



## THE NATIONAL CENTER'S DISASTER MENTAL HEALTH ACTIVITIES: PAST, PRESENT, AND FUTURE

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Because of recent events and because publication of this issue of the *Clinical Quarterly* was delayed, this summary, which was written several months ago, needed to be updated before we went to press. The National Center has been very involved in the immediate response to the Sept 11 terrorist attacks on the World Trade Center and Pentagon. Our website <[www.ncptsd.org](http://www.ncptsd.org)> has won national acclaim for rapidly providing educational materials for clinicians and the general public. A team of National Center staff from the Education Division in Palo Alto provided immediate consultation, training in disaster mental health, and debriefing for Department of Defense (DoD) personnel and their families at the Pentagon Family Assistance Center in Crystal City, Virginia. The National Center is also working with VA, other Federal, New York State, and New York City officials in planning the next phases of the post-Sept 11 mental health response. Therefore, I'll begin this summary with an historical overview of how we first got into the emergency/disaster mental health business. I'll finish by describing our current activities and plans for the immediate future.

### Background

#### Past Activities

Those of you familiar with the early history of the National Center for PTSD know that we were literally thrust into the disaster mental health business by the Loma Prieta earthquake of October 1989. That dramatic cataclysm, witnessed by millions of Americans watching the televised World Series game between the San Francisco Giants and Oakland A's, shook up the whole Bay Area, destroying (among many other structures) the main building at the Palo Alto VA Hospital.

Four days later a few of us made the hazardous trip from Palo Alto to Santa Cruz, the locale of the earthquake's epicenter. There we established a "helping the helper" program, led by Bruce Young, that provided crisis counseling and other psychological support to Red Cross personnel, school teachers, mental health workers and other local officials. We maintained that program in Santa Cruz for 18 months. During that time we had our first introduction to the National Emergency Disaster System and collaborated with officials from the Federal Emergency Management Agency (FEMA), the Public Health Service, military emergency technicians operating out of the Oakland Naval Hospital, in addition to the Red Cross and local disaster personnel. These activities were made possible by VA Secretary Derwinski's unprecedented decision to permit VA personnel to assist civilian federal and local authorities in the post-earthquake restoration of order to the entire Bay Area. Indeed, the first issue of this newsletter (*NCP Clinical Quarterly*, Spring 1990) describes these activities in detail, along with a page 1 photograph of Fred Gusman peering into the 30 foot deep fissure in Santa Cruz where the earthquake had its origin.

Since that time, disaster mental health has been one of the National Center's highest priorities. This is consistent with VA priorities in which the VA's fourth mission (after treatment, education, and research) is to assist in times of national emergencies and natural disasters. During the past 11 years, our activities in this area have been reported in our Annual Reports and in this newsletter. Without rehashing too many details, major accomplishments include collaboration with the DoD in preparation for the Gulf War, development of a disaster mental health manual that has been adopted

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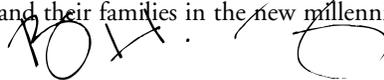
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## FROM THE EDITOR...

Though these are uncertain times, it is certain that after events of Sept11, the field of trauma services, research, and education will work at speeds greater than ever to improve service delivery to survivors and helpers and to increase the empirical knowledge about multi-modal interventions designed to mitigate and treat stress reactions. This will be most likely be accomplished by legislation, the development of interagency agreements, the innovative use of existing assets, new methods and forms of information dissemination, research, development of best practice guidelines and specialized treatment programs, as well as reviews and modifications of current programs and approaches to service. Much is underway already. In this issue, NC-PTSD Executive Director, Dr. Matthew Friedman gives a summary of how cooperative agreements with other government agencies are shaping the disaster mental health initiative of the National Center. Over the next year, the Clinical Quarterly will track efforts by key agencies to keep you informed of important developments.

Prior to the Sept 11th attack, two articles related to the VA/NC-PTSD primary mission of veteran care, were in press for this issue of the Clinical Quarterly. The first of these articles pertains to group treatment. There are several reasons why group treatment continues to be one of the most common forms of therapy for PTSD. Group treatment enables clinicians to assemble survivors who have had similar experiences; it provides a context in which to build a therapeutic community of acceptance and support; it provides a context enabling survivors to recognize the universality of PTSD symptoms and trauma-related problems; and, group treatment costs less in time and energy than equal amounts of individual treatment. There are two primary forms of group treatment: trauma focused exposure-based treatment involving a retelling of the trauma experience; and "here-and-now" focused treatment targeting current trauma-related problems, e.g., communication skills, anger management, stress management, interpersonal relations, employment, housing, substance abuse, etc. Facing diminishing clinical resources and the challenge to increase staff productivity while improving the standard of care, Repasky, Uddo, Franklin, and Thompson describe the VA New Orleans Trauma Recovery Program, an innovative time-limited group treatment model utilizing both trauma narrative and psychosocial management skills.

Another innovative effort to improve the standard of veteran care is described by Lyons and Root who present the work of the VA South Central MIRECC to meet the needs of families of veterans receiving treatment for PTSD. In addition to highlighting the important role of the family in the care of veterans, they frankly acknowledge the difficulties encountered engaging families in treatment and share their strategies to increase families' attendance and participation, including the use of a phone survey to identify obstacles to seeking services. Both articles represent VA clinicians' creative and thoughtful efforts to support and achieve the Department of Veterans Affairs Strategic Plan For Employees 2001-2006 goals to meet the needs of veterans and their families in the new millennium.



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by VA, DoD, and civilian programs (and which is accessible on both DoD and National Center websites), participation in crisis counseling following the Oklahoma City bombing, joint training with Readjustment Counseling Service of approximately 250 VA professionals in nine separate VISNs in disaster mental health interventions, and ongoing collaboration with VA's Emergency Management Strategic Healthcare Group (EMSHG) previously headed by General Joe Grey and currently led by Dr. Kristi Koenig.

Although we have been proud of these accomplishments, often achieved under the leadership of Fred Gusman and Bruce Young, we have been dissatisfied that such activities represented episodic responses to emerging situations rather than ongoing programmatic participation in the National Domestic Medical System's post-disaster mental health response.

All that changed last year when I was approached by Beth Nelson, Chief, Emergency Services and Disaster Relief Branch of the Center for Mental Health Services (CMHS). CMHS is a component of the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Ms. Nelson explained that guidelines for emergency mental health services, developed in the context of earthquakes, floods, hurricanes, and other natural disasters, did not appear to be appropriate for criminally-perpetrated mass casualty events such as the Columbine school shooting, Oklahoma City bombing, or the Pan American Flight #103 plane crash over Lockerbie, Scotland. PTSD rates are generally much higher following a criminal event and the duration of psychological distress may last much longer. (For example, traumatic reminders tend to be retriggered throughout the post-traumatic period by arrests, trials, sentencing, executions, and anniversaries, all of which may take several years to unfold.)

*Future activities will include best practices and training curricula with specialty modules for a wide array of audiences, surveys of federal/state practitioners and administrators, a consensus conference, disaster site surveys, program evaluation of the disaster response system in action, and empirical research.*

With the support and collaboration of Kathryn Turman, Director, Office for Victims of Crime (OVC) at the Department of Justice, Beth Nelson told me that CMHS

had decided to develop best practice guidelines for emergency mental health interventions following both criminal and natural disasters. She asked the National Center to take the lead in this multi-year endeavor. Under the leadership of Patricia Watson, of the Center's Executive Division, and funded by an Inter-agency Agreement between CMHS and the National Center, we have just completed the first year of this exciting initiative. There are three extraordinary aspects to this endeavor. The first is the project itself. The second is how it has affected Center programmatic involvement in the overall mental health component of the National Disaster Medical System. The third is how it prepared us to make a significant contribution following the September 11 terrorist attacks on the World Trade Center and the Pentagon.

Under Patricia Watson's leadership, we have reviewed: (a) all evidence-based research on emergency mental health interventions; (b) numerous reports on interventions in recent federally declared disasters due to either criminal or natural causes; (c) analyses of how the current Federal Response Plan does and doesn't work (with respect to legislative mandates, executive orders, earmarked resources, federal-state collaborative arrangements, etc.), and (d) all the diverse current training curricula concerning disaster mental health. Future activities will include best practices and training curricula with specialty modules for a wide array of audiences, surveys of federal/state practitioners and administrators, a consensus conference, disaster site surveys, program evaluation of the disaster response system in action, and empirical research. This initiative has brought together professionals from VA, CMHS, OVC, DoD, National Institute of Mental Health, state officials and experts from academia. National Center personnel, besides Patricia Watson, who are playing major roles in this endeavor are Joe Ruzek, Bruce Young, Fred Gusman, and myself. Other key players are Beth Nelson, Seth Hassett, Deborah DeWolfe and Diana Norboe (from CMHS), Skip Burkle and Paul Bolton (from the Johns Hopkins School of Medicine and Public Health), and Fran Norris (from Georgia State University).

As a result of this project, Patricia Watson, Joe Ruzek, and I have been invited to participate in several focus groups and meetings with colleagues based in other federal departments charged with different but complementary responsibilities concerning early mental health intervention following mass casualties. I have already mentioned CMHS and OVC as well as collaborative activities with DoD in my previous column. In addition, we have begun to establish programmatic relationships with FEMA, the American Red Cross, the National Domestic Preparedness Office, the Department of Transportation (who must intervene following airplane or

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railroad disasters), and the Department of Education (who direct the mental health response following school shootings). Our goal is to develop policies and procedures for effective coordination and collaboration following national emergencies and mass casualty situations. Finally, we have worked with Cameron Ritchie, Bob Ursano, Jim Stokes, and many others to plan a DoD sponsored conference on Early Intervention based on what the empirical literature can and cannot tell us about effective post-disaster mental health responses.

### Current Activities

#### Overview

In other words, when the September 11 attacks occurred, NCPTSD had acquired substantial collective experience with hands-on post-disaster interventions, education/training in post-disaster mental health, and assessment of the evidence-based literature on effective interventions following criminal or natural mass casualties. Of equal importance, NCPTSD had become part of the federal post-disaster mental health response network in which it had begun to establish its own niche.

Notable NCPTSD activities since the terrorist attacks include: utilizing our website <[www.ncptsd.org](http://www.ncptsd.org)>; hands-on consultation and intervention at the Pentagon with DoD personnel and families; and participation in federal, state (New York and Connecticut) and city (New York) short and long-range planning for the mental health response to this catastrophe, consultation to the New York Fire Department, and participation in a planning process for disaster research. In addition, Patricia Watson and Paula Schnurr have played the major role in coordinating NCPTSD initiatives with VA postdisaster activities, under the supervision of Al Batres, Chief, Readjustment Counseling Service, as well as VISN 3 leadership consisting of Mike Sabo, Mara Kushner and Henrietta Fishman. Finally, NCPTSD staff from all divisions have participated in a large-scale public education effort by providing over sixty interviews with the print and broadcast media in coordination with VA's Office of Public Affairs.

#### Education

Within hours after the September 11 attacks we mounted on our website Fact Sheets for the public and for professionals containing information and educational materials that were disseminated widely. Our website received between 13,000 and 31,000 page requests per day during the days and weeks following the disaster. Fact sheets for the public addressed issues such as:

- Common Reactions to Trauma

- Helping Survivors in the Wake of Disaster
- Terrorism and Children
- Disaster Rescue and Response Workers
- How Terrorist Acts Affect Veterans
- Self-Care and Self-Help Following Disasters, and other topics.

Fact sheets for professionals included the aforementioned topics as well as:

- Risk Factors for Adverse Outcomes
- Psychosocial Resources
- Phases of Traumatic Stress Reactions in a Disaster
- Mental Health Interventions
- Working with Trauma Survivors
- Pharmacologic Treatment of Acute Stress Reactions
- Treating Survivors
- PTSD Screen for Primary Care Settings
- Impact of Disasters on People with Severe Mental Illness
- Casualty and Death Notifications, etc.

In addition, we made our Disaster Mental Health Services: Guidebook for Clinicians and Administrators easily accessible as well as two videos: Children and Trauma and Hope for Recovery. Great appreciation has been expressed from many quarters for the rapidity, comprehensiveness, clinical utility, and scientific basis for these fact sheets, our disaster manual, and other materials. Credit for this accomplishment goes to Patricia Watson, Jessica Hamblen, Eve Carlson, Joe Ruzek, Bruce Young, Steve Southwick, Fran Norris, Candice Monson, and Kay Jankowski.

#### Disaster Relief at the Pentagon

Immediately following the terrorist attacks, Fred Gusman and five other Palo Alto-based NCPTSD staff (Joe Ruzek, Sherry Riney, Greg Leskin, Robyn Walser, and Kent Drescher) obtained clearance and permission from VA and DoD officials to travel to the Pentagon disaster. Once onsite, the NCPTSD team worked with DoD leadership, including Lt. Gen. John Van Alstyne and Col. William Huleatt, to coordinate the mental health disaster response at the Pentagon Family Assistance Center and the US Army Community and Family Support Center. For twenty-five days, the NCPTSD team worked closely with Col. Huleatt's SMART team to provide psychological support, consultation and education to DoD leadership and staff, Casualty Assistance Officers (CAOs), family members, and other disaster services personnel (e.g., American Red Cross, FEMA, FBI Crime Victims Services, and VA Benefits). The NCPTSD team provided twice daily debriefings to Pentagon staff, as well as

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psychoeducational presentations on early intervention and self-care strategies related to the Pentagon attack aftermath. Specifically, the NCPTSD team trained mental health staff on psychological first aid/ defusing/debriefings, identifying pathological reactions or behaviors, and encouraging self-care and healthy coping. In addition, the NCPTSD team joined DoD staff to form a collaborative, multidisciplinary team offering direct mental health services to Pentagon military and civilian employees, Pentagon families, and families of passengers killed on American Airlines flight 77. For example, the NCPTSD team accompanied family members during ceremonial visits to the Pentagon crash site. In addition, the NCPTSD team worked with Col. Huleatt to develop educational materials and survey instruments. A debriefing training manual was written to help instruct DoD mental health specialists to continue to facilitate debriefings integrating both the DoD and NCPTSD intervention strategies. Also, a program evaluation instrument, referred to as the Casualty Assistance Officers-Survey (CAO-S), was written to monitor the effectiveness of DoD's disaster response. The CAO-S measures perceived self-efficacy, utilization and satisfaction of resources and services, and global stress levels of CAOs. Results from this survey will be used to support policy planning for future disaster responses. Preliminary results indicate that CAOs were "very satisfied" with the VA's debriefings, as well as VA's benefit and compensation services. Members of the NCPTSD team continued to provide services until the conclusion of Phase I of the Pentagon disaster relief operation.

### Disaster Relief in New York

Finally, because of NCPTSD's aforementioned Interagency Agreement with SAMHSA's Center for Mental Health Services (which is the lead federal agency for the mental health response on all national disasters), we have participated in planning the overall disaster response for New York State and City. I visited Ground Zero at the World Trade Center site and met with federal, state, and city officials on September 21. Along with Patricia Watson, Joe Ruzek, and Fran Norris, I have remained involved in developing an overall master plan for the New York clinical response and for research during the weeks and months ahead.

### Activities in Connecticut

The Clinical Neurosciences Division, NCPTSD, VAMC, West Haven, CT has been working very closely with the Connecticut Department of Mental Health and Addiction Services in its response to the World Trade Center disaster and in its plans for responding to future disasters. A team of experts from the National Center for PTSD, the Yale

Department of Psychiatry, the Yale Child Study Center and the University of Connecticut Department of Psychiatry are meeting on a regular basis with officials from the State of Connecticut to provide consultation and training in disaster-related activities.

### New York Fire Department and Boston's Logan Airport

John Greene, PhD of the Behavioral Science Division, VAMC, Boston, MA has provided clinical services to firefighters and families of the NYFD in Manhattan. This activity has paved the way for research opportunities (see below). In addition, James Munroe, Rose Zimering, Suzy Gulliver, Chris Makary, and Barbara Niles have worked with families, airline employees and airport staff at Boston's Logan Airport, the point from which flights of two hijacked planes originated.

### Research

Terry Keane, Paula Schnurr, and I have also participated in NIMH discussions chaired by Farris Tuma and Dennis Charney to establish research priorities and to create new (fast track) mechanisms for funding research protocols concerning New York City, the Pentagon and other relevant sites. Terry Keane and Joe Ruzek have met with the New York Fire Department to plan research opportunities in that arena. Finally, I have been meeting with federal (New York) state and city officials to develop a coherent and efficient process for evaluating, implementing and monitoring New York-based research activities. It is clear that any research must complement and be well-integrated into ongoing community and clinical interventions.

It is also clear that NCPTSD will continue to play a major consultative/educational/research role in the post-disaster response for the next few years. I will keep you informed of these activities as they develop.

# TIME-LIMITED OUTPATIENT GROUP PTSD TREATMENT

STEPHANIE A. REPASKY, PSY.D., MADELINE UDDO, PH.D.,  
C. LAUREL FRANKLIN, PH.D., & KARIN E. THOMPSON, PH.D.

Group therapy is recommended as a potentially effective treatment for PTSD (1-3) and is associated with positive treatment outcomes across a variety of difficulties (1,3,4). Group treatment offers patients support, encouragement, and cohesion (1,4,5) and can be particularly therapeutic for combat veterans who may feel ostracized from society, misjudged, and/or blamed for their difficulties (6). The main goals of cognitive-behavioral group treatments for PTSD are to reduce the frequency and intensity of symptoms, enhance management of chronic symptoms, and improve quality of life (1). This treatment modality also offers a mechanism for providing effective, efficient treatment to a large number of veterans with modest demands on clinical staff (2).

The New Orleans VAMC PTSD Outpatient Clinic recently developed a time-limited, cognitive-behavioral group Trauma Recovery Program (TRP) to address the high demand for clinical services with limited resources. The TRP, conceptually divided into five-phases of treatment, is a two-year group treatment program for PTSD veterans. Veterans presenting to the PTSD program for treatment are assessed with a clinical interview and battery of self-report instruments. Veterans who report symptomatology consistent with PTSD, have no active substance abuse or psychosis, and are stable enough for, and interested in, group treatment are referred to the TRP. Veterans may also be followed by a PTSD staff psychiatrist for medication management. While not all veterans are appropriate, interested, or able to enter this program, over the past year, approximately 60% of all PTSD intakes have been referred to the TRP. Current participants number 118, 56% of whom are African-American, with an average age of 51. The majority served during the Vietnam era (68.3%), with an average of 11 months in combat. Each month, a cohort of approximately 15 male veterans begin the program. Each cohort is comprised of intakes from the previous month deemed appropriate for the TRP. Twelve one-month modules are conducted continuously, and every month, each cohort moves from one group to the next in sequence. That is, each month as one cohort moves out of a particular group, a new cohort moves into that group. In order to foster a time-limited, rehabilitative model, contact with the program gradually

decreases from weekly to biweekly and finally, monthly sessions (See Table 1). Although the program is designed for veterans to progress through groups sequentially, individualized treatment plans allow for veterans to repeat groups or proceed in a different order, if necessary. During the initial month, each veteran is assigned a case manager who meets with the cohort monthly to develop group cohesion and provide present-centered group treatment. Case managers are also available for crisis intervention as well as individual, marital, or family counseling, as necessary, and provide referrals to trauma focused treatment, as appropriate.

*In order to foster a time-limited, rehabilitative model, contact with the program gradually decreases from weekly to biweekly and finally, monthly sessions*

Phase I is directed at educating the veteran about PTSD and helping him to identify appropriate treatment goals. During PTSD Education, veterans receive a) education about PTSD symptoms and how these are addressed in treatment; b) instruction in sleep hygiene; and c) information on the impact of PTSD on family systems (7). Written educational materials are provided, which veterans are encouraged to share with significant others. Veterans then attend a motivation enhancement Problem Area Review Group. The aim of this group is to increase their awareness of problem areas for the focus of their treatment, thereby enhancing treatment planning and reducing the likelihood of relapse (8).

Phase II is organized around psychoeducational skills-based groups delivered over a period of four months. Anger Management Group focuses on identifying personal warning signs of increasing irritability, employing a time-out technique, and training in assertive behavior (9). Veterans also examine the origins and costs of aggressive behavior. Training in cognitive restructuring addresses the impact of common cognitive errors and provides techniques for developing more rational responses (10). Stress Management Group provides an introduction to a variety of relaxation skills and

**Table 1. Trauma Recovery Program**

Topic	# of Sessions	Session Duration
<i>Phase I: Orientation/Education (2 months)</i>		
1. PTSD Education	4	1 hour
· PTSD symptoms		
· Sleep hygiene		
· Impact of PTSD on family systems		
2. Problem Area Review	4	1.5 hours
· Identification of potential problems		
· Decision making to determine if it is a problem or not		
· Examines pro's and con's of behavior		
· Assists veteran with comparing own behavior to an "average guy"		
<i>Phase II: Coping Skills (4 months)</i>		
1. Anger Management	4	1 hour
· Identify personal warning signs of increasing irritability		
· Use of time-out to manage irritability		
· Examine benefits of changing behavior patterns		
2. Cognitive Restructuring	4	1 hour
· Identification of automatic thoughts		
· Identification of common cognitive errors		
· Development of more accurate, rational responses		
3. Stress Management	4	1 hour
· Introduction to various relaxation exercises		
· Emphasizes daily management of stress		
4. Relationship Skills/Social Support	4	1 hour
· Development of trust		
· Communication skills		
· Assertion versus aggression		
<i>Phase III: Developmental Perspective – Putting the Trauma in a Life History (3 months)</i>		
1. Pre-military Autobiography	4	1 hour
· Identification of Pre-military notions of topics such as relationships, trust, authority, emotional expression		
2. Military Autobiography	4	1 hour
· Identification of how military experiences influenced pre-military notions and continues to impact on current functioning.		
3. Three-way Mirror	4	1 hour
· Combines new insight on current behavior with coping skills previously discussed to encourage continued growth in one's recovery		
· Uses cognitive restructuring to re-examine current cognitions identified in Military Autobiography Group		
<i>Phase IV: Consolidation – Putting It All Together (3 months)</i>		
1. Relapse Prevention	2	1.5 hours
· Identification of personal triggers and warning signs of relapse		
· Development of relapse prevention plan		
2. Wellness	2	1.5 hours
· Emphasizes overall well-being		
· Exercise, medication management, nutrition		
3. Transition	2	1.5 hours
· Emphasizes long-term management of PTSD		
· Development of personal treatment contract		
<b>GRADUATION</b>		
<i>Phase V: Alumni (1 year)</i>	monthly	1 hour
· Continued support for recovery		

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REPASKY, UDDO, FRANKLIN, & THOMPSON

emphasizes the importance of acquiring new coping skills (7). Finally, Relationship Skills Group targets issues of trust and communication, with an emphasis on assertive communication skills (11).

Phase III, "Developmental Perspective," aims to help veterans identify, examine, and understand how relationships, experiences, and trauma over their life impact current functioning (12). Veterans spend the first month reviewing their pre-military histories, with a focus on identifying values, beliefs, and salient experiences prior to entering the military. Veterans then examine the impact of military trauma on their beliefs and cognitions associated with critical issues such as trust, intimacy, and authority. During the third month, the three-way mirror technique (pre-military, military, and post-military life review) assists veterans with understanding symptom development over the life span and to use new coping skills, combined with newly identified cognitions, to effect positive changes in current functioning (12).

*Although the program is designed for veterans to progress through groups sequentially, individualized treatment plans allow for veterans to repeat groups or proceed in a different order, if necessary.*

During Phase IV, Consolidation, veterans attend three months of biweekly meetings that reinforce healthy behavior and emphasize the importance of taking personal responsibility for continued recovery. Specifically, in Relapse Prevention Group, veterans identify personal triggers and signs of PTSD relapse and develop a plan to address these potential difficulties (13). The Wellness Group emphasizes positive self-care, such as exercise, nutrition, medical care, and hobbies (14). The final group of this phase, "Transition," focuses on developing a long-term plan to manage PTSD symptoms. To this end, a rehabilitation contract is developed that elicits specific behaviors the veteran agrees to practice to enhance recovery. It also identifies individuals who will provide social support and lists a relapse prevention plan (1).

Upon completion of Phase IV, veterans participate in a graduation ceremony consisting of an overview of the

program, introduction of each veteran, public pledge to recovery, and presentation of certificates. Significant others are encouraged to attend the ceremony.

Following graduation, veterans begin Phase V, which consists of monthly Alumni Groups, led by the case manager. These groups are designed to consolidate gains by providing booster sessions to review therapeutic techniques as well as to identify and address roadblocks or setbacks encountered in everyday life. Rehabilitation contracts are also reviewed and modified as needed.

Veterans complete follow-up assessment during the sixth and twelfth month to determine change from baseline in specific and overall symptoms, as well as provide ratings of usefulness and satisfaction with the program. To date, the standard self-report measures have not indicated change, however, subjective assessment did suggest improvement. One possible explanation for this discrepancy is that veterans do not perceive that their symptoms have changed, but rather that they are better able to cope with their symptoms. Therefore, it may be helpful to include measures of coping strategies and quality of life to assess treatment effectiveness. When asked to assess personal change, 66% of veterans (N = 29) indicated the program was helpful in improving overall symptomatology at six months. Veterans also listed specific areas of change and percentage of improvement in that area through a forced choice format in which percentages were listed in increments of 15 (See Table 2). Interestingly, 53% of veterans initially indicating

Table 2. Results of Subjective Assessment of Change at Six-months

Area of Improvement	N	Mean % of Change
Understanding PTSD	6	62%
Relationships	11	36%
Anger Management	21	46%
Sleep	10	44%
Depression	6	32%
Isolation	4	46%

In summary, a time-limited, comprehensive group therapy program that emphasizes rehabilitation and personal responsibility for recovery was designed to maximize diminishing clinical resources and provide effective, efficient treatment to the high number of veterans presenting for PTSD treatment. Preliminary data indicate that this format is beneficial to both veterans and clinical staff. Veterans have benefited from receiving a structured, therapeutic regimen that addresses major components of PTSD treatment. In addition, cohorts become highly cohesive as they progress

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through the program, and veterans within a cohort consistently prove to be an excellent source of social support and feedback for one another. Further, despite the group format, veterans are provided individualized treatment planning and support by their case manager. Clinicians have benefited because the number of veterans seen by each clinician has increased, while overall time expenditure has decreased, resulting in improved staff productivity and service delivery. The TRP provides a practical and attractive treatment option for the majority of veterans presenting for treatment. Treatment outcome will be assessed on an ongoing basis, and the program will be modified as needed to ensure that efficient treatment is provided without sacrificing the level of care.

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TIME-LIMITED OUPATIENT GROUP PTSD  
TREATMENT

REPASKY, UDDO, FRANKLIN, &amp; THOMPSON



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# WOMEN AND TRAUMA: A CLINICAL FORUM

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## **Training for Sexual Assault Counselors: Part II Bridging the Science-Practice Gap**

In this column we will present the outcome of a collaborative project between the National Center for PTSD (NCPTSD) and the California Coalition Against Sexual Assault (CALCASA). Part I of this project was reviewed in *NCPTSD Clinical Quarterly*, 10 (1). Whereas Part I focused on identifying the science-practice gap in the training of front-line rape crisis counselors, Part II will focus on bridging this gap by describing the development and evaluation of a new training manual for rape crisis counselors.

Our goal in developing a manual for rape crisis counselors was to integrate empirical information on the prevention and reduction of post-traumatic stress reactions into existing curriculums for training sexual assault counselors. More specifically, we set out to create a step-by-step guide for how to assess and address common trauma reactions in survivors of sexual assault. After reviewing a representative sample of training manuals (see Part I), we crafted an initial manual that included several modules, each one addressing different topic areas: (1) information on trauma and trauma reactions; (2) negative and positive coping; (3) challenging negative beliefs; (4) disclosure and; (5) referral guidelines. This manual was reviewed by three "content experts" for accuracy and for appropriateness of use with a sexual assault population.<sup>1</sup>

In order to obtain input and feedback from a diverse group of rape crisis counselors, three rape crisis centers in California were asked to participate in a three-hour workshop. The initial center, the Harvest of Wellness (HOW) foundation, serves rural and suburban communities in Southern California. Both new and seasoned sexual assault counselors reviewed the manual and provided important feedback on its length, tone, appropriateness, usability and readability. Large sections of the manual were eliminated, research information was placed in appendices, the number of modules was reduced, and the survivor handouts were made less clinical. The second center, the YWCA Rape Crisis Center of Santa Clara Valley, serves an urban and ethnically diverse community. Feedback from this center included helpful distinctions between what can be covered in one follow-up contact versus several follow-up contacts, examples of beliefs that may be unique to different cultural groups, additional input on the readability of the survivor handouts, and obstacles to making follow-up appointments. The last center, A Woman's Place of Merced, serves a large rural and Mexican population. Many of the sexual assault counselors attending this training provide counseling services concurrent with other activities (e.g. court accompaniment, hospital contacts). Consequently, feedback from this center included the importance of an easy to use checklist, shorter handouts, as well as the availability of handouts in Spanish.

After twenty-three drafts and iterations, a final product was circulated for evaluation. The final product includes three modules each with specific steps, "back-up" information, and survivor handouts (including handouts in Spanish). The first module, Psycho-education and Coping, is designed for first-time follow-up contacts. It includes an assessment tool to assess common reactions to trauma as well as information on the recovery process and what aids (positive coping) and hinders (negative coping) recovery. It also includes concrete suggestions for how to set up another appointment, and specific guidelines for when a referral is needed. The second module, Challenging Beliefs, is better suited for multiple contacts and will often require additional training. In addition to challenging rape myths, this module focuses on challenging other frequently held negative beliefs such as the ability to cope and beliefs about the future. The third module, Disclosure, focuses on what is known about the importance of disclosure and the consequences of concealment. It provides specific suggestions for how to disclose as well as information on when to disclose and to whom.

Preliminary analysis of the evaluation data indicates that the number of initial follow-up contacts did not increase significantly. However, there was an increase in the number follow-up appointments once an initial contact was made. Furthermore, counselors reported that they had become more effective in educating survivors about the recovery process, making a referral, challenging negative beliefs, and stressing the importance of disclosure. New counselors found the step by step guide more helpful than seasoned clinicians, and most reported that the handouts were helpful for those clients who could read above an eighth grade level.

The manual and its evaluation were recently presented at the California Coalition Against Sexual Assault Leadership Conference. Although there are still some changes to be made, the manual was seen as being consistent with the philosophy and needs of most rape crisis counselors. Indeed, this project has been a good exercise in how the scientist-practitioner gap can be lessened by including and incorporating the practitioner's perspective in the development of empirically sound training materials.

We thank Patty Resick, Heidi Resnick, and Elizabeth Meadows for their review of the manual.

A copy of the manual can be obtained from: California Coalition Against Sexual Assault (CALCASA), 1215 K street, Suite 1100, Sacramento, CA 95814 email: >dan@calcasa.org< Phone: (916) 446-2520

# FAMILY MEMBERS OF THE PTSD VETERAN: TREATMENT NEEDS AND BARRIERS

JUDITH A. LYONS, PH.D. & LESLIE P. ROOT, PH.D.

There is a growing recognition of the importance of family involvement in the care of PTSD. This emphasis originates from veterans/families who are requesting services and from VA staff who see family issues impacting on veterans' functioning. This article looks at the literature on relationship functioning, PTSD family treatment, and barriers to care. We also discuss the South Central (VISN 16) Mental Illness Research, Education, and Clinical Center (MIRECC) PTSD work group's ongoing research regarding veterans' families.

## Concern for the Family & Their Role in the Veteran's Care

It has long been recognized that PTSD is associated with impaired interpersonal functioning (1-3). The extent of PTSD's impact is becoming increasingly clear. In a study of married Vietnam veterans in which the veteran has PTSD, 70% report clinically significant relationship distress, in contrast to 30% of non-PTSD couples (4). The severity of PTSD symptoms correlates with partners perceptions of caregiver burden (5) and marital distress (6, 7). The picture is further complicated by the fact that some partners have their own pre-existing psychopathology, including their own trauma history (8).

The family's role in treatment is also a concern from a VA resource management perspective. An Australian study found that domestic conflict was the most frequent precipitant of calls to a Vietnam veterans crisis counseling line, and that such calls were among the most complex calls received (9). Meanwhile, a British team found that high levels of relatives' "expressed emotion" toward the patient (i.e., intrusiveness, criticism, and hostility) predicted poorer PTSD treatment outcome (10). Thus, we are starting to see empirical evidence of what many clinicians have long speculated, i.e., that family conflict can impede the trauma survivor's recovery.

It is important to not underestimate how reliant both the veteran and the VA system often are on the role family members, particularly spouses, play in the veteran's care. Engaging families in the veteran's treatment has been identified as one of seven VA "priorities of quality" for clinical services (11). Looking to the future as an aging veteran population suffers declining physical health, veterans (and VA) may become increasingly reliant on spouses and other family members for the veteran's daily care. Thus, it is

important to preserve these supportive relationships to the extent possible. There is still time to take action. Although 38% of all veterans seeking VA specialized outpatient PTSD care are presently either separated or divorced, 49% are still married and with their spouse (12).

## South Central MIRECC & Families of Veterans with PTSD

Both out of humanitarian concern for quality of life of the veteran and the family and out of pragmatic concern for provision of efficient and effective care to the veteran, South Central MIRECC has taken a major interest in PTSD family issues. In its first two years of operation, MIRECC

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funded three educational grants for new PTSD family services, representing 43% of all PTSD-related studies funded by this MIRECC. A PTSD work group is designing a phone survey to explore what families need and want from VA and to identify barriers that could interfere with receiving such services.

## "We Offered Services... but Families Don't Attend"

Many providers have assumed that family-oriented services, if offered, would be well-received and well-attended. The literature, however, suggests otherwise. Glynn and colleagues (13) found that 32-35% of veterans/families declined family therapy, whereas no one declined other PTSD treatment modalities studied. Work schedules, transportation

difficulties, and lack of childcare were cited as major barriers. Higher degrees of avoidance/numbing reported by the veteran were statistically associated with declining the offer of family therapy.

Low attendance was also reported by Cahoon (6). Sixty couples were divided into treatment and control groups. Those invited to participate in conjoint therapy expressed willingness to do so. However, only nine couples completed the intervention (14). These rates are similar to those reported in the literature on caregivers of individuals with schizophrenia (15).

### **Identifying Barriers to Family Involvement**

Given the stated interest on the part of patients, families, and clinicians, what accounts for such low participation? This is one of the questions the MIRECC PTSD work group is seeking to answer. Pilot data are being collected in Biloxi and Jackson, Mississippi during clinical programs provided for veterans' families. In Biloxi, the sessions are topic-focused educational presentations followed by group discussion, and clinical impressions are recorded. In Jackson, data are collected through surveys and focus groups within the context of all-day interactive/informational workshops. The sessions have attracted children, parents, siblings, husbands, wives, and friends of veterans of various eras with varied trauma histories. Through these efforts, we have examined several possible explanations for low attendance rates.

**Lack of need?** It would seem that lack of need can be ruled out as an explanation for low rates of family engagement. At both sites, family members reported being very troubled by the veteran's symptoms. Approximately half of survey respondents described themselves as walking on eggshells and living in constant stress due to the veteran's PTSD. Consistent with the literature (4), the veteran's emotional and behavioral withdrawal was reported to be particularly problematic. Respondents reported feeling lonely and pushed away by the veteran and complained of having no social life.

**Distance and scheduling.** Accessibility factors have been cited as treatment barriers by caregivers of other mentally ill populations (16-17). Survey respondents echoed that refrain in our samples.

Travel difficulties/distance was the barrier most frequently cited by Jackson participants. Some families traveled over 400 miles round trip to attend. Nearly half of participants traveled in excess of 200 miles. Travel distance was also a barrier noted by some participants in Biloxi.

Schedule conflicts with other role obligations (job, school, etc.) was the second most frequently cited barrier within the Jackson sample and the most frequently noted barrier within the Biloxi sample. The difference across

sites may, in part, be due to the fact that the Jackson sessions were held on Saturdays, whereas the Biloxi sessions were held during weekday work hours.

While based on limited sampling, these results suggest the need to be creative in minimizing logistical barriers. Clinics may need to offer evening or weekend options. Particularly in rural areas, family services may need to be bundled into a lengthier program or scheduled to coincide with the veteran's appointments to reduce the cost/benefit ratio of traveling 200 miles or more. One MIRECC-funded initiative currently underway is the development of a home-study skills-training workbook for spouses. Researchers will be comparing home-study outcomes versus group treatment outcomes.

**Procedures for invitation and veteran support for participation.** At both sites, some veterans expressed reservations about inviting families. Some feared embarrassment in front of their family due to their degree of impairment or worried that family would ask about traumatic experiences. Others feared that relatives would learn facts or techniques that they would later use to the veteran's disadvantage. Some were concerned that open communication with providers might jeopardize service-connected compensation.

In Biloxi, attendance remained below 3% regardless of whether announcements were mailed to all 300 veterans in the PTSD clinic or mailed selectively to patients known to have family members and judged likely to attend. In Jackson, all patients were informed of the family workshops, and patients were encouraged to nominate friends and family who they felt could benefit from knowing more about PTSD. Letters were sent directly to the family member 1-4 weeks in advance and a reminder phone call was made 1-2 days prior to the workshop. Attendance was steady at roughly 20% of nominated invitees at each Jackson session. Additionally, many family members attended who were not on the invitation list but had heard about the event from the patient. These findings suggest the importance of testing various procedures for inviting participation.

**Content of services being offered.** In a recent review, Riggs (14) conceptualized two major approaches to PTSD-related family/marital treatment: systemic and support. Systemic approaches use traditional marital/family therapy models to reduce relationship distress. Support treatments focus on bolstering family support for the trauma survivor, with the goal of reducing PTSD symptoms. Support treatments employ psychoeducational and skills training interventions to help cope with the identified patient's trauma-related symptoms. Our findings suggest that one reason spouses may decline to participate in therapies may be that neither of these treatment models fully meets spouses' need. Of 46 survey respondents in Jackson, 30 were spouses. The

remaining 16 included children, siblings, parents, friends, etc. On surveys and during focus groups, there was a noticeable difference in tone between spouses and others. Non-spouses reported a limited role in helping the veteran deal with PTSD symptoms. When asked what services would be helpful and what outcomes they would hope to achieve, non-spouses often requested interventions that would teach them about PTSD or reduce the veteran's symptoms. Some requested interventions to improve the relationship or reduce stress experienced by both parties. Such interventions are consistent with the support and/or systemic treatments described by Riggs. Thus, existing intervention models appear consistent with what non-spouses are seeking.

*The greatest demand among spouses was for therapies addressing their own needs. We received numerous requests for treatments to reduce the spouse's own stress level (not limited to PTSD-related stress factors).*

A very different picture emerges from spouses. A mismatch between what PTSD programs traditionally offer and what spouses want may present a significant barrier to engaging these partners in treatment. Nearly all spouses reported a very active role in helping the veteran manage PTSD symptoms, rating their role as large or "very large...more than the treatment team." They spoke of helping the veteran get to appointments and remember medications, orchestrating the family's lifestyle around the veteran's symptoms to minimize relapses, taking on roles that the veteran was not able to fulfill, etc. Many spouses discussed the difficulty of working outside the home as the primary breadwinner plus inside the home as the primary caretaker for children, aged parents, and/or the veteran. Just over one-third of spouses requested systemic interventions to improve the marriage or reduce stress that was shared by both veteran and spouse. There was little interest, however, in educational sessions about PTSD. Most reported having read about PTSD and having talked to many providers or organizations about the disorder. One woman expressed her frustration with being offered additional informational sessions: "What you're offering is how he

sick he is...what I need is what I can do to cope because I'm at the end of my rope."

The greatest demand among spouses was for therapies addressing their own needs. We received numerous requests for treatments to reduce the spouse's own stress level (not limited to PTSD-related stress factors). Many spouses wanted social activities to offset the isolation they feel. It is notable that, in Riggs' review of the PTSD family literature, care directed primarily at spouses' individual needs was not found. The overall mission and structure of VA services, with the emphasis on the veteran as the identified patient, may limit the degree to which VA clinicians can be responsive to such requests within VA clinics. Vet Centers may have somewhat more flexibility in this regard. Partnering with non-VA community programs may also open new options for care for spouses.

### Conclusions

One comes away from such family groups with an appreciation of the chronic stress experienced by significant others, particularly spouses. Accompanying this is the humbling recognition of how little we, as VA clinicians, have been able to do to offset this distress.

Traditionally, many of the interventions VA has offered have been informational sessions about PTSD diagnosis and treatment (classified in Riggs' review as supportive interventions). Although outcome data are lacking (14), such interventions may have been helpful to spouses earlier in their relationship with the veteran and may be exactly what friends, parents, and siblings are still looking for. However, they appear unlikely to meet the overwhelming needs currently identified by spouses.

Spouses may be far more interested in activities that include emotional support, social interaction, and skills training to reduce their own distress. Such emphasis on partner (rather than veteran) outcome reflects a departure from tradition. The effect of such spouse-focused treatment on PTSD symptoms, relationship quality, and caregiver burden remains to be tested. The group versus home-study project (discussed above) will focus on enhancing spouses' general coping skills and will measure outcome on symptoms, relationship quality, and perceived burden.

As discussed earlier, the second broad category of traditional PTSD-related family services is comprised of systemic, relationship-focused services. The effectiveness of family-wide interventions had not been empirically tested among families with PTSD, but Riggs did find case studies and unpublished dissertations supporting the effectiveness of marital therapy. The treatment effects reported were generally small, but changes on measures of global marital satisfaction, and problem-solving communication were

statistically significant. When surveyed, both spouses and non-spouses in our sample expressed moderate interest in such systemic treatments. Further study of these interventions is encouraged.

Many questions remain to be answered. Our preliminary data come from clinical groups. Families of veterans not engaged in treatment had no opportunity to be invited. Families who were unable to or chose not to attend had no opportunity to have their views included. To assess the needs of a broader population, we are using the present findings to guide construction of a more detailed telephone survey that will include both an urban (New Orleans, LA) and a more rural (Jackson, MS) sample.

Based on what we have learned to date, we offer the following recommendations to clinicians who are working with traumatized patients:

- Acknowledge PTSD as a family problem.
- Encourage family participation in care and care-planning.
- Be aware that emotional and behavioral withdrawal may have a greater impact on the family than more publicized symptoms such as flashbacks and anger outbursts.
- Have informational handouts available in the waiting area.
- Offer family services evenings/weekends or in conjunction with the veteran's appointments.
- Offer services addressing caregiver burden and caregiver coping.

We recognize that it is difficult to extend services beyond the veteran to address family members' needs when clinical resources are already stretched thin. However, in view of Tarrier et al.'s (10) finding that negative family relationships may interfere with PTSD treatment outcome if not addressed, we encourage clinicians and program administrators to view family intervention as time invested toward the veteran's recovery.

As our investigations yield more answers, findings will be disseminated to the field with the assistance of the MIRECC Education Core. The Education Core has designated a two-year theme, "Involving Families in Treatment", which will span diagnostic groups. This theme was carried through as the topic for MIRECC/VISN-16's annual VA PTSD conference, held July 31, 2001 in New Orleans.

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### Acknowledgments

The Jackson workshops were funded by a South Central MIRECC grant to former Jackson PTSD team leader Mertis Scott, F.N.P. Psychologist Jeffrey Kibler, Ph.D. will be assisting Dr. Lyons with her MIRECC-funded comparison of the home-study versus group skills training for spouses. Psychologist Fred Sautter, Ph.D. coordinates the South Central MIRECC PTSD work group and is leading development of the phone survey that will further assess family treatment needs and barriers to care.

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