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Veteran Interest in Family Involvement in PTSD Treatment

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The present study examined interest in family involvement in treatment and preferences concerning the focus of family oriented treatment for veterans ($N = 114$) participating in an outpatient Veterans Affairs outpatient posttraumatic stress disorder (PTSD) program. Most veterans viewed PTSD as a source of family stress (86%) and expressed interest in greater family involvement in their treatment (79%). These results suggest the need to consider increasing family participation in the clinical care of individuals with PTSD and to develop specialized family educational and support services for this population.

Keywords: family, veterans, PTSD, trauma, treatment

Individuals diagnosed with posttraumatic stress disorder (PTSD) typically endorse a number of intrapersonal difficulties that interfere with daily functioning. A growing body of research has also highlighted this population's interpersonal impairments. Trauma survivors who develop PTSD are more likely to exhibit reduced intimacy with partners, verbal and physical expressions of hostility, general relationship dissatisfaction, poor communication quality, low ability to resolve conflict, child rearing difficulties, and divorce (Keane & Barlow, 2002; Wilson & Kurtz, 1997). Interpersonal impairment may increase the risk for loss of social support, which has been identified as a significant predictor for the development of chronic PTSD in a series of studies on PTSD resilience and recovery (King, King, Foy, Keane, & Fairbank, 1999). In addition, PTSD symptoms in one intimate partner can adversely affect the functioning of the other partner, and PTSD severity has been associated with greater endorsement of caregiver burden, social withdrawal, and poor psychological adjustment in partners and spouses (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002; Manguno-Mire et al., 2007; Solomon, Mikulincer, & Avitzur, 1988). Secondary traumatization, in which a spouse or partner can manifest symptoms similar to those of PTSD, has also been cited as a risk for spouses and partners of individuals experiencing symptoms of traumatic stress (Franciskovic et al., 2007). The familial effects of PTSD often extend beyond the spouse; higher rates of parenting difficulty, poor family functioning, and behavioral problems in children of parents with PTSD have been reported as well (Byrne & Riggs, 2002; Zalihic, Zalihic, & Pivic, 2008).

The interpersonal difficulties associated with PTSD have important treatment implications, especially as positive social support is associated with decreased PTSD severity (Byrne & Riggs, 2002; King et al., 1999). Caregiver burden predicts less spousal engagement in the partner's PTSD treatment, and high levels of

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familial discord can have a deleterious effect on treatment and outcomes of veterans with PTSD (Sautter et al., 2006; Tarrier, Barrowclough, Haddock, & McGovern, 1999). Furthermore, having the partner of an individual with PTSD involved in treatment has been associated with significant reductions in PTSD and other psychological symptoms (Billette, Guay, & Marchand, 2008; Monson, Schnurr, Stevens, & Guthrie, 2004). Consequently, practice guidelines recommend that marital and family therapy be included in comprehensive treatment programs for PTSD (Riggs, 2000). These interventions may be conducted in conjunction with or following empirically supported treatments for PTSD.

We believe that the high prevalence rate of PTSD in veterans suggests a specific need in the veteran population for interventions focused on helping the family understand symptoms and behaviors related to PTSD and resolve interpersonal conflicts effectively. In addition, with a new generation of veterans returning from Operations Iraqi and Enduring Freedom who experience both psychological symptoms and relationship problems postdeployment (Renshaw, Rodrigues, & Jones, 2008), it may be especially timely and salient to review the spectrum of services provided to veterans with PTSD. Such services might include family psychoeducation, family therapy or support groups, couples therapy to improve relationship functioning, and partner-assisted therapy focused on PTSD symptoms (for examples of such therapeutic frameworks, see Glynn et al., 1999; Johnson, 2002; Monson et al., 2004; Sherman, 2006; Sherman, Zanotti, & Jones, 2005).

Continued programmatic development will require not only development of evidence-based treatments for couples and families, but also assessment of patients' perceptions of need for and timing of family interventions. For example, Sherman, Sautter, and colleagues (2005) surveyed partners of veterans with PTSD and found that almost two thirds of the sample endorsed the belief that treatment could assist them in coping, though only 28% were receiving treatment at the time. The interventions most commonly desired by partners were women's support groups (45%) and individual treatment for partners (19%). Further assessment of consumer preferences could inform interventions, and specific feedback from patients would provide guidance for clinicians as treatment is implemented. In this paper we sought to (a) describe family characteristics of veterans diagnosed with PTSD receiving treatment in our outpatient trauma recovery program, (b) report veterans' interest in family involvement in their treatment and their perceptions of family interest in receiving services, and (c) examine veterans' preferences concerning the focus of family services.

Method

Participants

Participants were 114 veterans enrolled in the outpatient Trauma Recovery Program at a Veterans Affairs (VA) medical center in an urban area in the Mid-Atlantic region of the United States. All participants had been previously diagnosed with PTSD through a semistructured interview and were participating in group psychotherapy. The study was designed to be an anonymous needs assessment, so only minimal demographic characteristics of the respondents were collected. However, very few veterans refused to fill out the brief survey, and thus we have no reason to believe that the demographics of this sample do not match those of our general outpatient population: 92% male, 61% African American, 29% White, 98% with at least a high school education, 63% not employed, and with an average age of 53.

Survey

The one-page, nine-question survey was designed to provide the treatment team with basic information about the extent to which veterans wished to have increased availability of family focused treatment in the overall program, in order to guide the design of future treatment options for family and couple interventions for veterans with PTSD. Family characteristics assessed included whether or not the respondent had a spouse/partner, the length of the relationship, if the respondent had children, whether the respondent him or herself believes that PTSD is a source of stress in the family or perceives that a family member feels that PTSD is a source of stress in the family, and which family member the respondent believed would attend a family or couples support group. Two items measured

interest in family involvement. Respondents were asked to rate how interested they would be in having their partner/family more involved in their treatment and how interested they thought their partner/family member would be in attending a family or couples support group on a scale of 1 (*not at all interested*) to 5 (*very interested*). Respondents were also asked to identify what information from a list of topics (communication tips, information on PTSD symptoms, PTSD and its impact on families, intimacy/relationships, coping with change/problem solving, other mental health concerns, or other information) they believed would be helpful for the partner/family and the respondent to obtain additional information on in such a setting.

Design and Procedure

All veterans attending outpatient treatment in a single week were asked to provide feedback on the survey. As the survey was designed to facilitate program development, information such as refusal rates and number of groups approached was not tracked. However, almost all veterans approached agreed to complete the survey, After incorporating the survey results into our treatment program, the findings appeared relevant to the larger scientific community, so Institutional Review Board approval to publish the data was secured.

Analyses

Descriptive statistics (means, standard deviations, and percentages) were used to summarize family characteristics, veteran interest in having their partner/family more involved in their treatment, perceived partner/family interest in attending a couples or support group, and preferences regarding the provision of family services. In order to assess characteristics of the veterans' family that may influence interest in family services, one-way analysis of variance (ANOVA) tests were used to examine mean differences in veteran interest in increased partner/family involvement in treatment and perceived family interest in attending a couples or family support group based on family characteristics (i.e., having a spouse/partner, having children, perception that PTSD is a source of family stress). Pearson's product moment correlations were calculated to examine the relationship between veteran interest in family involvement in treatment, perceived partner/family interest in attending a support group, and informational topics needed.

Results

Family Characteristics

Data from one participant was excluded from the description of family characteristics due to inconsistencies in responses to items on the survey. Almost all participants (97%) reported having family (spouse, children, sibling, and/or parent) and believed that PTSD was a source of stress within the family (86%). A majority of participants had a spouse/partner (74%). Mean length of the relationship was 21.32 years ($N = 81$; $SD = 12.94$; range 2 months to 50 years). Most respondents (85%) had children, and 30% had children living in the home.

Interest in Family Involvement and Preferences Regarding Family Services

Data from the three participants who did not report having family were excluded from all further analyses. Most participants expressed interest in greater family involvement in their treatment (79%) and believed that a family member would be interested in attending a couples or family support group (72%). Participants were interested in receiving information and/or providing their family with information on a number of topics, with PTSD and its impact on the family (85%), other mental health concerns (76%), and PTSD symptoms (74%) cited most often (see Table 1). Only 5% of respondents had no interest in any of the topics. Respondents predicted that spouses/partners (50%) would be most likely to attend a family support group, followed by children (23%), close friends (21%), siblings (13%), and parents (6%). Preferences concerning the timing of a group varied, with 36% of individuals citing evenings, 29% mornings, 18% afternoon, and 17% weekends as the best time for their family member to attend.

Table 1
Interest in Family Involvement and Informational Topics (N = 110)

Interest	*n*	%[a]	Mean[b]	*SD*
Interest in greater family involvement in treatment	107	79	3.54	1.43
Perceived family interest in attending a support group	108	72	3.33	1.43
Information topics requested				
PTSD and its impact on family	93	85		
Other mental health concerns	83	76		
PTSD symptoms	81	74		
Communication tips	73	66		
Problem solving	69	64		
Intimacy/relationships	62	56		
Other topics	2	2		
Any topic	105	95	4.21	1.83

Note. PTSD = posttraumatic stress disorder.
[a] Percentage of participants reporting *somewhat* (3) to *very interested* (5). [b] Possible scores range from 1 to 5, with a higher score indicating greater interest.

Relationships Between Family Characteristics, Interest in Family Involvement, and Informational Needs

Veteran interest in family involvement in treatment and perceived interest in family member/partner attendance at a couples or family support group did not differ based on family characteristics. Participants with a spouse or partner did not report greater interest in having their family more involved in their treatment, $F(1, 105) = .32$, $p > .05$, or perceive greater family/partner interest in attending a couples or family support group, $F(1, 106) = 1.45$, $p > .05$. Similarly, participants with children did not differ significantly in interest in greater partner/family involvement in treatment, $F(1, 104) = .217$, $p > .05$, or perceived partner/family interest in attending a couples or family support group, $F(1, 105) = 1.52$, $p > .05$. However, participants who indicated that PTSD was a source of stress in the family reported significantly greater interest in having their partner/family more involved in their treatment ($M = 3.73$; $SD = 1.33$) than participants who did not believe that PTSD was a source of family stress ($M = 2.64$; $SD = 1.55$), $F(1, 101) = 7.74$, $p = .006$. Perceived partner/family interest in attending a couples or family support group did not differ based on the participants' perception of PTSD as a source of family stress, $F(1, 102) = 1.55$, $p > .05$. Interest in greater partner/family involvement in treatment, $r(107) = 0.30$, $p < .01$, and perceived partner/family interest in attending a couples or family support group, $r(108) = 0.32$, $p = .001$, were significantly associated with number of desired informational topics.

Discussion

Over three fourths of the individuals surveyed believe that PTSD is a source of stress in the family and would like to see their family and friends more involved in their PTSD treatment. This high level of interest in family involvement in treatment existed whether or not the respondents currently had a spouse or children. These findings are notable, given the social isolation and difficulty trusting others that are often characteristic of PTSD. Research on coping supports the concept of matching desired social support to received social support as essential for psychosocial adjustment to diagnosis and treatment in cancer patients (Reynolds & Perrin, 2004). Offering treatment components mismatched to patient needs may result in an ineffective use of resources. We believe that the results of this study suggest that the paradigm for PTSD treatment needs to shift if it is to be matched to the stated needs of individuals with PTSD.

We propose that PTSD programs adapt to these concerns by increasing trauma-relevant services provided for couples and family members, and recent changes in public law may make family treatment more accessible throughout the VA system (Government Accountability Office, 2008). Individuals with PTSD may consider several groups of people to be part of their biological or chosen family (e.g., parents, spouse, children, siblings, close friends), so family relevant services should be flexible with target audience. Individuals in trauma-focused treatment should also be provided more services that will offer skills to improve their family relationships and facilitate family members' involvement in treatment. Gathering information about family participation in care should be a routine element of initial treatment planning for individuals with PTSD.

As patients' needs become known, it may be useful to implement a variety of family oriented activities, offering family member psychoeducation, adjunct couple therapy, or family support groups. Issues, such as trust and the limits of confidentiality, should be addressed in program development. Finally, additional feedback about family participation should be sought from participants and used in further treatment development efforts.

Although it seems clear that family interventions and psychoeducation are needed for individuals with PTSD and their loved ones, these aspects of treatment should be carefully developed for the specific needs of a traumatized population and then evaluated for effectiveness, as the needs of this population may be different from those of other consumer groups. Furthermore, the requirements of the potential family member must also be taken into account when designing these services. For example, over half of our sample indicated that they believed such services should be provided on evenings or weekends. This may be especially important if the family member is the primary provider for the veteran and their family. In addition, with the younger group of veterans returning from Iraq and Afghanistan, both the veteran and the family member may be more likely to be working during traditional work day hours, necessitating services after hours or on weekends (Batten & Pollack, 2008).

It is important to note that this preliminary study was constructed simply as a program development tool, and thus the items on the questionnaire were not subjected to a process of instrument validation. For example, some questions asked both what the respondent wanted and what they perceived their family members would want within the same item. Thus, it is impossible to provide a specific interpretation of results in which we can reliably say whether these services or informational topics would be more useful or relevant for the veteran or for his or her family members. However, given the very consistent direction and level of response found in this study, we believe that it is clear that there is significant interest in this area to merit both further treatment/program development, as well as more carefully controlled research into veteran needs and preferences for family informed services.

In summary, PTSD often results in social alienation, withdrawal, and conflicted interpersonal relationships, which can significantly impact family and social relationships. Loss of social support from the family, diminished social skills, and distrust further contribute to impaired occupational and interpersonal functioning. Family participation in treatment for PTSD may provide opportunities for increased support and improved functioning of the individual, not just within the family, but also in work and the community. However, in PTSD treatment, family participation has been insufficiently addressed, even though studies of other severe and chronic mental disorders suggest that family participation may have beneficial effects (McFarlane, Dixon, Lukens, & Lucksted, 2003). Given the degree of social dysfunction commonly seen in individuals diagnosed with PTSD, it is imperative that family support and participation be given greater emphasis in both research and treatment.

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Correction to Batten et al (2009)

In the original online version of the article, "Veteran Interest in Family Involvement in PTSD Treatment," by Sonja Batten, Amy Drapalski, Melissa Decker, Jason DeViva, Lorie Morris, Mark Mann and Lisa Dixon, (*Psychological Services*, 2009 Vol. 6, No. 3, 184-189), the copyright for the article was listed incorrectly. This article is in the Public Domain. The online version has been corrected.