The REACH Project: A Multi-Family Group Psychoeducational Intervention for PTSD

Michelle D. Sherman, Ph.D.
Oklahoma City VAMC
South Central MIRECC
University of Oklahoma Health Sciences Center

Ellen P. Fischer, Ph.D.
South Central MIRECC
VA HSR&D Center for Mental Healthcare Outcomes & Research
University of Arkansas for Medical Sciences

Overview:

1. Rationale for creation of REACH (Reaching out to Educate and Assist Caring, Healthy Families)
2. Selection of the evidence-based model to tailor for PTSD and the VA
3. The REACH intervention
4. Participation, outcome, and satisfaction data
5. Implications

Rationale for Creation of REACH

- 75% of married/cohabiting veterans referred for mental health evaluation at the Philadelphia VA had “some family problem” in the past week
- 86% of veterans in a VA PTSD outpatient program report that PTSD is a source of family stress
- Mental Health Advisory Team (MHAT 6) report (Nov., 2009)
  - Marital problems increasing every year since first survey (2004)
  - 16% of soldiers surveyed reported plans to divorce or separate
  - Higher rates among soldiers with multiple deployments

Sayers, 2009; Batten et al., 2009

What About the Partners?

- Partners of veterans with PTSD experience:
  - High levels of caregiver burden
  - High levels of overall psychiatric stress
- Compared to partners of veterans without PTSD, they report:
  - Lower relationship satisfaction
  - Poorer psychological adjustment

Jordan et al., 1992; Calhoun et al., 2002;
Beckham et al., 1996; Manguno-Mire et al., 2004

Desire for Family Involvement

- 79% of veterans express interest in greater family involvement in an outpatient VA PTSD program
- Over ¾ of live-in female partners of veterans with PTSD rated getting couples/family therapy as very important in coping with PTSD in the family
- Conjoint treatment has been found to be effective with other disorders (depression, substance abuse, schizophrenia)

Sherman et al., 2004; Batten et al, 2009;
Beach et al., 1996; Jacobson et al., 1991;
O'Farrell et al., 2006; Pfammatter et al., 2006

History of Family Psychoeducation (FPE)

- Manualized interventions originally created for schizophrenia, schizoaffective disorder, and bipolar illness – generally 9-month programs
- Goal: To equip families with the skills known to reduce relapse and improve quality of life
- Emphasis on:
  - Careful assessment of patient/family history and functioning
  - Education about the illness
  - Problem-solving

Research Base for FPE

- Meta analyses have concluded that benefits of FPE for schizophrenia (when added to standard pharmacotherapy) include:
  - Reduced risk of relapse
  - Remission of residual psychotic symptoms
  - Enhanced social & family functioning
  - Financial savings

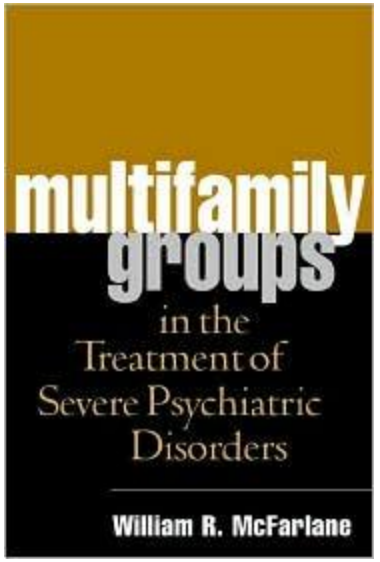
** Findings are robust across cultures & sustainable across time.

** FPE is increasingly being used with a variety of other mental illnesses

- Further, families who get FPE report:
  - Less burden
  - Decreased burnout & distress
  - Fewer psychosomatic difficulties
  - Greater effectiveness in helping their loved one

Oklahoma City VA's REACH Project

- REACH = Reaching out to Educate and Assist Caring, Healthy Families
- Chose McFarlane's Multifamily Group Model due to its strong evidence base & group format
- Modified for use in the VA system and for use with PTSD
- Funded in 2005 as part of VACO Mental Health Enhancement funding



Development & Tailoring to the VA

- 2 focus groups (veterans with SMI/PTSD and family members)
- Goal = To better understand the needs and treatment preferences of local families
- Findings:
  - Veterans want family involvement to help family better understand their illness
  - Family members want to be involved in veteran's care
  - Want evening services
  - Inviting family members should occur though the veteran
  - Both individual family and group sessions would be helpful

REACH PTSD Cohort Eligibility Criteria:

1) Primary diagnosis of PTSD
2) Residence within 90 miles of the VAMC
3) Adult family member/friend willing to participate

Exclusion criteria:

1) Primary substance abuse disorder
2) Imminent danger to self or others

Engagement Procedure-Referrals

- Worked with staff from variety of programs:
  - PTSD program
  - Ambulatory Mental Health Clinic
  - Inpatient psychiatric unit
  - Mental Health Intensive Case Management
  - Primary Care Mental health
  - Day treatment program

- "On-call" REACH psychologist meets with interested veteran immediately after his/her scheduled psychiatric appointment

Engagement Interview

1. Warmth, good eye contact, welcoming, a "guest in our home" mindset
2. Motivational interviewing
3. Emphasis on helping them achieve goals by involvement of family member
4. Describe structure of program
5. Offer to schedule 1st session OR offer to follow-up by phone after they talk to their support person

Engagement Sessions

- Between July 2006 and October 2009, we had engagement sessions with 378 unique veterans living with PTSD
- 213 (56%) unique veteran/family dyads have gone on to participate in the REACH clinical program

REACH: Three Phase Program

- Phase One: Four weekly 45-minute single family sessions
- *Goals:*
  - Build rapport
  - Assess precipitants & prodromal signs
  - Begin to enhance coping strategies
  - Define goals for this family
  - Assess social history, family resources, support network
  - Identify family strengths

Phase II: Six weekly 90-minute multi-family classes

- **Goals**:
  - Psychoeducation about PTSD and its impact on family
  - Teach communication, problem-solving and coping skills
  - Relationship enhancement
- 4-8 families
- Facilitated by two psychologists

Phase II: Six weekly 90-minute multi-family classes

- Structure:
  - Check-in and follow-up on homework
  - 20 minute didactic (interactive) presentation
  - Split into break-out groups (veterans and support persons) for 15-20 minute presentation/discussion
  - Reconvene for entire class demonstration and in-session practice
  - Assign homework

Phase II (cont).

CLASS TOPICS:

1. PTSD diagnosis, treatment, and effects on relationships
2. Managing anger/conflict effectively and promoting wellness
3. Communication skills
4. Creating a low stress environment
5. Depression and its impact on the family
6. Problem solving / Phase II Graduation

Phase III

Six monthly 90-minute multi-family groups

- **Goals**: Practice with problem-solving process; Review and rehearsal of skills from Phase II; Support maintenance of gains
- Recent graduates join veterans/families who have participated for several months
- Mean number of attendees = 12.5 (n=65 classes)

Phase III Outline

- Check in
- Brief didactic/interactive presentation, covering one of the Phase 2 topics. Share and discuss a new handout related to that topic.
- Open the floor for discussion and sharing of effective coping strategies
- Problem-solving exercise

Summary of Participation in Clinical REACH

	Enrolled	Completed
Phase I	213	184 (86%)
Phase II	145	122 (84%)
Phase III	122	102 (84%)
Phases I–III	213	102 (48%)

Evaluation Component of REACH

- ~95% of participants in clinical REACH Program consent to voluntary REACH evaluation

- Veterans and family members complete a battery of self-report measures at 4 times
  - Baseline
  - End of Phase 1
  - End of Phase 2
  - End of Phase 3

Baseline characteristics of participants in change analyses

	Veterans (n=62)	Family (n=59)
Age (mean (IQR))	57.6 (58-62)	54.7 (50-62)
% Male	100%	5%
% Married	86%	92%
Race/ethnicity		
White	83%	80%
Hispanic	8%	0%
Black	6%	9%
Native American	2%	10%

Baseline characteristics of participants in change analyses

	Veterans (n=62)	Family (n=59)
Education		
Less than HS	8%	10%
HS/GED	32%	42%
Some college	36%	32%
College graduate+	21%	15%
No information	3%	-.-
Relationship to veteran		
Spouse	-.-	90%
Parent	-.-	5%
Sibling	-.-	3%
Child	-.-	2%

Increases in REACH program content: knowledge and empowerment

	Veterans (n=62)		Family (n=59)	
Measure	Mean	Effect Size	Mean	Effect Size
PTSD Facts	6.1**	0.46	6.9**	0.52
PTSD Understanding	0.9**	0.80	0.8**	0.48
PTSD Coping	0.5**	0.47	0.4**	0.32
Empowerment[1]	0.6	0.06	14.7**	0.54

[1] Rogers (veterans)/Koren (family)

** $p<0.01$

Improvements in interpersonal relationships and symptom severity

	Veterans (n=62)		Family (n=59)	
Measure	Mean	Effect Size	Mean	Effect Size
Social Support[1]	3.1*	0.36	3.7	0.29
Problem Solving[2]	0.3	0.06	1.7*	0.31
Relationship Satisfaction[3]	0.8	0.15	1.2	0.19
Symptoms (Brief Symptom Index)				
Global Sx Index	-0.2*	0.31	-.-	-.-
Depression	-0.3**	0.41	-.-	-.-

[1] Multidimensional Scale of Perceived Social Support

[2] McCubbin Family Problem Solving Communication Scale

[3] Dyadic Adjustment Scale-7

* $p<0.05$ ** $p<0.01$

Increases in perceived ability to cope and empowerment correlate with improvements in interpersonal relationships

Correlation Coefficients

Outcome	Perceived Coping		Empowerment	
	Veterans	Family	Veterans	Family
Social Support[1]	0.51**	0.05	0.30*	0.30*
Problem Solving[2]	0.64**	0.31*	0.29*	0.47**
Relationship Satisfaction[3]	0.44*	0.30	0.02	0.35*

[1] Multidimensional Scale of Perceived Social Support

[2] McCubbin Family Problem Solving Communication Scale

[3] Dyadic Adjustment Scale-7

* $p<0.05$ ** $p<0.01$

Satisfaction with REACH

- >95% of veterans (n=155) & family members (n=144):
  - Were “very satisfied” or “mostly satisfied” with the REACH Program
  - Were “very satisfied” or “mostly satisfied” with their doctors
  - Rated the quality of REACH as “excellent” or “good”
  - Said REACH “helped a great deal” or “helped somewhat”
  - Said they would recommend REACH to someone with a similar need

Implications

- REACH is a feasible, well-received family intervention for combat trauma
  - Additional tool for clinicians at other VAMCs
  - Assessing need for modifications to tailor REACH to appeal specifically to OEF/OIF-era veterans
  - Assessing need for modifications for delivery of family services in CBOCs by mid-level practitioners

- Appropriate for delivery in a military setting?
  - Need to assess feasibility & acceptability
  - Consider shortening
  - Consider who best to offer – military chaplains?

REACH Project

Additional Project Staff

- Clinicians: Alan (“Dutch”) Doerman, Psy.D. (USAF Col., Ret.), Lee Thrash, Ph.D. (OKC)
- Research assistants: Josie Freeman, Adrienne Prince
- Consultants: William McFarlane, MD (Maine), Lisa Dixon, MD (Baltimore), Richard Owen, MD (Little Rock)
- Data analysis: Xiaotong Han, M.S., Silas Williams (Little Rock)

Thank you

- Michelle Sherman
  - Michelle-sherman@ouhsc.edu
  - 405-456-5171

- Ellen Fischer
  - FischerEllenP@uams.edu