. Led by mentors who themselves have achieved recovery, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills and self-care. www.nami.org/peertopeer

**NAMI Family-to-Family** is a free, 12-week course for family caregivers of adults living with mental illness. An evidence-based practice taught by trained NAMI family members who have relatives living with mental illness, the course provides caregivers with communication and problem-solving techniques, coping mechanisms and the self-care skills needed to deal with their loved ones and the impact on the family. Also available in Spanish. www.nami.org/familytofamily

**NAMI In Our Own Voice** is a public education presentation. It enriches the audiences' understanding of how the more than 58 million Americans contending with mental illness cope while also reclaiming rich and meaningful lives. Presented by two trained speakers who themselves live with mental illness, the presentation includes a brief video and personal testimonials, last 60-90 minutes and is offered free of charge. www.nami.org/ioov

**NAMI Connection** is a recovery support group for adults living with mental illness regardless of their diagnosis. Every group is offered free of charge and meets weekly for 90 minutes. NAMI Connection offers a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. The groups are led by trained individuals who are in recovery—people who understand the challenges others living with mental illness face. www.nami.org/connection

**NAMI Basics** is a free, educational program for parents and other primary caregivers of children and adolescents living with mental illness. The course is presented in six different classes, provides learning and practical insights for families and is taught by trained parents and caregivers who have lived similar experiences with their own children. www.nami.org/basics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