

Veterans' Perspective on PTSD Support Groups

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Introduction

Post Traumatic Stress Disorder (PTSD) is a topic that has prompted a substantial amount of research from the U.S. Department of Veteran's Affairs (VA). As a result, the types of treatments available to effectively treat PTSD are becoming clearer.

Population

PTSD is the one of the most commonly observed psychiatric disorders in the Veteran population because it consistently causes issues of persistent social, occupational, and interpersonal functioning impairment (Ahmadizadeh, Ahmadi, Anisi, & Ahmadi, 2013; Robertson et al., 2004).

Epidemiology

Seven to eight percent of the general U.S. population is diagnosed with PTSD at one point during their lifetime, however, the prevalence rate among certain subgroups, such as active duty military personnel and Veterans, is much higher (Gates et al., 2012). For example the prevalence of combat-related PTSD in US military Veterans starting from the Vietnam War may be as high as 17% (Gates et al., 2012; Richardson, Frueh, & Acierno, 2010).

Purpose

The VA is one of the premier authorities on the treatment of PTSD due to its emphasis on research and dissemination of knowledge on the latest evidence-based practices. Therefore it is important for the VA to systematically research Veterans' subjective opinions of their PTSD Support Groups in order to identify efficient, patient-centered, cost-effective care that effectively treats chronic symptoms of PTSD (Allen & Bloom, 1994; Sharpless & Barber, 2011; Sloan, Gallagher, Feinstein, Gayle Beck, & Keane, 2013).

Literature Review

Methodology

Included in the literature review are single-studies, meta-analysis, systematic reviews, and multiple clinical practice guidelines from psychological institutions. No exclusionary criteria was set for sample size, however publications types that were included are books and journal articles accessible through Oregon Health and Science University (OHSU) subscriptions. The only two exclusionary criteria are the age restriction, and diagnosis. Participants of each study were adults, at least 18 years old and although there was no restriction of comorbidity, PTSD was required to be the primary diagnosis, met by the DSM-IV criteria.

Cost

Lifetime prevalence rates of PTSD for civilians are reported anywhere from 8 to 13%. Soldiers from Iraq, Afghanistan, and Vietnam are cited from 25 to 31%. The rates among Veterans with histories of military sexual trauma range from 29% to 60% (Gates et al., 2012; Goodson et al., 2011; Kearney, McDermott, Malte, Martinez, & Simpson, 2012; Richardson et al., 2010; Sloan et al., 2013).

Symptoms of PTSD often persist for decades, with as many as 40% exhibiting symptomology of intrusive thoughts, emotional numbness, sleep disturbances, outbursts of anger, and avoidance 10 years after onset (Kearney et al., 2012). Comorbidities of substance use disorders and affective disorders with PTSD are also extremely high, as only 17% of Veterans have a single diagnosis of PTSD (Sharpless & Barber, 2011). In addition, feelings of intense guilt and self-loathing are common with PTSD and the social isolation that develops can escalate to the point where it can resemble agoraphobia (APA, 2013).

The relationship between the symptoms of PTSD and physical and mental comorbidities, impaired work ability, and high rates of suicide attempts create social and interpersonal problems for both the Veteran and their community (Allen & Bloom, 1994; Campanini et al., 2010; Foa, Gillihan, & Bryant, 2013; Rafaeli & Markowitz, 2011; Robertson, Rushton, Bartrum, & Ray, 2004). 1999 and 2004 the Veteran compensation for PTSD increased from 1.72 to 4.28 billion dollars, exceeding the societal cost of PTSD of any other anxiety disorder (Sharpless & Barber, 2011). Along with reports of diminishing quality of life, PTSD is associated with poor health outcomes related to cardiovascular, neurological, gastrointestinal and immunological disorders (Collie, Backos, Malchiodi, & Spiegel, 2006; Foa et al., 2013; Goodson et al., 2011). One systematic review of “disability from unintentional injury” found that PTSD increased the nonfatal burden of injuries by 53% (Foa et al., 2013; Goodson et al., 2011).

Treatment Overview

The American Psychiatric Association (2004), National Center for PTSD sponsored by the U.S. Departments of Defense and Veterans Affairs (DoD/VA, 2010), and Institute of Medicine’s (IOM, 2007) clinical practice guidelines for the management of PTSD state that the first-line interventions are the utilization of specific psychotropic medications with adjunctive psychotherapy. Innovative PTSD-focused therapies are becoming available including prolonged exposure therapy (PE therapy), trauma-focused cognitive processing therapy (TF-CPT), non-trauma-focused cognitive processing therapy (non-TF-CPT), psychodynamic psychotherapy, eye movement desensitization and reprocessing (EMDR), stress inoculation training (SIT), and psychodynamic psychotherapy.

Meta-analyses and systematic reviews state individual Evidence-Based trauma-focused therapies such as trauma-focused CPT, EMDR, and PE appear to have the most empirical

evidence to support their effectiveness, making them first-line treatment interventions (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Goodson et al., 2011).

The DoD/VA clinical practice guidelines recommend clinicians *consider* using group treatment for PTSD as group treatment *can* improve health outcomes (Sloan, Bovin, & Schnurr, 2012). Data indicates several advantages to offering group treatments to patients with PTSD (Sloan et al., 2013). From an administrative perspective, groups offer increased efficiency in treating multiple patients simultaneously and are a cost-effective means of training therapists in providing trauma-focused therapy, since most groups are co-led by two therapists (Sloan et al., 2012). From a clinical perspective, groups provide an opportunity for patients to interact with others who share similar experiences, which may reduce the stigma and sense of isolation many patients with PTSD endure. The supportive group environment also allows patients to rebuild a sense of safety and trust, which is particularly important for their social functioning. Lastly group formats also provide a built-in social network to provide support and increase commitment to therapy and level of engagement, which is extremely important considering that patients with PTSD have historically high attrition rates ranging from 20 to 38% due to their symptoms of avoidance (Barrera et al., 2013; Crosby, 2015; Steiner, 2014; Yalom & Leszcz, 2005).

Gaps

Of the Veterans who are able to engage in the intensive courses of manualized trauma-focused treatment sessions, the recidivism rates of PTSD symptomology remain extremely high with a minority of patients fully resolving their PTSD symptoms (Bisson et al., 2013; Bomyea & Lang, 2012; Campanini et al., 2010; Markowitz, 2010; Schnurr et al., 2012). One large study utilizing TF-CPT, 60% patients retained their PTSD diagnosis at post-treatment, and 70% met criteria for PTSD at one-month follow-up (Steenkamp & Litz, 2013). In another large trial

utilizing PE, 59% of patients continued to meet diagnostic criteria of PTSD post-treatment (Schnurr, Hayes, Lunney, McFall, & Uddo, 2006). Given the number of Veterans with PTSD who may not be able to participate in individual exposure-based therapy due to comorbidities and emotional dysregulation, additional treatments suitable for broad implementation are needed (Kearney et al., 2012).

After first-line interventions, it is unclear which therapies should be trialed next as all show positive outcomes of some kind when compared to the waitlist control groups (Bisson et al., 2013; Bomyea & Lang, 2012; Ehlers et al., 2010; Sloan et al., 2013; Sloan et al., 2012; Watts et al., 2013). Limitations in research require providers to use their clinical judgment and not employ the exposure therapies and some VA's offered more case management services and others offered more intensive individual and group therapy services (Barrera, Mott, Hofstein, & Teng, 2013; Bomyea & Lang, 2012; Campanini et al., 2010; Dieperink et al., 2005; Steenkamp & Litz, 2013). Providers are not consistent in the therapies they provide due to patient therapy preference, patient adherence to recommended treatments, and a patient's ability to engage in therapy. Many patients have strong preferences regarding the types of PTSD treatment they are willing to engage in and are unable to complete the gold standard trauma-focused therapies (Barrera et al., 2013; Campanini et al., 2010; Foa et al., 2013; Monson et al., 2008; Sloan et al., 2012).

Evidence in more cost-effective methods of PTSD therapy is needed because no single intervention is universally effective for those who are unresponsive to available evidence-based, trauma-focused therapies (Bomyea & Lang, 2012). Currently there is no compelling evidence proving the efficacy of groups exists, which is surprising considering group therapies have been

in use since World War II due to the practical and clinical advantages of group-based formats (Barrera et al., 2013;).

One study conducted by Schnurr et al. (2001) compares the efficacy of TF-CBT versus non-TF-CBT group therapies, but no randomized control trials on the efficacy of PTSD groups have been performed. Multiple observational studies recorded the efficacy of group therapies for PTSD and established group therapy efficacy in reducing chronic symptoms of PTSD in Veterans (Allen & Bloom, 1994; Bellino, Rinaldi, Brunetti & Bogetto, 2012; Britvić, Radelić, & Urlić, 2006; Campanini et al., 2010; Creamer & Forbes, 2004; Kansas, 2005; Kim et al., 2012; Knight, 2006; Rafaeli & Markowitz, 2011; Robertson et al., 2004; Schnurr et al., 2001; Sloan et al., 2012; Sloan et al., 2013). However observational studies are not as robust as randomized control trials so group therapies are not likely to be viewed as the most effective treatment option available. The methodological constraints associated with carrying out a RCT for groups with a sample size large enough to effectively rule out confounding variables may explain the lack of literature.

Relation to the Clinical Problem

In 2006 the APA Presidential Task Force on Evidence-Based Practice defined evidence-based practice as “the integration of best characteristics, culture, and preferences” (Litz & Salters-Pedneault, 2008). This parallels the Institute of Medicine’s aims for the improvement of healthcare delivery to be safe, effective, timely, efficient, equitable, and patient-centered (IOM, 2001). Despite the VA’s increased use of evidence-based practices in an attempt to improve their quality of care very few studies have actually explored patients' opinions on their PTSD therapy (Johnson & Lubin, 1997; Mott et al., 2013; Rosen et al., 2004). This is concerning considering social acceptance is a significant factor in a Veteran’s successful integration of trauma

(Ljubotina, Pantic, Franciskovic, Mladic, & Priebe, 2007). The growing numbers of new Veterans from Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND) diagnosed with PTSD are adding to the vast number of Veterans already being treated, the VA should be ready with efficient, effective, patient-centered and evidenced based group and individual psychotherapies that incorporate supporting Veterans reengage in society and build relationships with their community (Cifu et al., 2013; Foa et al., 2013; Owens, Baker, Kasckow, Ciesla, & Mohamed, 2005).

Project

Setting

The VA is on the forefront of PTSD-research and disseminates trainings on the assessment and treatment of trauma to the largest number of mental health providers in the United States (Litz & Salters-Pedneault, 2008). They have stated their goal is to “disseminate almost real-time, program specific education that will keep staff continuously apprised of new information on best practices and research,” “link research, guideline development and implementation, clinical tools, sharing of best practices, and real-time data analysis,” and “create a continuous expansion of the evidence base and increased knowledge generated by a spirit of inquiry” (Ruzek, Friedman, & Murray, 2005). Therefore gathering more information on patient preferences and the efficacy of PTSD-centered group therapy, evaluating for improved efficacy in real-time, and disseminating best practices falls right in line with their strategic goal and promotes their authority.

While the treatment of chronic PTSD in Veteran populations has advanced significantly, there is still much to learn (Creamer & Forbes, 2004). Current evidence on the efficacy of PTSD Support Group is lacking and the few studies that included treatment satisfaction scores found

that participants reported high satisfaction with the group treatment and perceived benefit from the groups. This suggests that patients are benefiting in ways that are not measured in current clinical trials (Sloan et al., 2013) no information was found in the literature reporting the preferences of Veterans seeking treatment at VA for their PTSD. Instead the focus has been on the treatment outcomes measured by rating scales once a diagnosis has been established. Holistic treatments of PTSD that take into consideration the Veteran's individual presentations of PTSD symptomology must be further researched through nursing science. The aim of this clinical inquiry project is to gather Veterans' subjective reports of the VA's PTSD Support Group they are attending for evaluation and quality improvement. The data gathered adds to the scarcity of information regarding patient-centered treatments, initiate a discussion regarding the efficacy of Supportive Group Therapy, and ultimately lead to improved outcomes for Veterans with PTSD. In addition the Veteran feedback can also provide information regarding secondary gain from PTSD treatment interventions, which can then be further enhanced after being better understood.

Implementation

The inclusion criterion for the project consists of Veterans with a PTSD diagnosis, currently attending an established PTSD Support Group that meets bi-weekly at a Portland VA Medical Center (P-VAMC) Outpatient Mental Health Clinic. Permission was granted by the P-VAMC PTSD clinical director and approval was received by both the P-VAMC and OHSU Institutional Review Boards.

The plan was to gain support from clinicians on the PTSD Clinical Team (PCT) to participate in disseminating the voluntary, anonymous questionnaires. Facilitators of six PTSD Support Groups agreed to participate in the clinical project, with a total of 55 possible Veteran participants assigned to those six groups.

The project design was to distribute and collect questionnaires once at each of the six PTSD Support Groups. To avoid overwhelming the participating Veterans the anonymous, voluntary questionnaire consisted of nine multiple-choice questions on one double-sided sheet of paper (see Appendix A; Mateo & Foreman, 2014). The first three questions were demographic. Questions 4 – 8 were comprised of questions with pre-selected answers and the instructions “chose all that apply.” Each question included an “other” option with room for the Veterans to submit additional comments. Topics covered in the questionnaire include: reasons why Veterans attend their PTSD Support Group; barriers & facilitators of their attendance; what alternatives to PTSD Support Group would the Veterans engage in; and how does PTSD Support Group compare with other forms of PTSD treatments. The last question was an “additional comments” section to allow the Veterans to share any additional information not already solicited in the questionnaire.

The questionnaire packets contained materials needed for the Veterans to complete and the facilitators to return the questionnaires. The Veterans were given the printed questionnaires, pens, and blank manila envelopes for the Veterans to collect the questionnaires in and seal to protect from facilitators accessing the results.

The facilitators were to read the instructions and a paragraph detailing the project purpose, potential risks and benefits, confidentiality, consent, and policy on coercion (see Appendix B); and pre-addressed inter-department mail envelopes for the facilitators to use to return the group questionnaires in once completed.

The facilitators presented and distributed the questionnaires at their next scheduled meeting. The facilitators instructed to hand out one questionnaire per attendee, to determine how many Veterans were present that day and chose not to fill out the questionnaires. As the

facilitators presented the questionnaires to the Support Group they read the directions and disclosures aloud. They asked for a volunteer from each group to collect the completed and blank questionnaires, and seal them in an unmarked manila envelope. The facilitators left the room for approximately 15 minutes to allow the group to complete the questionnaires in complete anonymity. The facilitators returned to the group and collected the sealed manila envelope, which they returned to the investigator in a pre-addressed intra-department envelope.

After the six manila envelopes were received, the results of the Veterans' subjective feedback were aggregated and summarized using descriptive statistical data analysis (Explorable.com, 2010; Freeman & Julious, 2005; Princeton, n. d.).

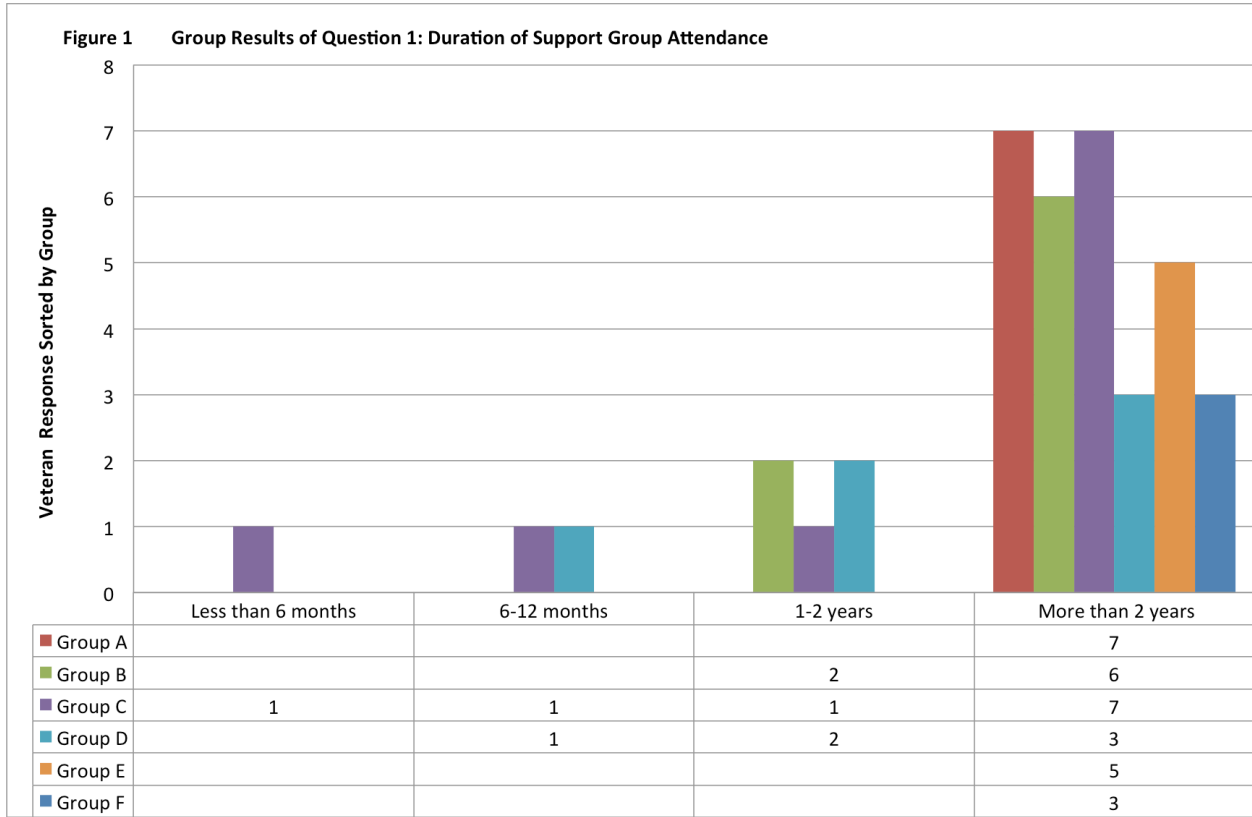
Outcomes

Of the 55 Veterans assigned to the six PTSD Support Groups, 39 Veterans were present at group the day the questionnaires were handed out. All 39 Veterans chose to participate in the project and completed the questionnaire so the data from every questionnaire was included in the final results. The willingness of every Veteran to participate in the project is significant, and could indicate that Veterans are anxious to provide feedback. Although the VA solicits feedback from Veterans in the inpatient setting, the opinions of Veterans utilizing the services of their local Outpatient Mental Health Clinic have not been captured.

The questionnaires were kept in their envelopes and labeled "Group A" through "Group F" according to the order in which they were received. Group F had the fewest participants present and Group C has the greatest. Both group and individual data will be presented. However, the primary data for the project is the aggregated group data.

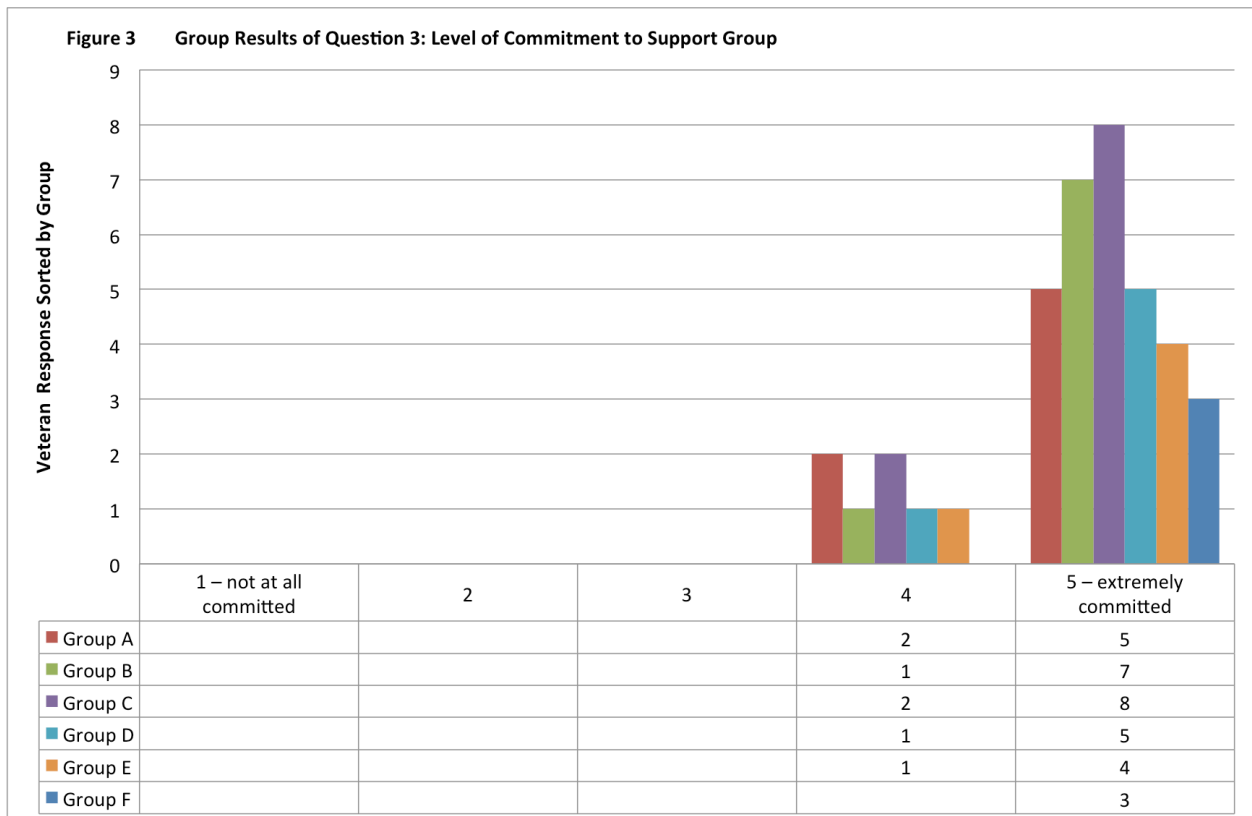
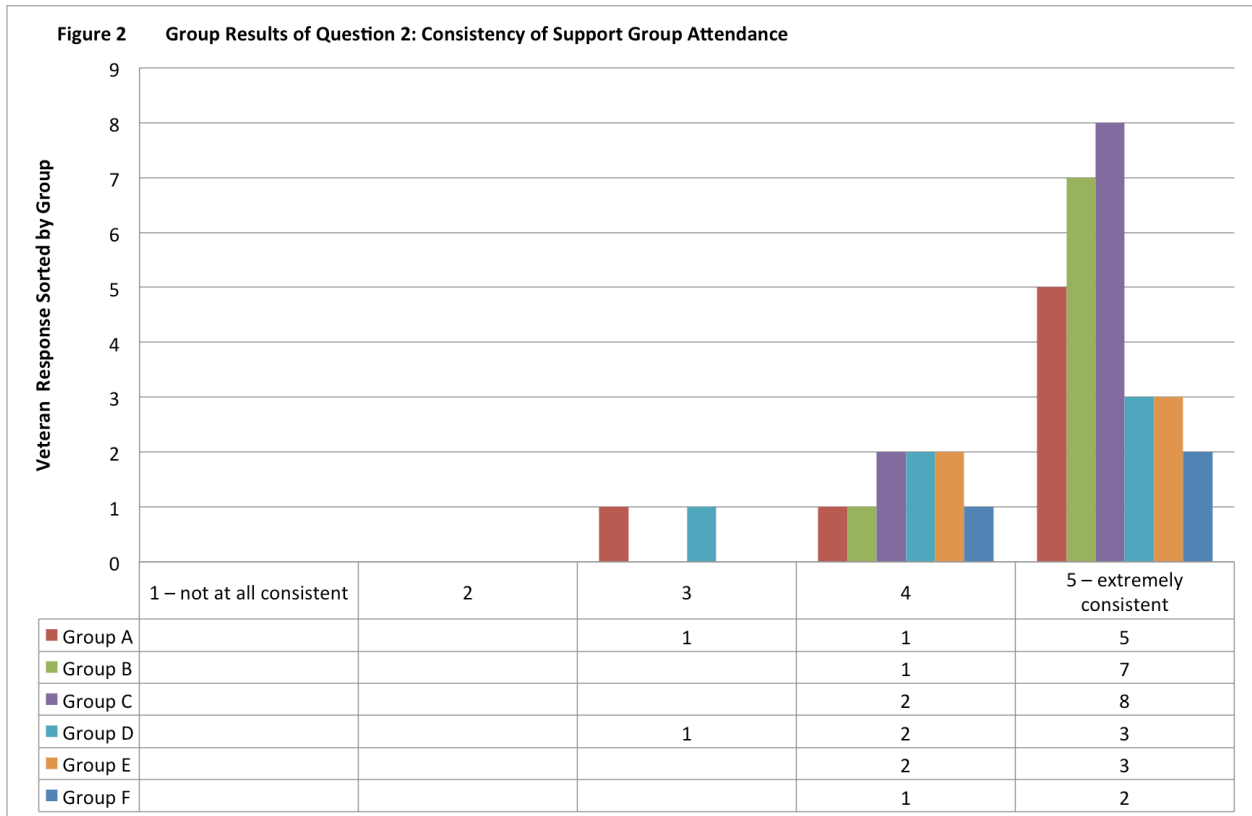
Despite the size difference among the six groups, the results of the questionnaires' first three questions were similar. Figures 1 – 3 display the numerical results in detail. Displayed in

Figure 1, one of the 39 Veterans has been attending group less than 6 months. Two stated they

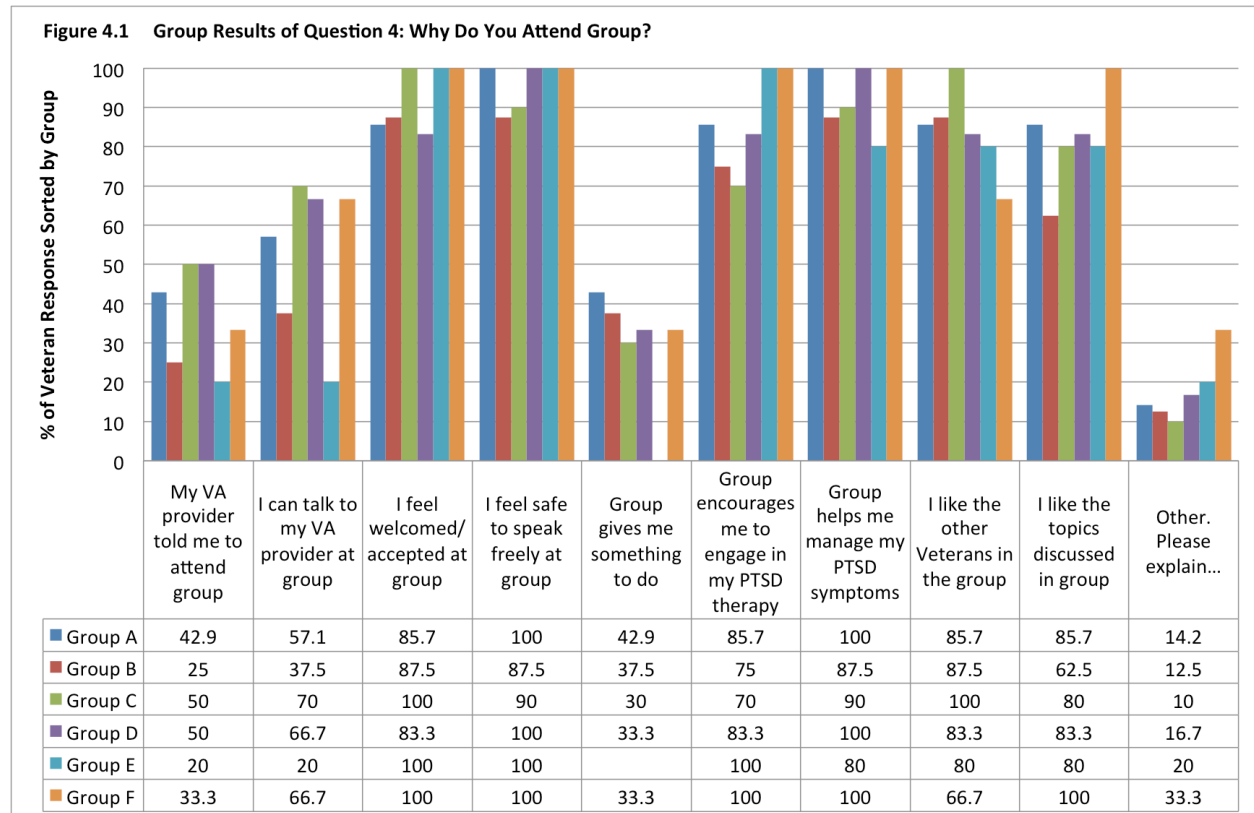


had been attending for 6-12 months. The majority, 31 of the 39 (79.5%), report they have been attending group for “more than 2 years.”

Results of Question 2 and Question 3, seen in Figures 2 – 3, reveal all Veterans reported their “Consistency” or “Commitment” attending the meetings being greater than or equal to 4 out of 5, which correlates with the length of time the majority of the Veterans have been attending their PTSD Support Groups. Two Veterans reported their level of “Consistency” a 3 out of 5, and the majority, 28 (71.8%), reported being “5 – extremely consistent.” Likewise with “Commitment” seven Veterans (23%) reported their commitment at 4 out of 5, and the remaining 32 Veterans (67%) rated themselves “5 – extremely committed.”



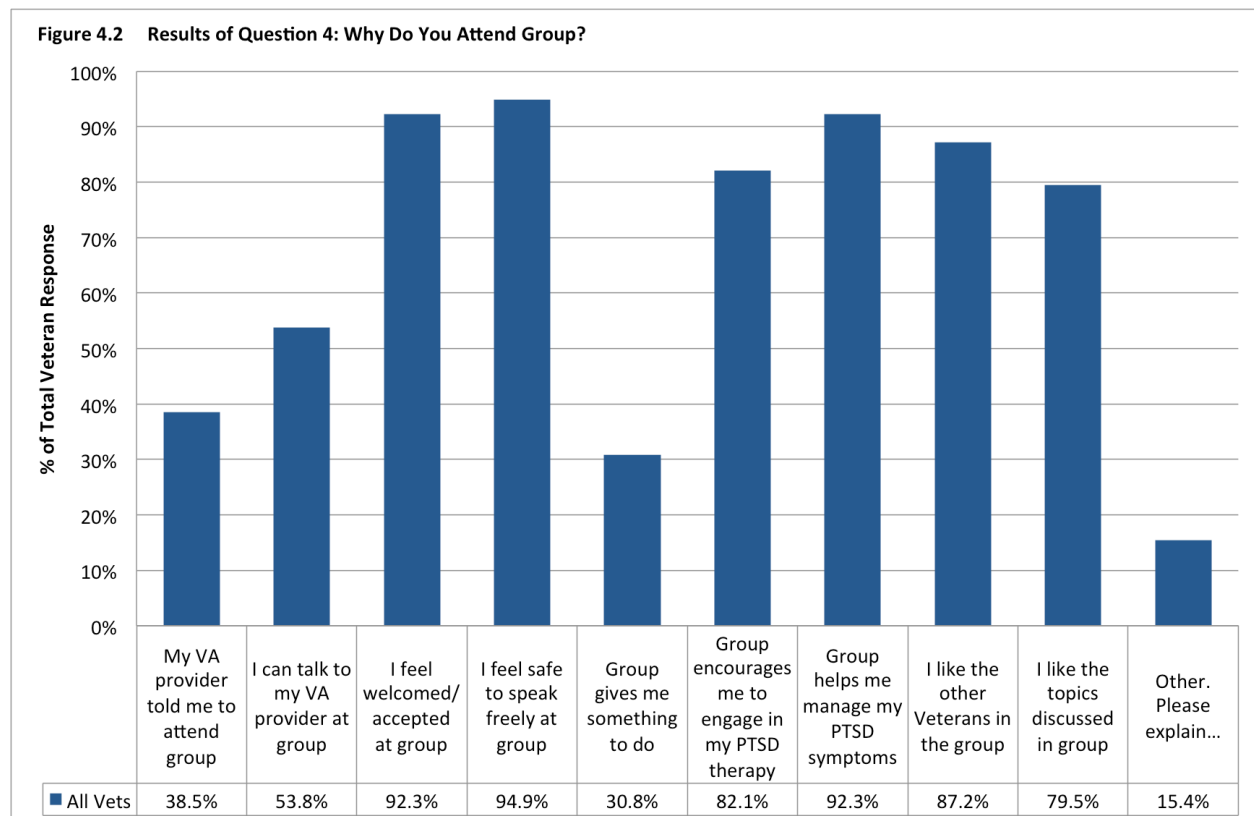
To account for the size differences in the six groups, the results of the remaining six questions will be describe with percentages. Numeric responses will be noted when warranted. To ensure complete anonymity unique comments made by Veterans in questions 4 – 7 and 9 will be displayed, arranged in alphabetical order.



Question 4 asks, “Why do you attend group?” to answer the question why Veterans choose to attend their PTSD Support Group. Slight variations within the group responses can be seen in Figure 4.1. However the aggregate data is displayed in Figure 4.2.

“I feel safe to speak freely at group” is the most selected reason why the Veterans choose to attend their PTSD Support Group. “I feel welcomed/accepted at group” was the second most selected response. Consistent with literature on effective group dynamics, creating a nonjudgmental space for participants to share their ideas is critical, especially for Veterans whose experiences may seem extreme or controversial compared to civilians (Allen & Bloom,

1994; Barrera et al., 2013; Sharpless & Barber, 2011; Sloan et al., 2013). Symptoms of negative alterations in mood and cognition experienced by Veterans with PTSD may make them feel “alone,” that “the world is a dangerous place,” and “if people knew what I was thinking, they would think I was crazy.” In response they isolate and avoid social interactions. Additionally many Veterans with PTSD struggle with hypervigilance and hyperarousal responses related to their trust issues (Britvić et al., 2006; Creamer & Forbes, 2004; Kansas, 2005; Campanini et al., 2010; Robertson et al., 2004; Schnurr et al., 2001; Sloan et al., 2012; Sloan et al., 2013). Feeling “safe” “welcomed” and “accepted” in Support Group parallels the literature on effective, therapeutic group facilitation.



The second most selected response is “Group helps me manage my PTSD symptoms.” Although this is seen as the purpose of the PTSD Support Group if an environment for growth is not provided, Veterans would not attend.

The least chosen responses for Question 4 are “Group gives me something to do,” and “My VA provider told me to attend group.” The fact that these two options were not chosen may be reassuring to the group facilitators, knowing the majority of Veterans are not attending out of boredom or coercion. One Veteran submitted a comment for Question 4 (see Table 1). One benefit of PTSD Support Group Therapy is that Veterans are able to feel acceptance through the normalizing effect of having other Veterans with similar PTSD-related symptomology surround them. This normalizing affect helps them identify with their thoughts and feelings and how these thoughts and feelings influence their actions. Comment number five, “To keep my PTSD symptoms in check and to improve my quality of life and to help others in my group,” illustrates how Veterans are able to practice modeling, encouraging, and altruism, which fosters their sense

Table 1 "Other" Comments from Question 4: Why Do You Attend Group?

1. I feel I belong.
 2. I have been thinking about committing suicide and my counselor/facilitators are assisting me.
 3. It's my lifeline.
 4. Opportunity to regularly meet with men my age the experience of having served in the military during the Vietnam Era.
 5. To keep my PTSD symptoms in check and to improve my quality of life and to help others in my group.
 6. Trust like that in Vietnam.
-

of competence and purpose (Crosby, 2015; Steiner, 2014; Yalom & Leszcz, 2005). This Veteran reports attending group to not only work on his PTSD, but to support his fellow Veterans.

Question 5 asks, “What makes it HARD for you to attend group?” to identify possible barriers of Veteran attendance to their PTSD Support Group. 39 barriers were selected, displayed in Figure 5.1.

“Difficult traveling to group” was identified by 28.3% of the Veterans being the greatest barrier to group attendance, displayed in Figure 5.2. The second greatest barrier cited by 23.1% of the Veterans is “Personal motivation/energy.” This may be because some Veterans travel as

Figure 5.1 Group Results of Question 5: What Makes It HARD To Attend Group?

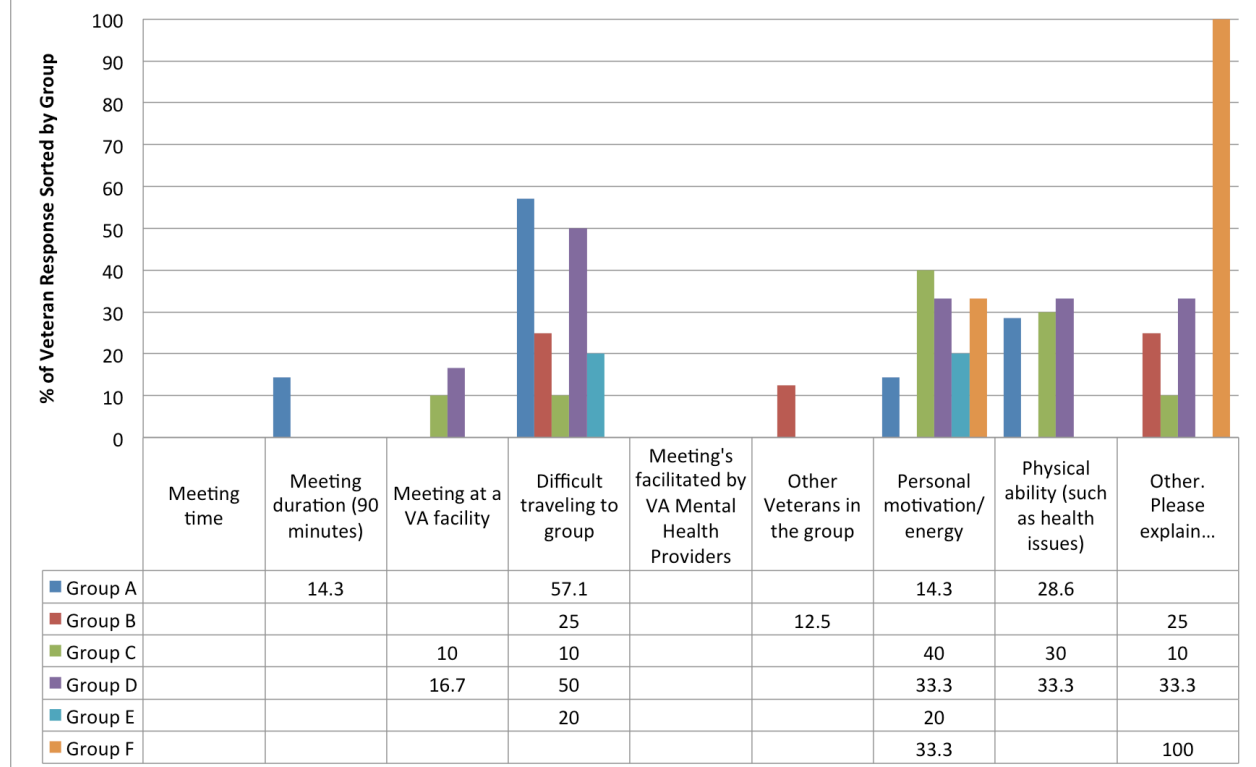
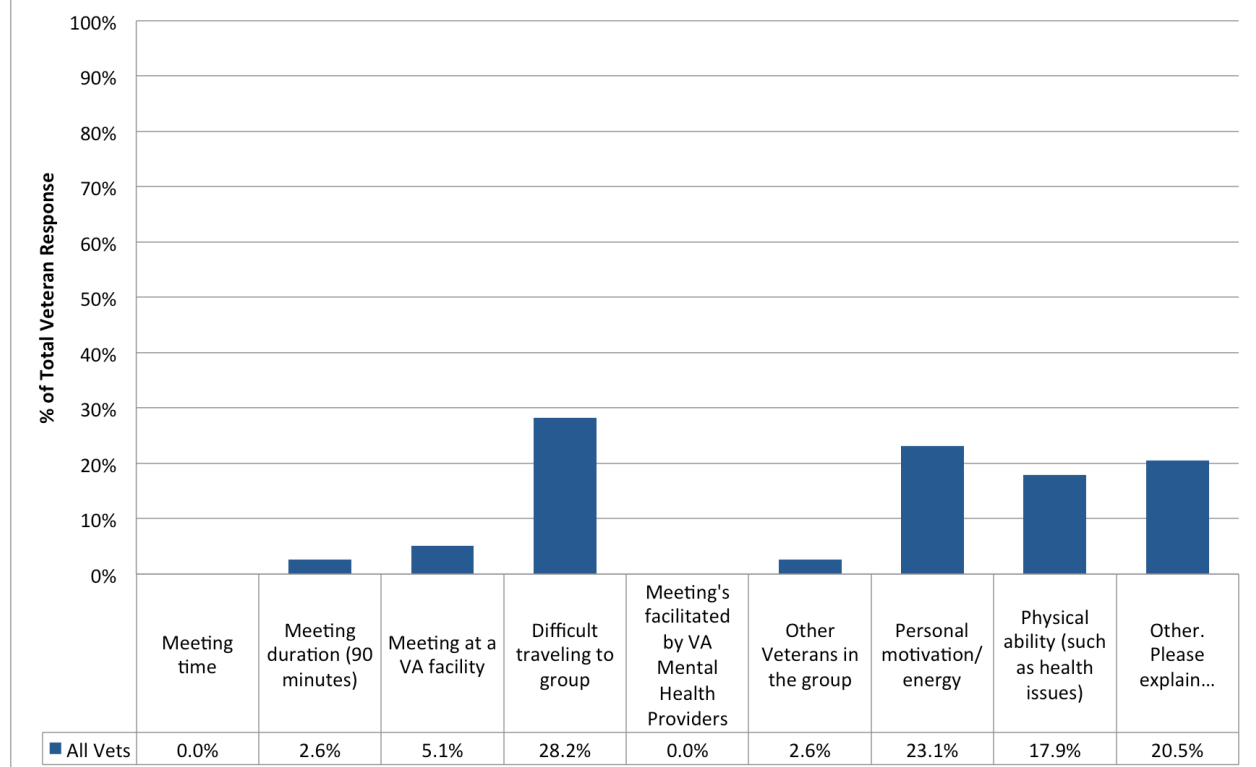


Figure 5.2 Results of Question 5: What Makes It HARD To Attend Group?



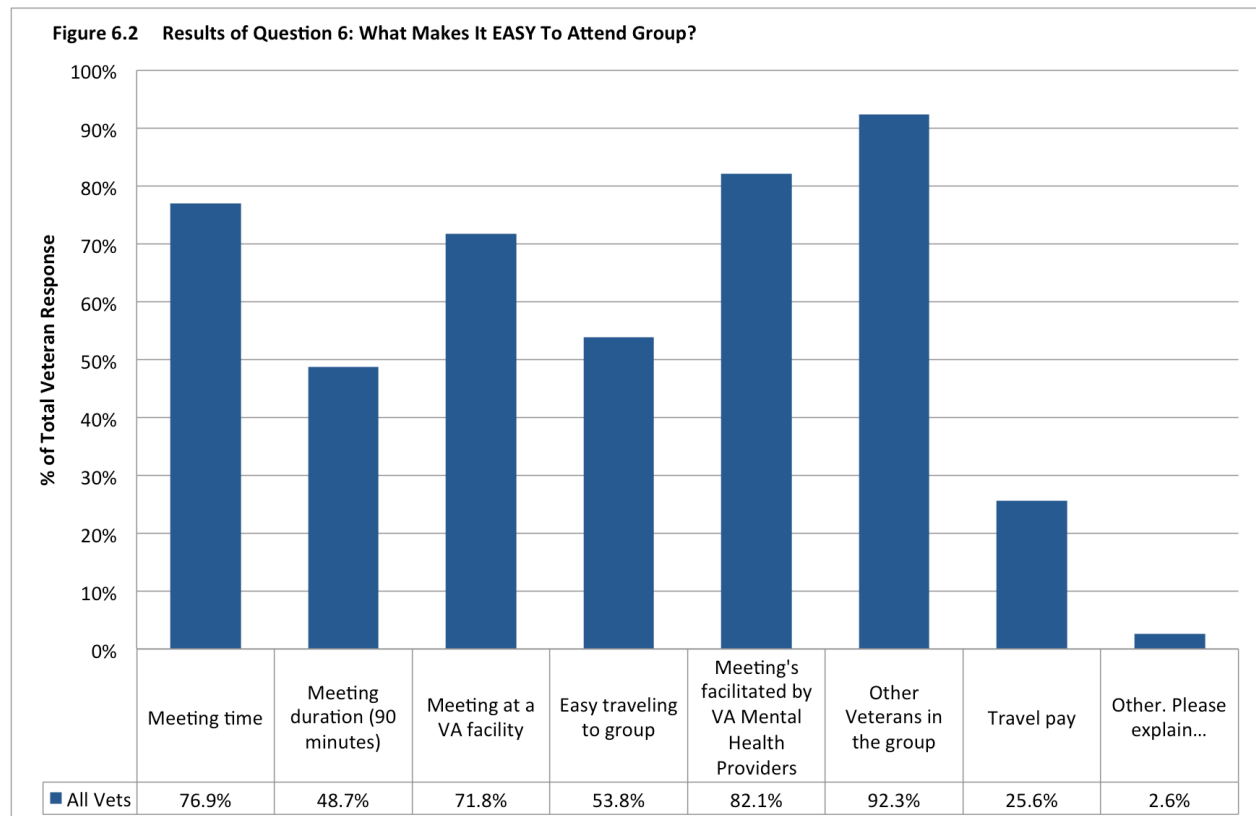
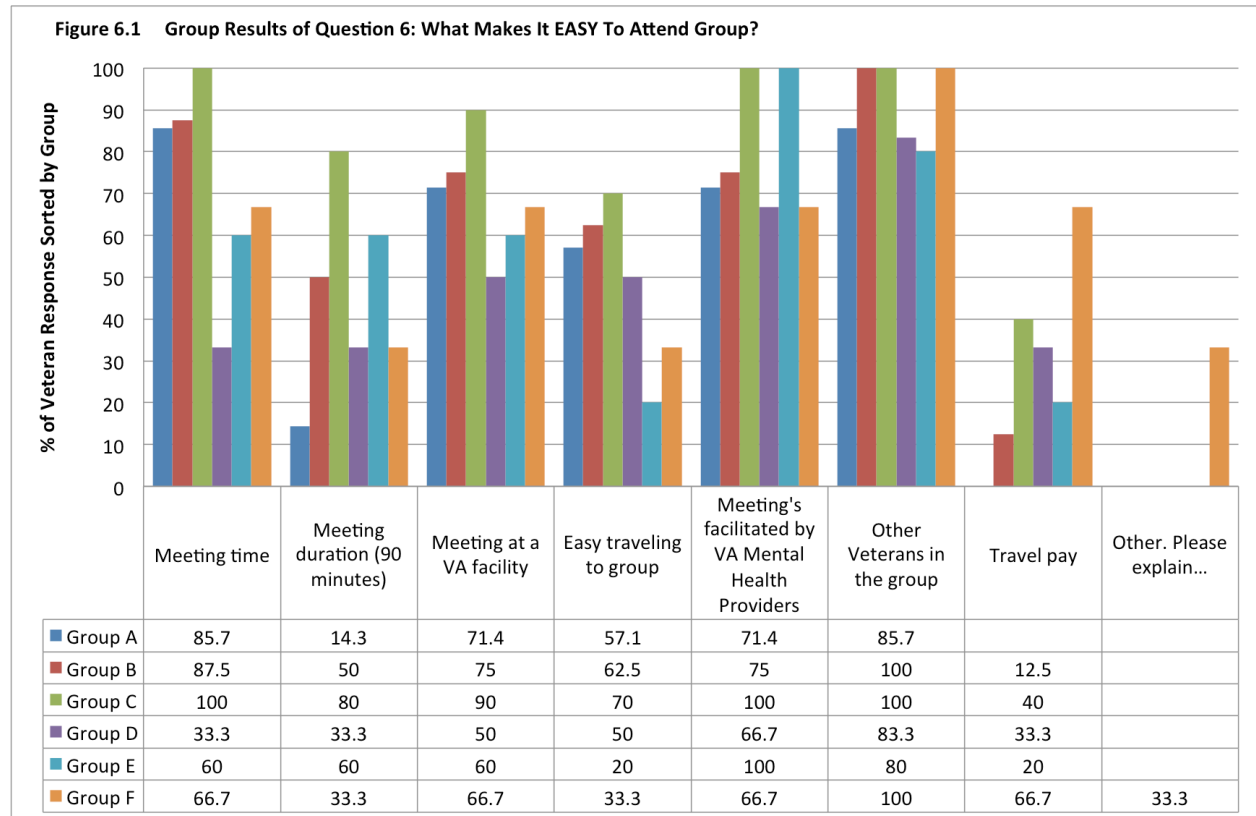
far as 200 miles to the Portland VA Outpatient Mental Health Clinic, while others live within a 5 mile-radius.

Question 6 asks, “What makes it EASY for you to attend group?” to identify possible facilitating factors of Veteran attendance to their PTSD Support Group. 177 facilitating factors were selected in Question 6, displayed in Figure 6.1.

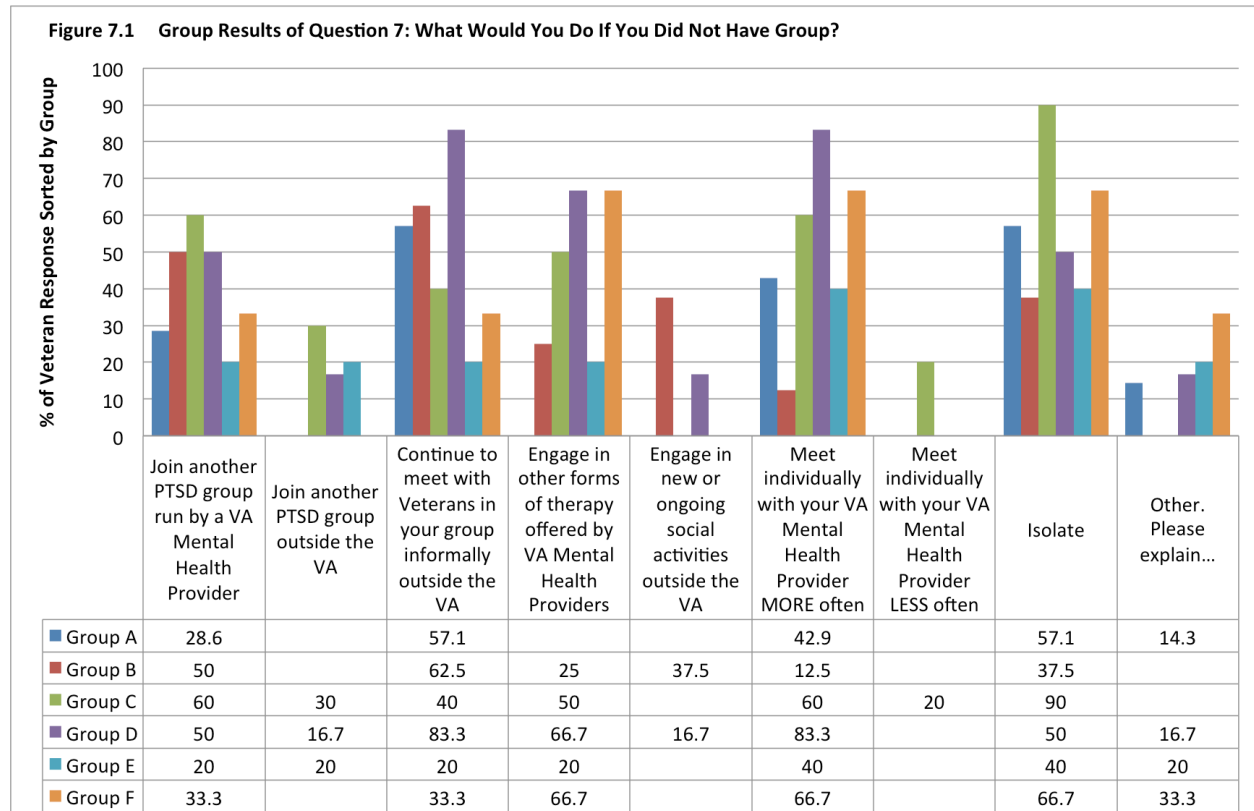
92.3% of the Veterans selecting “Other Veterans in the group” and 82.1% selected “Meeting’s facilitated by VA Mental Health Providers” as the top two facilitating factors of Veteran attendance, shown in Figure 6.2. This supports the result of Question 4, highlighting the unique advantage therapeutic groups have addressing the negative symptoms of PTSD. The Veterans are eager for opportunities to interact with others who share similar experiences, helping to reduce their sense of stigma and isolation and increase a sense of safety and trust. The results suggest that groups provide a built-in social network that supports an increased commitment to therapy and level of engagement, which is important for the Veterans’ PTSD symptom management.

71.8% of the Veterans cited “Meeting at a VA facility” and 53.8% of the Veterans report, “Easy traveling to group” as a facilitator of attendance. It is possible that the “difficulty traveling” and lacking “motivation/energy” cited in Question 5 might be related to PTSD symptomology of avoidance and isolation rather than the location of the Support Group meetings and the issues surrounding travel.

Six barriers were recorded in the “Other” section of Question 5. One facilitator of attendance to PTSD Support Group was recorded for Question 6. Table 2 lists the unique comments and will be displayed in the following section.

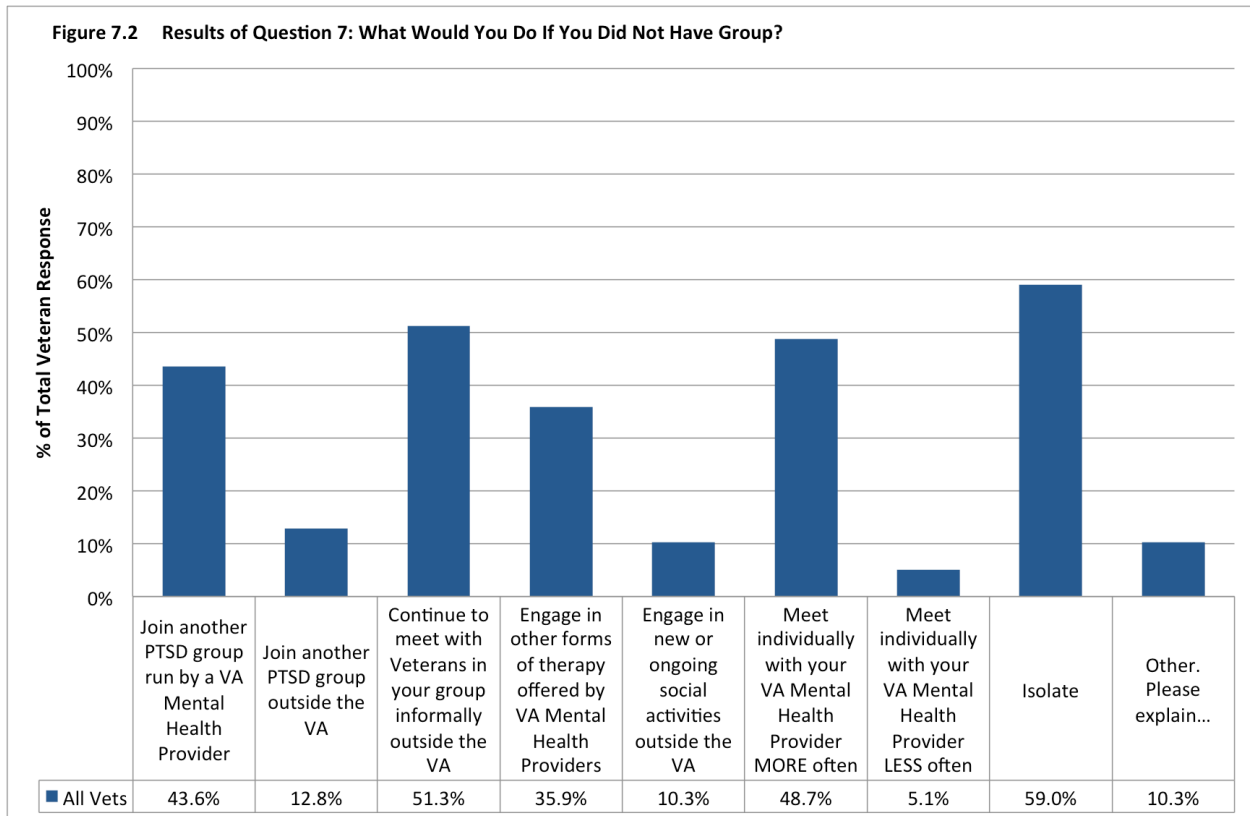


Evidenced by the results of Question 7, this built-in social network may not necessarily translate into increased PTSD symptom management skills. Question 7 is “What would you do if you did not have group?” 108 Veteran responses were selected, see Figure 7.1, along with three unique comments listed in Table 3. Figure 7.2 displays the aggregate data to provide a clearer picture.



51.3% of Veterans reported they would “Continue to meet with Veterans in your group informally outside the VA” due to the tight-knit community built in these Support Groups to continue to work on their PTSD symptom management informally with their fellow Veterans. 10%-13% of the Veterans reported they would join or engage in other non-VA related groups or social activities where they would be using the skills learned through PTSD-related therapies.

59% of the Veterans stated they would “Isolate.” These results suggest that although the Veterans enjoy a sense of comradery, safety, trust, and an increased level of commitment to their



PTSD Therapy meeting on a regular basis, they may not be applying the skills to other areas of their life. These Veterans may be using the PTSD Support Groups to fulfill their need for social interaction and not feel the need to expand their “safe zones.”

“Meet individually with your VA Mental Health Provider MORE often” was selected by 48.3%, making it the third most popular response to Question 7. More individual sessions create more burden on the Provider’s schedule, less availability for other Veterans to be seen, and increased cost to the healthcare system overall. Alternatively, groups are a cost-effective therapeutic modality providing effective PTSD treatment and therapy to multiple Veterans simultaneously with little increased burden on the Mental Health Therapists facilitating each group.

Examples of skill transference or engagement in other non-VA related activities were not evident in Question 7’s Comment section. One of the four comments left in Question 7,

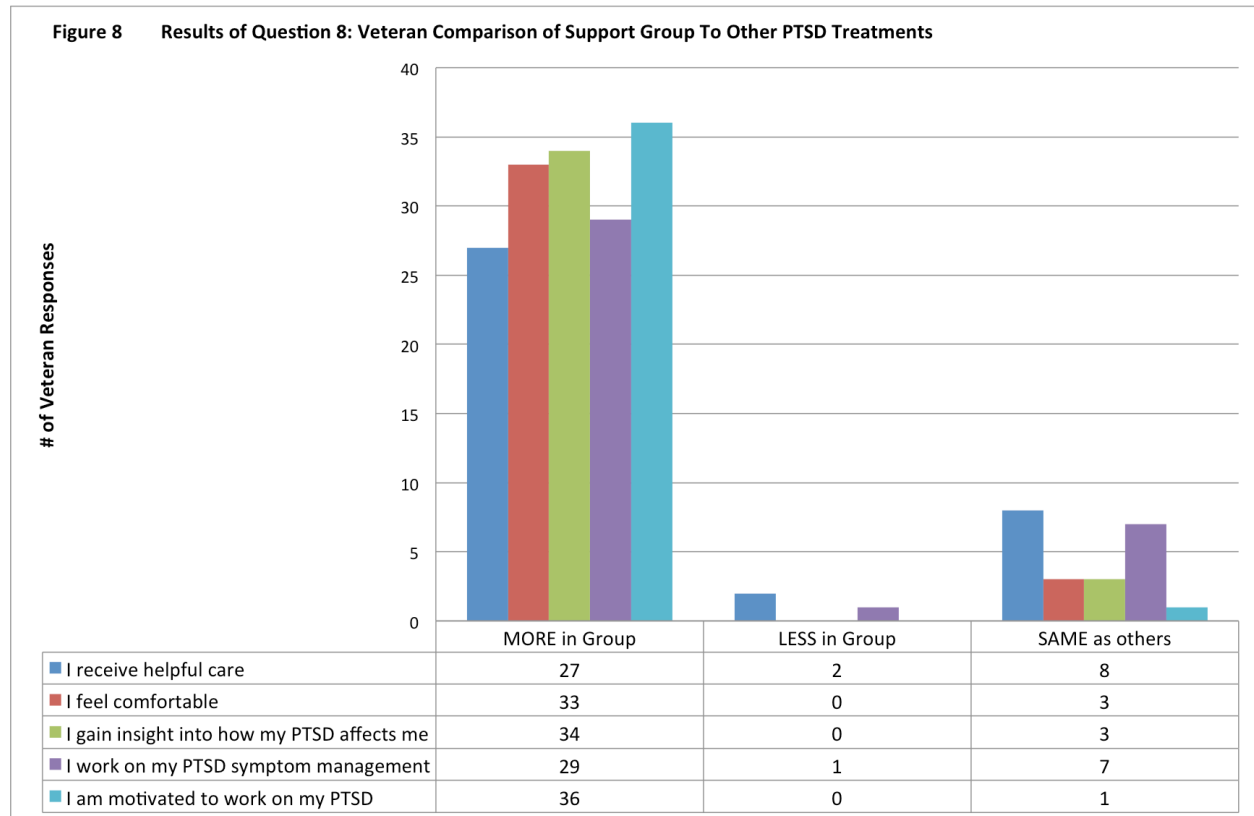
displayed in Table 3, provides a concrete action that would be taken if the Veterans' PTSD Support Group dissolved. This is the first comment, "Commit suicide." The comment is likely connected with an earlier comment left in Question 4, "I have been thinking about committing suicide and my counselor/facilitators are assisting me." While the option to "commit suicide" may be unique to this individual case, many Veterans with PTSD struggle with suicidal ideation and nihilist thinking related to negative alterations in mood and cognition caused by trauma (Ahmadizadeh et al., 2013; Campanini et al., 2010; Foa et al., 2013; Robertson et al., 2004; Sloan et al., 2013).

Table 3 "Other" Comments from Question 7: What would you do if you did not have group?

- | | |
|----|--|
| 1. | Commit suicide. |
| 2. | Don't care to have to think about this group ending, I have been in other VA group (combat type) [PTSD]. |
| 3. | I don't know, not a problem at this time. |
| 4. | I need the group to process! |
-

Support Groups normalize of depressed thoughts, exercise behavioral activation, increase a sense of belonging and accountability between the group members, and ultimately enhance members' sense of competence and purpose (Crosby, 2015; Yalom & Leszcz, 2005). Therefore, although the comment is alarming, it should not be dismissed. The four comments illustrate how highly the Veterans value their Support Group.

The results of Question 8 help explain why the Veterans reported high levels of "Commitment" to their PTSD Support Group and "Consistency" in their attendance throughout the years. In order to be eligible for a Support Group the Veterans enrolled completed at least one other form of PTSD-focused therapy. Figure 8 displays the Veterans' subjective comparisons of their current PTSD Support Group with rounds of other PTSD treatments. The results indicate the majority of Veterans surveyed feel more "comfortable," "motivated to work on their PTSD symptom management," and receive more "helpful care" in their PTSD Support



Group than in other PTSD-focused therapies they have participated in the past. The Veterans’ subjective comparisons should be interpreted with caution due to possible hindsight biases as well as the fact that the results are limited to the Veterans who report being either a “4” or a “5 – extremely committed” to their PTSD Support Group. If the absent Veterans were also polled, the results differ as their absence suggest they are less committed to and consistent with their Support Group attendance.

Similar to the results of Question 8 and the comments left for Question 7, the comments

Table 4 "Other" Comments from Question 9: Additional comments (OPTIONAL)	
1.	Has been a blessing to me and helpful in my PTSD recovery and adjustments in my life.
2.	I will miss my one-one counselor.
3.	I've felt very comfortable and safe in our group. I've shared and have listened to others about similar challenges - which has given me much needed hope, and much needed help through the years.
4.	It is an excellent group that keeps me wanting to come back.
5.	It's a good therapy for me.
6.	This is important to me!

left for Question 9 listed in Table 4 primarily focus on the Veterans' commitment and devotion to their PTSD Support Group. One interpretation is that the Veterans have become dependent on PTSD Support Group therapy for symptom management and social engagement and do not feel the need to utilize their skills to engage in other non-VA related activities.

Implications and Recommendations

The participating Veterans reported high satisfaction with their PTSD Support Group and offered minimal suggestions for improvement, displayed in Table 2. This result could be due to the Veterans being extremely committed to their PTSD Support Group, extremely consistent

Table 2 "Other" Comments from Questions 5 & 6: What makes it HARD/EASY for you to attend group?

HARD

1. Angry Veterans make me feel unsafe.
2. Panic/Anxiety attacks
3. Schedulers changing meeting times.
4. The only times I've missed group was when I was out of town or sick. I've attended every group that I could through the several years I've been a member.
5. Waiting area
6. Weather

EASY

1. Front desk staff are compassionate.
 2. Restroom is large and always clean.
-

with their attendance, and having attended their Support Group for longer than 2 years. Of the feedback listed in Table 2, the issues of "Panic/Anxiety attacks," "Angry Veterans make me feel unsafe," and "waiting area" are tangible problems Support Group facilitators can address. For example the possibility of increased emphasis on utilizing PTSD symptom management skills to self-soothe can be an area for practice improvement.

The response of this Veteran population presents a picture of highly satisfied participants involved in PTSD Support Groups. Follow-up questionnaires could focus on a larger, more diverse population of Veterans who attend PTSD Support Groups. Future projects can focus on gathering the opinions of Veterans who were not present on the day that this questionnaire was

distributed. Those who only attend group on occasion may provide valuable insight into the gaps in patient care and ways these PTSD Support Groups could improve because they may not be quite so highly motivated to participate and engage in the group process.

Gathering the opinions of Veterans who have joined a PTSD Support Group within the past six months would provide valuable information needed for a more critical quality assessment of PTSD Support Groups. It is possible that Veterans new to the group decide within the first six months if the PTSD Support Group format is a “good fit” for them. If this is the case, it would be highly beneficial for group facilitators to understand what these new group participants identify as facilitating and deterring factors in their group attendance in order to take relevant quality improvement measures. However the skewed demographics could also be due to the fact that no new members have been added within the last six months to the PTSD Support Groups included in this project. In this case it would be important to interview the group facilitators to better understand the process of adding new Veterans to a Support Group.

Lastly, demographic information on age, gender, military sexual trauma, combat trauma, and war era was not collected. Identifying possible patterns or themes related to these specific populations may allow for more targeted, effective, patient-centered PTSD Support Group therapy.

Conclusion

The disparity between Veteran reports of being highly committed to practicing their PTSD symptom management skills in Support Group but not implementing them in a non-VA setting is significant. Despite the fact that 82.1% of the Veteran surveyed stated they attend group because, “Group encourages me to engage in my PTSD therapy,” and 93% reported they are, “More motivated to work on their PTSD” in group than in other forms of PTSD-focused

therapy, only 10.3% stated they would, “Engage in new or ongoing social activities outside the VA,” if the groups were no longer offered. It is concerning that 59% reported they would “Isolate.” A future goal would be that 60% of the Veterans would take the skills they have been practicing at group and apply them to expanding their “safe zone” while 10% would continue to struggle with their chronic PTSD symptoms of avoidance, hypervigilance, and negative alterations in mood and cognition. This difficulty for Veterans who are highly committed to participating in their PTSD Support Group to implement their PTSD symptom management skills in the real-world setting presents an opportunity for improvement and should be further studied.

Summary

PTSD is the one of the most common psychiatric disorders in the Veteran population, with a prevalence rate as high as 29% to 60% for those with histories of military sexual trauma (Ahmadizadeh et al., 2013; Gates et al., 2012; Goodson et al., 2011; Kearney et al., 2012; Richardson et al., 2010; Robertson et al., 2004; Sloan et al., 2013). PTSD is associated with diminished quality of life and poor health outcomes related to cardiovascular, neurological, gastrointestinal and immunological disorders, which represents significant additional health care cost per diagnosis (Collie et al., 2006; Foa et al., 2013; Goodson et al., 2011). Social acceptance is one of the most significant factors in a Veteran’s successful integration of trauma so providing PTSD Support Group therapy could be an efficient and cost-effective approach to provide patient-centered care (Ljubotina et al., 2007). Currently the DoD and VA clinical practice guidelines recommend that clinicians consider using group treatment for PTSD as group treatment can improve health outcomes, however there is no compelling evidence demonstrating the efficacy of PTSD Support Groups despite the fact that group therapies have been utilized

since World War II (Barrera et al., 2013; Sloan et al., 2012). Despite the VA's increased implementation of evidence-based practices to improve the quality of care provided, few studies have explored Veterans' opinions of the PTSD therapies they have completed (Johnson & Lubin, 1997; Mott et al., 2013; Rosen et al., 2004). The aim of this clinical project was to systematically identify what Veterans like and dislike about their PTSD Support Group in order to determine ways to improve the quality of PTSD Support Groups.

The results of the project reveal that the vast majority of the participating Veterans report high rates of loyalty to their group and are consistent in their attendance. The Veterans stated that they are more comfortable, motivated to work on their PTSD, and receive more help in group than in other forms of PTSD therapies. They value their PTSD Support group so highly that the majority of Veterans have been faithfully attending their group for more than two years and can identify minimal barriers to their attendance. At the same time 60% of the Veterans reported that if their Support Group no longer met, they would isolate instead of engaging in new or ongoing non-VA related social activities. The disparity between Veteran reports of being highly committed to practicing their PTSD symptom management skills in group but not implementing them in a non-VA setting identifies a problem that can be addressed by PTSD Support Group facilitators for improved patient outcomes.

Further studies surveying a more diverse population of PTSD Support Group participants and collecting demographic data on the participants' age, gender, history of military sexual trauma or combat trauma, and service era are needed to identifying possible patterns or themes related facilitators and barriers of participation for these specific populations. Targeted attempts to solicit the feedback of Veterans who attend their PTSD Support Group on a more intermittent basis, who have been attending group for less than 6 months, and those who no longer attend

group could provide valuable insight into why some Veterans “drop out” of group while Veterans who highly valued their time attending PTSD Support Group decided they no longer needed the support and were able to confidently travel outside their “safe zone.” The additional data gathered could identify specific areas where quality improvement are needed for a more targeted, effective, patient-centered PTSD Support Group therapy.

The DoD and VA have gone to considerable lengths in an attempt to make evidence-based care available to all patients with PTSD (Steenkamp & Litz, 2013). However the growing numbers of new Veterans from Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND) diagnosed with PTSD are adding to the vast number of Veterans already being treated. The VA should be ready with efficient, effective, patient-centered and evidenced based group and individual psychotherapies that incorporate supporting Veterans reengage in society and build relationships with their community (Cifu et al., 2013; Foa et al., 2013; Owens et al., 2005). This study is a beginning attempt to identify the benefits of a PTSD Support Group for Veterans and provides initial data for further investigation to provide best care for this important and growing patient population.

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Appendix A: PTSD Support Group Questionnaire

PLEASE DO NOT WRITE YOUR NAME ON THIS SURVEY

- 1) PLEASE CIRCLE the number of years & months you have been attending this support group
Less than 6 months 6-12 months 1-2 years More than 2 years

- 2) PLEASE CIRCLE your consistency attending this support group in general
1 – not at all consistent 2 3 4 5 – extremely consistent

- 3) PLEASE CIRCLE your level of commitment to this support group in general
1 – not at all committed 2 3 4 5 – extremely committed

- 4) Why do you attend group? PLEASE MARK ALL THAT APPLY
 - My VA provider told me to attend group
 - I can talk to my VA provider at group
 - I feel welcomed/accepted at group
 - I feel safe to speak freely at group
 - Group gives me something to do
 - Group encourages me to engage in my PTSD therapy
 - Group helps me manage my PTSD symptoms
 - I like the other Veterans in the group
 - I like the topics discussed in group
 - Other. Please explain:

- 5) What makes it HARD for you to attend group? PLEASE MARK ALL THAT APPLY
 - Meeting time
 - Meeting duration (90 minutes)
 - Meeting at a VA facility
 - Difficult traveling to group
 - Meetings Facilitated by VA Mental Health Providers
 - Other Veterans in the group
 - Personal motivation/energy
 - Physical ability (such as health issues)
 - Other. Please explain:

(FLIP TO NEXT PAGE)

6) What makes it EASY for you to attend group? PLEASE MARK ALL THAT APPLY

- Meeting time
- Meeting duration (90 minutes)
- Meeting at a VA facility
- Easy travelling to group
- Meetings Facilitated by VA Mental Health Providers
- Other Veterans in the group
- Travel pay
- Other. Please explain:

7) What would you do if you did not have group? PLEASE MARK ALL THAT APPLY

- Join another PTSD group run by a VA Mental Health Provider
- Join another PTSD group outside the VA
- Continue to meet with Veterans in your group informally outside the VA
- Engage in other forms of therapy offered by VA Mental Health Providers
- Engage in new or ongoing social activities outside the VA
- Meet individually with your VA Mental Health Provider MORE often
- Meet individually with your VA Mental Health Provider LESS often
- Isolate
- Other. Please explain:

8) How does this group compare to other forms of PTSD treatments you have participated in (such as classes, individual therapy, CPT, PE, ACT, etc.) PLEASE CHECK ONE BOX

	MORE in this group	LESS in this group	SAME as other treatments
I receive helpful care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel comfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I gain insight into how my PTSD affects me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I work on my PTSD symptom management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am motivated to work on my PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9) Additional comments (OPTIONAL):

(THANK YOU FOR COMPLETING THIS SURVEY)

Appendix B: Instructions for Facilitators and Participants

The purpose of this questionnaire is to gather Veterans' opinions on the PTSD Support Group they attend. The survey is completely anonymous. The surveys will be collected in sealed, blank manila envelopes to ensure complete confidentiality, and group facilitators will not have access to the surveys or individual responses. By filling out the questionnaire you are consenting to participate in the project. However, you may choose not to complete the survey. If you are uncomfortable completing the survey you may turn in a blank survey.

The facilitator will ask for a volunteer from your group to volunteer to collect all the surveys, and seal them in an unmarked manila envelope. The facilitators will then leave the room for approximately fifteen minutes to allow the group to complete the surveys in complete anonymity. After the facilitators return to the group and collect the sealed envelope the facilitators will then return the sealed envelopes in pre-addressed intra-department envelopes.