

Evaluation of a Group Intervention for Veterans Who Experienced Military-Related Trauma

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ABSTRACT

Military-related trauma and veteran status have been linked with posttraumatic stress symptoms, depressive symptoms, and other personal and interpersonal difficulties. While many treatment evaluations for people with posttraumatic stress exist, few veteran populations or group formats have been evaluated. This report presents an evaluation of the Veterans Transition Program (VTP)—a group-based treatment for veterans who experienced a military-related trauma that is negatively impacting their lives. Fifty-six veterans attended the VTP; all attended every session and completed pre- and post-tests assessing posttraumatic stress and depressive symptoms. Significant pre- to post-test improvement was

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found on all scales. These findings demonstrate the potential benefit of the VTP and encourage further research.

Mmilitary-related trauma has been associated with psychiatric disorders such as posttraumatic stress disorder (PTSD) and depression (Rundell & Ursano, 1996). Additionally, major depression is often comorbid with PTSD (Foa, Keane, & Friedman, 2000) and posttraumatic stress symptoms (PTSS) that fall below the *DSM-IV* diagnostic threshold (Yarvis & Schiess, 2008). While PTSS are often the focus of clinicians and researchers who work with military members, major depression occurs approximately three times as frequently as PTSD among Canadian Forces (CF) members (Sareen, Belik, Stein, & Asmundson, 2010). Further, researchers have argued that there is a causal link between traumatic experiences and depressive symptoms in CF members (Nelson et al., 2011). Taken together, these findings demonstrate that trauma impacts military members' posttraumatic stress and depressive symptoms.

One cause of veterans' emotional distress is the sudden loss of the military community, which gave support and meaning to military members' lives, and is without substitute (Sweet, Stoler, Kelter, & Thurrell, 1989). This loss of support and cohesion can exacerbate the difficulties associated with post-deployment and post-service life (Koshes, 1996). One platform well suited to address interpersonal difficulties and feelings of isolation, while normalizing the experience of trauma and providing member support, is group therapy (Yalom, 1995). Group treatments have growing support in military contexts (Shea, McDevitt-Murphy, Ready, & Schnurr, 2009), which may be due to group approaches addressing socially avoidant tendencies in a safe and structured environment (Greene et al., 2004) and connecting with other veterans mediating trauma recovery (Ray, 2009).

Despite group interventions frequently being used to treat veterans (Rosen et al., 2004), scant research has evaluated group programs for PTSS (Sloan, Feinstein, Gallagher, Beck, & Keane, 2013). This limited literature does indicate that group treatments for PTSS are beneficial, however treatment study dropout rates are high (mean of 26.5%). Reported dropout rates are similar to

individual therapy dropout rates with similar populations and are a major barrier to treatment success. Further, little is known about how outcomes, other than PTSS, are impacted by group treatments for people with PTSS.

The present study is an evaluation of the Veterans Transition Program (VTP)—a multimodal group designed to reduce the effects of trauma exposure by targeting PTSS and addressing secondary civilian reintegration difficulties (e.g., interpersonal issues) in veterans exposed to military-related trauma. Components of the VTP include (a) peer support; (b) psychoeducation; (c) emotion regulation skills training; (d) re-enacting the target traumatic event; (e) reducing barriers to care; and (f) identifying and working on future goals. The VTP uses a retreat model (i.e., weekend-long sessions), which is designed to be more convenient for veterans than weekly sessions and to recreate the supportive and cohesive environment found in the military, therefore reducing dropout. The objectives of the current study were to evaluate the effectiveness of the VTP via (a) posttraumatic stress and (b) depressive symptom change from pre- to post-program.

METHOD

Participants

The current study included veterans who were referred to the VTP by word of mouth (e.g., healthcare providers, peers). To be included, veterans needed to have a military-related trauma that was negatively impacting their lives. Events needed to be defined by the client as traumatic and distressing, thus the event and the PTSS could have been below the *DSM-IV* diagnostic threshold for PTSD. Further, the event had to have occurred while in the military; however, it did not have to be combat related. Veterans were excluded if they had active psychotic symptoms, suicidality, or would not commit to abstain from drug and alcohol use during sessions.

Our sample consisted of 56 male veterans who had a mean age of 41.3 years ($SD = 14.0$). Twenty-six were married or in a common-law relationship, nineteen were single, ten were divorced or separated, and one was widowed. Among participants, 48 were

Caucasian, 6 were First Nations (i.e., indigenous), 1 was Latin American, and 1 was Arabic. Participants served in military conflicts as recent as Operation Enduring Freedom (Afghanistan) and as distant as the Korean War.

Measures

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item (four-point scale) self-report measure of depressive symptoms in adults. Participants respond by rating how they felt during the past two weeks, including today. The total score indicates depression severity, with higher scores reflecting greater depression. A score of 13 or greater is classified as dysfunctional.

The Trauma Symptom Inventory (TSI; Briere, 1995) is a 100-item self-report measure (four-point scale) of PTSS as well as the intra- and inter-personal difficulties associated with posttraumatic stress, which has been used to evaluate group treatment for trauma (Bradley & Follingstad, 2003). It has three validity scales and ten clinical scales. Previous research identified which clinical scales most strongly correlate with each PTSD symptom cluster: (a) Intrusive Experiences (IE) with re-experiencing, (b) Defensive Avoidance (DA) with effortful avoidance, (c) Depression (D) and Impaired Self-Reference (ISR) with numbing, and (e) Anxious Arousal (AA) with hyperarousal (McDevitt-Murphy, Weathers, & Adkins, 2005). Raw scores are converted to *T*-scores, with higher scores indicating greater symptom severity. A *T*-score of 65 or greater is classified as dysfunctional.

Procedure

A pre- to post-test design was used to evaluate the effectiveness of the VTP. An assessment packet—including the BDI-II and TSI—were administered to participants at the beginning of the first day and at the end of the last day of the VTP.

Treatment

The Veterans Transition Program (VTP) is a group-based intervention designed to reduce PTSS and promote adjustment to civilian life in military veterans. Each group had two leaders—either

two psychologists or one psychologist and one physician (all were licensed and had at least five years of group experience)—and two paraprofessionals (i.e., veterans who completed a 20-hour paraprofessional certificate program training them on basic therapeutic skills, which was established and administered at the University of British Columbia by the second author). Paraprofessionals modeled caring and support to other group members. Groups consisted of six to eight veterans each. The VTP used a weekend-long retreat format, meeting during three weekends with approximately four weeks between each meeting, resulting in approximately 80 hours of therapy. The reason for using a retreat format was to increase treatment convenience, recreate the supportive and cohesive environment found in the military, and reduce veteran dropout. Sessions occurred at a retreat center in British Columbia. These three weekends represented the three phases of treatment.

Phase 1. During the first phase (four days), forming and building a strong group was emphasized. Members learned active listening skills, such as paraphrasing, reflecting empathically, and refraining from giving advice. They were also educated on trauma, trauma symptoms, and trauma symptom management (e.g., emotion regulation skills such as diaphragmatic breathing and grounding). During this phase, writing activities were used to solicit veterans' military and nonmilitary traumatic experiences. Members then shared their writing with the group. Both in the group and individually with the group leaders, veterans identified their most distressing traumatic event (i.e., target trauma). At the end of the first and second weekends, members were taught how to identify actionable goals in three life domains: professional, relationships, and self-care. Between weekends, members pursued one of their goals and reported their progress to the group at the beginning of the following phase.

Phase 2. During the second phase (four days), each group member participated in his own therapeutic enactment (TE) (for a more complete explanation of the theoretical underpinnings of TE, see Westwood & Wilensky, 2005; Westwood, McLean, Cave, Borgen, & Slakov, 2010). TE consists of recreating the target trauma identified in phase 1. Group members are utilized in the TE by playing the various roles of those present at the traumatic

event. The group member whose scene is being enacted watches the scene from a third-person perspective (as if watching a movie), plays himself in the scene, and plays other roles. This process is done in a slow (approximately two hours per enactment) and scripted manner. Throughout the enactment, one group leader processes with the identified member, soliciting his or her beliefs and emotions. By taking various roles within the event, the member gains clarity regarding the experience and challenges long-held beliefs. The second group leader attends to other group members—processing with them as they engage in or observe the enactment. Further, group members who play roles in the TE provide feedback from the perspective of the other people at the traumatic event. The purpose of experiencing the event again and from different perspectives, hearing feedback from group members, and hearing feedback from group leaders is to modify long-held beliefs—thereby decreasing associated distress.

Phase 3. The focus of the third phase (two days) was clarifying and working toward the goals that group members identified in phases 1 and 2. First, members solidified their goals by declaring them in front of the group, and members helped one another problem solve how to achieve those goals. To help veterans accomplish their professional goals, specific job-finding skills were taught, including resume building and mock interviews. Human resource specialists were brought in from the community to teach these skills. To help veterans with their personal relationship goals, communication skills were taught and practiced. This was further enhanced by the group leaders holding a half-day workshop for significant others, educating them on PTSS and how to communicate with their partners. Finally, to help veterans with their self-care goals, representatives from healthcare organizations that support veterans were brought in to explain their services and respond to questions and concerns from group members.

Treatment Fidelity

Group leaders were trained by the treatment author (M.W.) in several steps. First, the trainee received the treatment manual and met with M.W. several times to discuss the VTP. Next, the

trainee attended the VTP as a trainee observer. Then, the trainee attended the VTP as a non-lead clinician, gradually taking more leadership roles in the program while being supervised by the lead clinician. Once becoming a lead clinician, sessions were videotaped and supervised by M.W.

DATA ANALYSES

In the present study, BDI-II total score and the four TSI scales that most strongly correlate with the four PTSD symptom clusters (McDevitt-Murphy et al., 2005) were included in the analyses. The one exception was that the D scale of the TSI—which correlates with numbing—was not used due to its overlap with the BDI-II (Snyder, Elhai, North, & Heaney, 2009). Instead, the ISR scale was used, which similarly correlates with numbing. Thus, the TSI scales evaluated were the AA, IA, DA, and ISR scales.

Paired-sample *t*-tests were conducted to analyze pre- and post-test differences on the total scores for the BDI-II and the four TSI subscales. Skewness and kurtosis values were examined, following the recommendations of Tabachnick and Fidell (2006). None of the scales departed from normality. In addition to statistical significance testing, the Cohen's *d* standardized mean difference effect size was reported. According to Cohen's (1988) criteria, an effect size of 0.2, 0.5, and 0.8 represent small, medium, and large effect sizes, respectively.

A second set of analyses were conducted to examine clinically significant change from pre- to post-test. Based on similar evaluations of group treatment for trauma (e.g., Simon & Sliwka, 2012), we utilized the method articulated by Lambert and colleagues (Lambert, Hansen, & Bauer, 2008). There are two components of evaluating clinically significant change: (a) statistical reliability and (b) scale scores changing from indicating dysfunction to indicating function. Lambert and colleagues' method results in each participant's change being organized into one of four categories: (a) recovered (i.e., reliable change and scores moving from dysfunctional to functioning); (b) improved (i.e., reliable change); (c) unchanged (i.e., no reliable change); or (d) deteriorated (i.e., reliable change toward greater dysfunction).

TABLE 1. Change from Pre- to Post-Veterans Transition Program

| | Pre | | Post | | <i>t</i> | Cohen's <i>d</i> ^a |
|-------------------------|----------|-----------|----------|-----------|----------|-------------------------------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | | |
| BDI-II (n = 53) | 23.54 | 11.91 | 11.51 | 10.14 | -8.90*** | -1.22 |
| TSI (n = 54) | | | | | | |
| Anxious Arousal | 62.31 | 9.65 | 57.61 | 9.61 | -3.71*** | -0.50 |
| Intrusive Experiences | 68.11 | 13.17 | 63.09 | 14.06 | -3.23** | -0.44 |
| Defense Avoidance | 63.89 | 10.47 | 59.65 | 10.23 | -3.46*** | -0.47 |
| Impaired Self Reference | 63.20 | 10.63 | 57.67 | 9.11 | -3.88*** | -0.53 |

Note. BDI-II = Beck Depression Inventory-II; TSI = Trauma Symptom Inventory. ^a0.20 to 0.49 = small; 0.50 to 0.79 = medium; 0.80 or greater = large. ***p* < .01. ****p* < .001.

In the present analyses, only participants whose pre-test score on a given scale was in the dysfunctional range were analyzed for clinically significant change for that scale. Thus, different scales have different *ns*. Further, the standard error of measurement (used for determining statistical reliability) was based on participants in the dysfunctional range for that particular scale. We defined dysfunction via the measure's norms: BDI-II scores above 12 and TSI *T*-scores above 64 (Beck, Steer, & Brown, 1996; Briere, 1995).

RESULTS

Of the 56 veterans who began the VTP, *all* completed the three phases of the program and the clinical measures. Any scale with 20% or more missing items was excluded from analyses, resulting in the removal of 2 TSIs and 3 BDI-IIs. If less than 20% of the items were missing, data were imputed using the expectation maximization (EM) algorithm (Tabachnick & Fidell, 2006), resulting in 12 (0.2%) imputed items. Further, TSI validity scales were examined for each participant and none were beyond the acceptable range.

Regarding statistically significant change, of the five scales analyzed, all demonstrated statistically significant improvement from pre- to post-test and all of them had effect sizes greater than 0.2. The greatest symptom reduction was observed with the BDI-II. The results are presented in Table 1.

TABLE 2. Clinical Significance Between Pre- and Post-Veterans Transition Program

| | Recovered | Improved | Unchanged | Deteriorated |
|-------------------------------------|------------------|-----------------|------------------|---------------------|
| | % (n) | % (n) | % (n) | % (n) |
| BDI (n = 39) | 56.4 (22) | 23.1 (9) | 20.5 (8) | 0 (0) |
| TSI | | | | |
| Anxious Arousal (n = 20) | 50.0 (10) | 20.0 (4) | 20.0 (4) | 10.0 (2) |
| Intrusive Experiences (n = 32) | 37.5 (12) | 25.0 (8) | 15.6 (5) | 21.9 (7) |
| Defense Avoidance (n = 29) | 51.7 (15) | 17.2 (5) | 31.0 (9) | 0 (0) |
| Impaired Self-Reference (n = 25) | 64.0 (16) | 12.0 (3) | 20.0 (5) | 4.0 (1) |

Note. BDI-II = Beck Depression Inventory-II; TSI = Trauma Symptom Inventory.

Regarding clinically significant change, most veterans either recovered or improved, with the greatest improvement occurring on depressive symptoms (79.5%) and the least on intrusive experiences (62.5%). Consistently, veterans were most likely to deteriorate on intrusive experiences (21.9%). The results are presented in Table 2.

DISCUSSION

The findings presented in this article support the effectiveness of the Veterans Transition Program (VTP)—a group-based treatment for veterans who experienced a military-related trauma that is negatively impacting their lives—for reducing posttraumatic stress symptoms (PTSS) and depressive symptoms. Further, of the 56 veterans who attended the VTP, *none* dropped out of treatment.

Among all of the symptoms assessed, depressive symptoms had the greatest statistically and clinically significant reduction from pre- to post-test. While evaluation of treatments for people with military-related traumas often focuses on PTSS, depressive symptoms often result from trauma (Nelson et al., 2011) and are more prevalent in the Canadian Forces than PTSS (Sareen et al., 2010). Thus, the reduction of depressive symptoms in this sample may be more clinically meaningful than the reduction of PTSS.

Among PTSS, numbing (measured by the ISR scale) had the greatest statistically and clinically significant reduction while re-experiencing (measured by the IE scale) had the least. This suggests that the VTP differentially impacts the four PTSD symptom clusters—although our sample size is not large enough to evaluate this statistically. Symptom clusters changing at different rates has been demonstrated in psychotherapy studies with people who have PTSS (Nishith, Resick, & Griffin, 2002). Notably, re-experiencing does not decrease as rapidly as the other symptoms. This has been explained as resulting from clients changing their coping from avoiding to processing the trauma. Although processing eventually results in reduced re-experiencing, initially clients recollect the trauma more frequently and more vividly. Future VTP research with follow-up assessment is important to test this hypothesis and evaluate if changes persist, remit, or increase over time.

Other than symptom change, a benefit of the VTP was that none of the veterans dropped out of treatment. This finding is important since dropout is typically high in studies of group treatments for people with PTSS (Sloan et al., 2013). To increase retention, a retreat-style group was used, increasing convenience for veterans compared to weekly meetings and recreating the military cohesion lost following military separation. While it is unknown what facilitated 100% treatment completion, the lack of dropout is cause for optimism regarding retreat-style group interventions.

Our findings support the value of the VTP; however, several limitations exist that encourage future research. First, this study was not controlled. Using a controlled design with randomization to treatment and control groups would improve the internal validity of VTP evaluation and add to our understanding of the VTP's impact. Ideally, a control group with the same format as the VTP (e.g., three weekends, same number of leaders) but that did not include the same active ingredients (e.g., therapeutic enactment, psychoeducation) would be used to test if the effects are caused by the group format or the proposed active ingredients. Also, while significant change was found in our sample, we can only speculate why this change occurred. Future research ex-

aming potentially mediating variables such as cohesion, social learning, and emotional expression would aid our understanding of the process of change in VTP participants. Regarding the measures used, while the TSI has strong psychometric support (Briere, 1995), it is not the gold standard of trauma assessment, nor does it assess PTSD diagnosis. Therefore, using a diagnostic assessment, such as the Clinician-Administered PTSD Scale (CAPS; Blake, Weathers, Nagy, & Kaloupek, 1995), would increase clarity regarding if and to what extent the VTP impacts PTSD. Further, using a measure such as the PTSD Checklist (PCL; Weathers et al., 1993) would facilitate better comparisons of VTP outcome and other treatments for PTSS. Also, the inclusion criterion for this study was that veterans had a military-related trauma that was negatively impacting their lives. While we chose not to require a diagnosis of PTSD for inclusion because we did not want to exclude veterans we thought could benefit from the VTP, future research with diagnostic cut-offs would increase sample homogeneity and aid the understanding of how much the VTP leads to clinically meaningful improvement. Finally, information about the traumas experienced, such as the specific type of trauma, reactions to the trauma, and when the trauma occurred, would be valuable for understanding the sample.

While many questions remain regarding the effectiveness and efficacy of the VTP, this non-controlled study provides preliminary support for the VTP as helpful for veterans with post-traumatic stress symptoms. Future research is needed to reach stronger conclusions about the VTP and the populations and situations in which it is most warranted.

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