WAR TRAUMA FOCUS GROUP: A CLINICAL GUIDE

Department of Veterans Affairs

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A central aspect of the treatment of post-traumatic stress disorder (PTSD) is the remembering, describing, and cognitive-emotional integration of the traumatic event. For the veteran with PTSD, this involves a systematic re-exposure, in imagination and memory, to the sensations, feelings, and personal meanings associated with fear, loss, pain, guilt, violence, and atrocities witnessed and perpetrated in time of war. This paper describes and outlines the conduct of one vehicle for such therapeutic exposure, the War Trauma Focus Group.

The trauma group outlined here describes a format currently being used at the Clinical Laboratory and Education Division of the National Center for Post-Traumatic Stress Disorder. Aspects of group operation are modified by leaders, reflecting the styles and theoretical convictions of the individual staff members concerned. Nonetheless, the following guidelines represent in some detail a general approach which has been repeatedly used and revised across the last decade. This material expands upon an earlier description of the conduct of our trauma groups (Rozynko and Dondershine, 1991), and the interested reader may wish to consult that paper.

There is at present no clearly established validated process for treatment in such groups. Empirical outcome studies demonstrating efficacy of a particular therapeutic approach relative to alternative interventions have yet to be conducted. The conceptual and pragmatic guidelines described in this chapter are based on clinical experience and theoretical ideas, and will require future research scrutiny.

Theoretical Basis of the Group

There is little argument with the view that combat and combat-related experiences in time of war meet the criteria established in DSM-IIIR for a traumatic event. They remain, thankfully, "outside the range of normal human experience", and they "would be markedly distressing to almost anyone" (American Psychiatric Association, 1987, p. 250). Not surprisingly, the psychological aftermath of exposure to the events of war includes, for many veterans, experience of the symptoms of post-traumatic stress disorder. These symptoms are related in complex ways to a host of additional problems in living experienced by help-seeking veterans. In actuality, these individuals commonly provide the therapist with plenty of current problem material, in addition to the emotional upset and suffering associated with past combat experience. There

are marital and relationship problems, familial violence, substance abuse, unemployment or job difficulties, social isolation, criminal involvements, and financial stresses. Clearly, comprehensive and effective treatment will require sustained attention to these ongoing difficulties in living, which may appear to deserve greater therapeutic priority in view of their obvious currency relative to events distant in time and geography. There are, however, several compelling reasons which support the examination during treatment of the war experiences of veterans suffering from post-traumatic stress disorder.

Central Importance of War-Related Memories

Victims of combat-related PTSD have problems with integrating and managing their traumatic memories (Figley, 1985), and the exploration of war experiences and memories is a core therapeutic task in treatment for combat-related PTSD. First, the traumatic events experienced in wartime are thought be a major etiological influence on development of combat-related PTSD. Severity of exposure to combat has been found to be the best single predictor of the disorder (Foy, Sipprelle, Rueger, and Carroll, 1984). Many of the aversive and life-disrupting symptoms of PTSD are clearly related to combat and other war issues. War content is frequently found in nightmares, intrusive thoughts and images, flashbacks, and inappropriate responses to innocuous stimuli which resemble those experienced in war (e.g. car backfires sounding like gunfire, Asian-Americans looking like Vietnamese).

A second reason for examining war memories in therapy is that many veterans attribute their post-war problems in living to their war experiences. Their understanding and formulation of their problems is important, both because it may have implications for current functioning and because it is related to their expectations of therapy and of the change process.

Third, it is often the case that veterans will have previously avoided disclosing details of their war experiences. When these details are explored, important issues (e.g. related to self-esteem, guilt and shame, anger and blame, relationships with authority figures, etc.) may emerge, along with interpretations and cognitive distortions related to the events and issues. Jellinek (1987) observed that the Vietnam veteran commonly experiences conflict around two main issues: the discrepancies "between his actual behaviors in combat

and the idealized expectation he had of how he should have acted", and "between things he didn't do during combat and the resultant feelings of guilt or shame he feels today" (p. 209). The thoughts and feelings associated with these perceived discrepancies (and with other aspects of war experience) may continue to exert a negative influence on present experience and coping attempts, and their examination during therapy may result in better improvement.

A final reason for focusing on war-related memories is that some recent evidence suggests that exposure to war-related stimuli and memories may help reduce re-experiencing symptoms, as well as the anxiety and depression associated with combat-related PTSD (e.g. Keane, Fairbank, Caddell, and Zimering, 1989).

For the reasons listed above, one of the goals of therapy is to enable the veteran to "re-process" his war experiences, and the therapist's task is to "assist the client to remember not only the traumatizing points, but also the circumstances surrounding the points. In the process of recalling, new insights emerge which purge and neutralize the traumatic nature of the memory" (Wilson, 1988, p. 260). Although there are many theoretical approaches to therapy with combat veterans, most encourage, in practice, the verbalizing of traumatic experiences and the re-experiencing of aspects of the trauma in imagination. Different treatments contain common practices while explaining those practices in different ways.

Models of Intervention and Change

Therapists with different theoretical outlooks, while encouraging a detailed remembering of the trauma experience, may see their task differently. Therapeutic models differ in their emphasis on the cognitions associated with trauma, the physiological arousal associated with traumatic stimuli, styles of coping with traumatic memories and associated emotions, the patient-therapist relationship, and other aspects of the therapeutic undertaking.

To oversimplify, cognitive models see the recounting of trauma as a means for accessing thoughts and feelings associated with the events, and they see therapy as centering around the reframing or restructuring of those thoughts and feelings which are causing problems. Therapy is a process by which the client is led to "reappraise the serious life event, and the meanings associated with it, and make the necessary revisions of his inner models of himself

and the world" (Horowitz, 1982, p. 729). Cognitive therapists focus on helping the patient to identify and examine his interpretations of the trauma, and to modify or supplement them. It is assumed that misinterpretations of the trauma experience may sometimes result in dysfunctional post-trauma coping or add unnecessary misery to appropriate sadness or fear.

Behavioral models rely partly on principles of classical conditioning to explain development and recovery from post-traumatic stress disorder. Therapy is seen as a process through which the patient learns that the cues (external and internal, including memories of the events) associated with the trauma in the past no longer predict the onset of actual traumatic events, so that physiological arousal and emotional intensity necessary to survival can decrease. Methods of direct therapeutic exposure (including "flooding" and "implosion") are used to present trauma cues, and the patient remains in imagined or real contact with the cues until arousal begins to subside.

"Stress management" treatment approaches focus on improving the ability of the veteran to cope with his war stressors (memories and cues associated with war-related events, and symptoms of PTSD) and other negative life situations. In this conceptualization, retrieval of traumatic memories serves to provide the patient with a sample of real-life stressors so that he can practice new (and, hopefully, more effective) coping responses. These new coping skills are developed in the context of more manageable problem issues, and only applied to trauma-related stressors after they have been practiced and proven helpful in other contexts (cf. Flannery, 1987).

Despite such differences in conceptualization, it is worth stressing that, in practice, most treatments attend to each of the elements of exposure, cognition, expression of feelings, generation of physiological arousal, "working through processes", and relationship factors. Notice the presence of multiple treatment elements in the following description of the "essential components" of therapy for combat-related PTSD:

> "(1) the analysis in context of combat with recovery of dissociated memories and affects;
>
> (2) the teaching of techniques which allow strong emotions to be tolerated without resort to neurotic escape;

(3) the discovery of "acceptable" meanings for the combat experience; and

(4) the realization that trauma is as much a process as a disorder and, as a process, it is comprehensible, manageable, and compatible with leading a relatively normal life" (Rozynko and Dondershine, 1991, p. 161).

We believe that the suggestions put forward in this paper may be applied by practitioners utilizing a variety of theoretical perspectives. The approach taken here attempts to combine aspects of the models outlined above, and is animated by three guiding concepts: a commitment to a "developmental" or historical approach; active encouragement of in-session emotional arousal; and an emphasis on integration of cognitive, behavioral, and affective interventions.

Developmental Approach

The processing and integration of traumatic experience is an individual process. Although two persons may be exposed to what is nominally the same event, each reacts to different aspects of that event, each has a different set of physical, emotional, and cognitive responses, and each goes about coping in his or her own way. A developmental approach to PTSD treatment acknowledges this person-specific nature of trauma, by emphasizing the relevance of prior life experience (and, especially, prior traumatic experience) to the response to extreme events. The victim is understood to bring his/her whole self to the traumatic event, and what results is a product of the interaction of prior events and the war trauma itself.

This developmental perspective often conflicts with a tendency on the part of many combat veteran patients to view all of their problems as a result of war experience. Therefore, one goal of the war trauma group is to challenge this tendency, to encourage participants to explore how their responses to trauma originate, in part, with themselves and their life experiences. A major therapeutic task is the uncovering of what the patient brought to the traumatic experience, who he was at the time. This emphasis helps to guide him to become aware of the interpretations he made about the event and his individualized responses to it.

Although such a focus on "predisposing factors" should be part of trauma work, we are not advocating blaming the victim. The traumatic events themselves are seen as the primary causes of PTSD; discussion of pre-trauma life events and coping helps to individualize treatment and facilitates the patient's understanding of trauma impact.

Encouragement of In-Session Emotional Arousal

Current theories of fear reduction suggest that emotional change requires the accessing of certain key emotion-related cognitions, and that emotional arousal is an indicator of the processing of emotional experiences (Foa and Kozak, 1986; Foa, Steketee, and Olasov Rothbaum, 1989). If emotions are not expressed by the patient, it is unlikely that the therapeutically-important memories have been accessed, and what is not accessed cannot be made the stuff of therapeutic focus.

Memory is facilitated by presentation of retrieval cues. In the context of the war trauma group, cues are brought to mind by instructing the patient to describe his life experiences in detail. To get at war memories, therapists "walk the patient through" his reception of a draft notice, basic training experiences, arrival in Vietnam, and so on, probing for details and thoughts and feelings at the time. Therapists ask "What did you see?" or "What did it say to you?". These internal cues (which can be supplemented by photographs or other external memory prompts) serve to "bring to the surface" old memories, creating a context wherein specific traumatic events are more likely to be recalled.

As they facilitate the memory processes of their group members, therapists are charged with managing the intensity of patients' emotional experience in the group. This is important because exposure to war memories will be counterproductive if they are experienced as retraumatizing (e.g. as flashbacks).

To intensify emotional experiencing, the therapist can ask the patient to identify sounds, smells, physical sensations (e.g. wetness) of any kind. During the patient's moment-by-moment account of a traumatic event, the therapists' questions can be phrased in the present tense (e.g. "What are you feeling now?"). To permit intense emotions, it should be made clear to participants that, during the group, they are not to soothe (e.g. offer Kleenex) or comfort those

engaged in actively remembering their traumas, unless otherwise directed by the therapists.

Similarly, therapists can lessen the intensity by asking more conceptual questions ("How did you interpret what was happening in front of you?") and using past-tense questions. They can ask patients to imagine that they are looking at the events from a geographically or temporally more distant vantage point ("If you were standing on the hill to your left, surveying the scene in front of you, what would you have seen?" or "Imagine that you, as you are now, were in that hooch on that day, observing the events; what would you have seen?"). Intensity can also be lessened by stopping the recollection process, checking the reactions of the patient, having him take some deep breaths or otherwise relax, and so on.

Therapists should be alert to "cognitive avoidance" on the part of the patient. Because the details may be upsetting to recall, some individuals may find ways of avoiding focusing on the important material. Such avoidance strategies may include dwelling at length on less upsetting events (and using up available time), rushing through trauma descriptions, using abstract or otherwise unemotional ways of describing events, and withholding key events or actions.

Group leaders have dual and somewhat incompatible goals regarding exposure to memories. They must ensure that participants feel supported and able to cope with the task of revealing their experiences, and at the same time prevent avoidance of emotional material by directing the patient's account and descriptive style where necessary, and by asking probing questions to determine whether the patient is omitting important aspects of the traumatic experience (e.g. commission of atrocities, mutilation of bodies, torture, rape, collecting of "trophies", etc.).

Integration of Cognitive, Behavioral, and Affective Interventions

The approach to helping described here assumes that change will be accomplished most effectively by a combination of interventions. Behavior, cognition, emotion, and physiological arousal are interdependent aspects of experiencing which exert influence on one another. Positive coping responses may help generate positive emotions or constructive thinking. Positive coping thoughts may help

to reduce counterproductive emotional arousal and set the scene for more effective coping behaviors.

Elicitation of emotional experience is important because it helps to demonstrate to the patient that strong emotions can be tolerated and need not be avoided. Remembering of "affectively-loaded" events may also render current symptoms and behavior more understandable and predictable for the patient. The arousal of emotion indicates that important cognitive content is in fact being addressed, and helps identify that material which may be most constructively examined by patient, group, and therapist.

When the cognitions related to strong emotion are identified, they can be examined for their accuracy and for their elements of exaggeration and distortion. Patients can be helped by therapists and group members to see the connection between thoughts and emotion, and to reframe or restructure their interpretation of events: "What rules of life did I bring home from the war? Do I still need them?" "What did I learn in Vietnam that I can use today?" (Rozynko and Dondershine, 1991, p. 161).

The instigation of behavior change is also a central task of the therapists. The patient equipped with newly learned coping behaviors can use them to help control his arousal, deal more effectively with interpersonal stressors, elicit support from significant others, and solve problems in living. New, constructive action is very important to recovery, in that an attempt to respond to a problem situation in a new way can have a powerful effect on feelings and thoughts. Commonly, the replacing of aggressive with assertive communication can lead to different, more positive responses from those close to the patient, and these new responses may encourage him to view his significant others differently and to feel differently about them. Often, in trauma groups, an action can be identified which, if performed by the veteran, may have potential for particularly significant impact. The reestablishment of contact with an important family member, or a telephone call to the the family of a war buddy may be the most effective means of changing negative feelings or challenging distorted interpretations of past and current relationships and events.

Failure to use interventions in any of these areas may lead to less effective treatment. For example, failure to elicit emotional arousal may suggest that relevant events and associated cognitions have not

been identified and therefore cannot be addressed in therapy. Elicitation of strong emotion without help in constructively thinking through or reframing the memories may result merely in an additional traumatic experience for the patient, with no accompanying sense of progress in managing negative emotions or improved sense of control over his life. A failure to attend to interpersonal communication or other coping skills may condemn the patient to a continuing exposure to frequent stressful experiences which will undermine his developing abilities to manage his emotions and his thinking.

This argument for incorporating cognitive, behavioral, and affective treatment methods is based on the observation that cognitive, affective, and behavioral systems exert mutual influence on one another. A related argument is provided by Foy (1992), who noted that these different intervention strategies are related to different (but, often, equally important) treatment goals: "exposure strategies are employed in the reduction of intrusive memories, flashbacks, and nightmares related to the original traumatic experience(s). Cognitive restructuring strategies are designed to deal with problems of meaning attributed to traumatic experiences, or related associations and assumptions that are maladaptive. Finally, skills training strategies are oriented toward teaching coping skills that either reduce personal distress or provide additional means of meeting interpersonal demands" (pp. 53, 55).

Before the Group Begins

The group process described here takes place in a larger program context. First, patients have been screened and selected for participation in the trauma group. Those considered for membership are non-psychotic veterans who are judged by staff to be motivated and likely to benefit from the group; only vets with experience in-country are eligible. There are at the present time no established empirical criteria enabling us to judge which patients will be most likely to benefit from these groups. Probable contraindications currently include, but are not limited to, those noted by Foy (1992) in regard to flooding: significant cardiovascular disease, and presence of severe forms of thought disorder. In our treatment setting, the entire program team meets to discuss whether each patient can handle or benefit from the specialized group, and a decision is made. Each cohort of group participants is selected to maximize intragroup support and minimize problems between group members. Next, there

is much preparation of the patient for participation in the war trauma group. Each patient has resided in the inpatient environment for approximately seven weeks before starting detailed trauma work. During those weeks he has been exposed to a wide range of therapeutic experiences, including stress management, relaxation training, anger management, communication training, "feelings lab", autobiography group, and so on. He has learned how to self-disclose in groups, how to give feedback, how to benefit when others are the focus of group discussion, and so on. These skills are intended in part to help him cope with the emotions activated in the war trauma focus group. They are especially important given that, prior to group participation, the use of sedating doses of neuroleptics or benzodiazepines is curtailed. Finally, the trauma work takes place concurrently with other therapeutic activities. Most importantly, members attend "process" groups (often run by the same leaders), where patients can discuss and cope with their reactions to the more intense group, and where they can examine their relationships and functioning outside the group. The war trauma group described here is not conducted as a "stand-alone" group.

The importance of this particular group is communicated to patients in implicit and explicit ways. As Rozynko and Dondershine (1991) note, "the group is given a "high prestige" value, is led by senior staff, and is afforded precedence over competing activities" (p. 158). Patients understand that they must earn participation in the group by demonstrating motivation and capacity to benefit from it.

Just as patients are prepared for the group by what has gone before in their treatment, the group leaders have also been furnished with some critical information. On the basis of program intake assessments (especially, the psychosocial history), documention of previous treatments, and staff observation and communication during the early weeks of the inpatient stay, the war trauma group therapists will have some idea of the traumatic events (including childhood trauma) experienced by each of the participants. This will guide their activities and enable them to be sensitive to and to probe for critical content issues.

Roles of the Therapist

Groups are led by a team of two therapists. It is critical that group leaders have a good understanding of the history of the war (e.g. events, locations, units, life in the field, varieties of experience of

different ethnic groups) and the changing reactions of the American population at large. Familiarity with developmental psychology is also important, since early traumas and life transitions will be examined in the group. While staffing realities will of course dictate choice of therapists, under ideal circumstances one of the therapists will be a veteran with experience in country, the other a non-veteran. Male and female cotherapists are also desirable. It is critical that therapists be perceived by patients as knowledgeable and experienced in trauma work.

The therapists, of course, have a variety of roles in the group. As in all counseling, one key role is that of "educator". It is important that the participants be helped to understand the relationships between their PTSD and anxiety symptoms and their traumatic memories. It is also important that they be reassured, when appropriate, as to the "normalcy" of various aspects of their experience (e.g. increased dreaming, amnesias for some events, presence of physical symptoms, presence or absence of strong emotion, difficulty of discerning real from imagined past events) as they begin to explore their memories. Jelinek (1987) identified one of the educational messages central to conduct of these groups: "A key message we try to impart concerns the reawakening of unpleasant memories and feelings from their traumatic experiences and their perception that they will lose control and perhaps hurt others or themselves. The group leaders should openly address this fear of uncovering unpleasant emotions and also try to reassure the veterans that that although the feelings may be extremely frightening, they can be dealt with in a new manner without negative consequences" (p. 211).

Other key roles or behaviors of the therapist include:

Structuring and Presenting Rationale

A central role of the leaders is concerned with the structuring of the group: making clear the purposes of the group, it's rules, the design of the group (length, session content and sequencing, etc.), its place in the larger program, and expectations regarding therapist and patient roles and tasks. Patients should be provided with an understanding of these issues in order to enable them to use the group effectively and in order for the group to function smoothly. (See "Expectations of the Patient" section below for specific content to discuss for purposes of structuring). This information can be presented and discussed

during the first group session, and reinforced at the beginning of later sessions or as necessary.

The other aspect of structuring has to do with presenting a model of change to group members, providing them with an understanding of why the group is structured as it is, what they can expect in the various phases of the group, how the group activity is expected to facilitate change, what personal changes are expected, and how they will use the group experience as they move forward into their life after discharge. This building of a rationale for war trauma focus group activity is a very important tool for the establishment of a collaborative therapist-client relationship. Foy (1992) outlined a simple "common-sense" rationale for individual flooding treatment, one that is also useful as part of the rationale for the war trauma group context:

> "The patient is told that painful experiences must be dealt with psychologically in order for healing to occur. Those memories that have not been worked through are connected to many reminders of the experience. When these reminders occur, painful memories of the original experience are activated. The veteran has learned to stop the pain by escaping or avoiding these reminders. However, the patient now lives in fear of both the painful memories and the reminders, and his life is hemmed in by them. Flooding is described as a procedure whereby an individual can re-experience the painful memories in a safe place where it is permissible for the feared emotional reactions to occur. The potential benefit is that it may be possible to reduce the reactivity to the painful memories so that the veteran is less fearful of them. In this way, the veteran may regain control, rather than continuing to be controlled by PTSD symptoms" (pp.55-56).

Foa (1993) also included, as part of an explicit rationale for rape-related PTSD treatment, some statements which can be adapted for use with individuals with combat-related PTSD (rape-related words have been changed to war-related terms):

> "Often the experience comes back to haunt you through nightmares, flashbacks, phobias, depression, and other ways because it is "unfinished business". What we are going to do is the opposite of our tendency to avoid discomfort. We will help you to process the experience by having you remember what

> happened to you and stay with it long enough to get more used to it. The fleeting images or thoughts about the (traumatic event) that you do have, like flashbacks or dreams, stop short of processing the whole experience when the intense fear or emotions make it too uncomfortable. We will help you to use your imagination to approximate the memory as closely as possible, not only seeing the (event) in your mind, but also trying to relive it with all the emotions and feelings you felt at the time. The goal is to be able to have these thoughts, to talk about the (war experiences), or see cues associated with (them) without experiencing the intense anxiety that is disrupting your life".

Foy (1992) also stressed the importance of encouraging realistic expectations of therapy outcome. In line with his recommendation, treatment expectancies should be explored upon entry into the program. It is also important to examine this topic during the discussion of trauma group rationale (and later, at the end of the group), because veterans often have unrealistic expectations of the special effectiveness of the war trauma focus group, which may be seen as the centerpiece of the treatment program itself. Participants must understand and accept that, despite their willing participation in a well-run war trauma focus group (and a well-run treatment program), some of their strong emotions and problems associated with the war will be with them for life. A realistic treatment goal will be to manage those problems and emotions in a more successful manner, thereby limiting their adverse effects.

Team-building

In speaking of individual therapy with Vietnam veterans, Lindy (1988) noted that "the survivor (accustomed to a world in which he gives no one, save other survivors, access to memories of his traumas and losses) risks allowing the therapist (a sensitive but unfamiliar figure who could do more harm than good) to enter beneath his "trauma membrane""(pp. xxiv-xxv). This risk taking is perhaps even more evident in the group situation. Clearly, self-disclosure of fear- and guilt-eliciting events and expression of intense emotion will require an environment in which participants perceive support, safety, confidentiality, and freedom from legal consequences. It is the task of group leaders to help create such an environment. The room itself must be quiet and free of distractions; it must completely free of interruptions by other staff members and patients.

A major part of the structuring of a safe environment involves the defining of expectations regarding feedback from one another. Groups leaders clearly state that "we're here to understand, not evaluate or justify. We are not here to judge one another but to give feedback in order to help ourselves look at our experiences in more detail and understand them better". This expectation is repeated many times during the course of the group.

Interpersonally, what is being sought is not a closeness with others that may have been missing in Vietnam. The bonds that develop between group members will be artificial ones that will in most cases end with discharge from the program or aftercare. Rather, mutual support is being created for the purposes of the group, in order to enable self-disclosure, mutual sharing of thoughts and feelings, constructive feedback, and between-session emotional support.

This group supportiveness is encouraged in various ways. First, clear expectations for group solidarity are communicated to patients, before the group by other patients and in written program descriptions, and during the first week of the group as rules and expectations are outlined by the leaders. Second, during the first group session members are asked to spend time together outside of the group on an ongoing basis for the duration of the group (e.g. to sit together at meals, participate in a weekend outing together, etc.). Third, leaders conduct a person-by-person structured assessment of the Vietnam military histories of participants in front of the group, and then encourage an exploration of similarities and differences in experience. Potentially divisive feelings and thoughts about differences between units, jobs, times in Vietnam, intensity of combat exposure, wartime race relations, and so on can be discussed, and similarities in experience can be highlighted.

Although team-building is important, group leaders need to be alert to the occasional necessity of removing a disruptive person from the group, and to the occasional usefulness for some individuals of supplementing group participation with individual war trauma focus work. Individual attention may be helpful if the veteran is struggling with disclosure of sensitive issues (i.e. perpetration of atrocities, homosexuality). Disclosure can be encouraged in the presence of an individual therapist, and then be more confidently repeated in the group context. Individual therapy may also be warranted if the patient is particularly abreactive or if he is at risk for dissociative

flashbacks. Under these circumstances, the individual sessions may allow for slower pacing and more controlled exposure to traumatic memories. Generally, between one and five sessions are suitable; the members should be informed that their intent is to augment rather than replace the group process.

Directing and Questioning the Patient

In eliciting the pre-military life history and military experiences of each participant, therapists may behave differently depending upon the patient. Some group members will provide this material in an appropriately detailed and chronologically organized manner, so that the primary job of the therapist is to ask for elaboration of potentially significant material and to control the pace of the telling. More often, patients will need more significant structure and therapists will lead them through their accounts in a question-and-answer format. It is important to note that the group described here is very much directed by the therapist. During the individual recounting of past experiences, group members do not speak. They participate only later in the group, when each in turn is asked to "check-in" and when open discussion of issues takes place.

Whatever the style of the information solicitation, therapists are oriented towards enabling the veteran to identify and elaborate on particular issues associated with four time periods: childhood to time of induction; military training; "in country" experiences; and post-war. These time periods are described to the patient and termed the "four-sided mirror", with each side reflecting different but connected aspects of personal development.

With regard to the pre-military period, critical issues for identification and elaboration include: significant turning points, both positive and negative; significant relationships and relationship problems; experiences of abuse as victim and as perpetrator; and expectations of the military life and of war (see Appendix A for a more detailed listing of issues). Therapists help the patient to see and comprehend his own transitions, by asking him to describe how he is changing (cognitively, behaviorally, physically) at each critical event, stopping him at each turning point and asking: "What are you doing with that experience?".

With regard to military training, the therapist wants the patient to get in touch with that eighteen-year-old again, to locate the "kid" in

uniform. What values and strengths and weaknesses did he bring to the military? What made the transition from civilian life easy or hard? What habitual ways of coping did he use? And what happened to the person that entered the military as he progressed through his training experiences? Some examples may help to illustrate these ideas. Consider the natural athlete, who found things easy in the first weeks, when physical conditioning was emphasized, and felt good about himself as a result. Another person, faced with the personally-overwhelming task of map reading, felt stupid. As a result of upbringing, a third patient may have entered the military with intact natural family values regarding the respect of his elders. He may have viewed authority figures as "good people", because those in authority behaved in good ways in his past. These expectations may have been violated within minutes of entering the service. Another patient, raised by an abusive father, may also have found that military authority figures were sources of abuse, but processed that information far differently than the first. The therapist attempts to help the patient discover how training affected him and how he went about integrating his old understandings of the world with his new experiences.

In the recounting of war experiences, the therapist is interested to learn about the patient's roles in the various traumatic events, as well as the content of his thoughts (interpretations, conflicts, judgements) and feelings (anger, fear and panic, guilt, sadness) as the events occurred. He or she is also interested in "firsts": first day in country, first time exposed to fire, first time engaging in direct fire with the enemy, first time seeing the wounded, first time seeing the dead.

Exploration of the post-war period is concerned with the experiences associated with return home (e.g. reactions of family and friends, avoidance of or attempts at disclosure of wartime experiences, resumption or avoidance of past relationships, PTSD symptoms and responses to them, views of the public reaction to the war), and other significant events (especially other trauma).

The aim in all of this exploration is to elicit memories that are of emotional significance. In order to help the patient retrieve his emotional experience as well as event memories, therapists model talking about emotions, reflect back and request elaboration of emotional content produced, and gently probe for feelings associated with the events being described.

Therapists must remember that the most significant events are not necessarily what we would predict. Often, trauma counselors direct patient attention to what they think is "the big one", overlooking an objectively less severe event which may have made a greater psychological impact. One of the authors worked with a Vietnam medic who received the Purple Heart. His combat experiences were important, but not the sole focus in the trauma group, because after it emerged that he was discharged from duty due to malaria, further exploration of the topic led to his disclosure that he had deliberately ceased taking his malaria pills in order to contract the disease and engineer his escape from combat. This action was a source of enduring shame and guilt for the patient, and an important therapeutic focus.

Directing and Questioning the Group

One of the tasks of the therapist is to make sure that each participant learns something about himself while listening to the account of his peer. To help with this task, the therapist, when finished with each individual, can ask group members in turn: "What did you learn about you today?". After the focus patient has disclosed that he stopped writing his family during his tour, other group members might share that "I never had anybody to write" or "I didn't stop, but I never told them the truth" or "I was protecting them or protecting myself".

Group discussion takes place when indicated by the therapists, typically after the person receiving individual attention has finished, for the current session, with his remembering. As the discussion takes place, leaders can ask questions and draw attention to important issues related to the fear, guilt, loss, shame, and other themes associated with the trauma. Reactions of other group members can be carefully explored and support can be expressed.

Identifying Trauma-Related Cognitions

As noted above, the goal of the elicitation of war memories is not just to bring trauma-related emotions to the surface. It is also to help the therapist and patient identify the thoughts associated with those emotions. As the individual recounts his experience, therapists should be listening with an ear toward discovering important interpretations imposed on the traumatic events. These

interpretations then form the basis of future discussions about the meaning of the traumas and possible responses to them.

There are many common types of interpretations which are worthy of therapeutic focus. Some have to do with blame and responsibility for actions (or lack of action). For example, if a group member accepts an exaggerated degree of blame for the event, such an interpretation can cause ongoing emotional upset and block constructive motivation for change. A second therapeutically-important category of cognition has to do with self-labels. What does the participant believe about himself as a result of the event? As an example, consider the person who committed an atrocity. He may believe "I am dangerous" (or "I am not human" or "Underneath it all, human beings are all capable of behaving like animals"). If he believes he is dangerous, he may avoid developing the kinds of interpersonal relationships which would improve his life and create new sources of satisfaction.

Examples of therapeutically-important negative cognitions which are commonly encountered during work with war-traumatized veterans are listed in Table 1, under the column entitled "Common Cognitions". Identification of such interpretations or cognitions about various aspects of the traumatic events will lead to a therapeutic focus on those that require further examination or challenge. The methods of cognitive therapy (e.g. Beck, Rush, Shaw, and Emery, 1979) will be especially useful in this task.

Self-Care

Trauma work is stressful and it is the responsibility of the therapist to engage in a process of self-care. Similarly, it is the responsibility of the program administrator to promote a process of stress management for staff. Specifics of self-care are little different from those we espouse for our patients. They include the practice of self-disclosure of problems and feelings and the seeking of social support, the balance of work and nonwork activities, and regular involvement in relaxing activities and exercise. It is also recommended that trauma group leaders be supervised, that amount of trauma/exposure work be limited and case load moderated appropriately, and that therapists be rotated out of trauma group leadership periodically. It is possible that trauma counseling may hold special risks for therapists (cf. McCann and Pearlman, 1990) and

group leaders and their supervisors should be alert to this possibility.

Therapists must be alert to their own emotional and cognitive processes. Group leaders may find themselves avoiding hearing the horrific details of combat experience and atrocities in order to avoid emotional discomfort. Also, it is not unusual for group leaders to find themselves making moral judgements about the actions of participants, judgements which may influence their behavior toward them. Therapists bring their own history to the sessions, and this history may include exposure to traumatic events not unlike those of their patients. Supervision should address these issues.

Expectations of the Patient

As noted in an earlier section of this paper ("Structuring and Presenting Rationale"), it is the responsibility of the group leaders to give clear expectations to each group member about the purposes of the group, its rules, the design of the group (e.g. length, session structure), its place in the larger program, and expectations regarding therapist and patient roles and tasks. This information is presented and discussed during the first group session.

Our groups utilize the following rules: confidentiality, through which members agree not to disclose the contents of discussion outside of the confines of the group; freedom from legal prosecution for reports of illegal warzone activities; no candy, food, or smoking; no leaving the room (no bathroom breaks); no touching; no politics; no "therapizing" of one another; no violence or threats of violence; and showing of mutual respect among members of the group.

Session Design and Sequence

There are three war trauma focus group meetings each week, and each meeting lasts approximately two hours. Meetings are best scheduled during the morning hours, and at the beginning part of the week. Mornings ensure that any emotional upset prompted by participation can be processed in the afternoon hours, and will be less likely to spill over and become the responsibility of a lean-staffed evening shift. Similarly, groups should not be scheduled for fridays because any problems resulting from exposure to traumatic memories will become the responsibility of weekend staff who may not be as familiar with the patients.

Week One

The first week of the war trauma focus group is a week of group preparation. Each session begins and ends with a "check-in", when each member (including leaders) in turn shares his current feelings and any issues or unfinished business relevant to the moment. During session one, group leaders encourage each member to introduce himself, and they introduce themselves as part of the same process. Group rules are outlined. Leaders set the scene for disclosure of the darker aspects of the war experience; they make it clear that it is understood that in time of war many rules of morality and personal conduct may be put aside, that innocents are hurt and killed, that combatants often "cross the line" in their feelings and behavior. Various additional issues may be explored, depending on the nature of the individual members and expected group dynamics. These include: existing anger or other problems between individuals in the group; how to deal with disbelief in another member's account; dealing with a female group leader in relation to open disclosure, expressions of vulnerability in front of a woman, etc.

During session two, members are shown a video entitled "Dear America" (see Appendix B), which includes footage of Vietnam and readings from letters written by veterans and their families during the war. Feelings and issues raised by the viewing are discussed in the group, and in this way the group begins to move toward confrontation of the war experience.

In session three, similarities and differences between individual members' Vietnam experiences are explored. In turn, and in front of the group as a whole, each patient is interviewed by a group leader regarding his military experience: when and where he was in Vietnam, which service he was in, his rank and role, his awareness of public attitudes toward the war, his use of drugs, his decorations, and so on. These disclosures enable the members to gain familiarity with one another, and additional divisive issues may be explored: officers vs. enlisted men, enlisted vs. drafted, heavy combat duty vs. lighter exposure to combat, etc. These issues are discussed and used to underline the importance of communication of mutual respect and the avoidance of minimization of one another's wars.

This session also presents an opportunity to explore feelings about the group leaders themselves. Some veterans felt betrayed by

authorities during the war, while others are very angry at the "system" (including the VA system); these feelings should be discussed during this initial week. The aim is to allow expression of these attitudes and reach agreement in the group that the issue has been sufficiently addressed so that the group can move on to its primary business. If ignored or suppressed, such feelings may interfere with the conduct of the focus group, as illustrated by the following comments of a PTSD program staff member:

> "It was as if some of the staff couldn't understand where it was coming from and they reacted either defensively leading to an us vs. them combative mode, or over-apologetically, or perhaps worst, squashed the verbal anger in the group prematurely and while superficially it appeared that they were controlling the group, the patients were seething and not really involved in the talk of the group."

Exposure Weeks

Each week after the first is devoted to a given group member. The leaders meet to decide the order in which patients will be asked to share their experiences and describe their traumatic memories. Factors influencing the decision include readiness to share and expected influence on other members' ability to disclose affective material.

The exposure sessions are likely to be especially stressful and upsetting for participants. At the end of each session of focused remembering, therapists remind the group to continue to pull together as a team. Members are asked to be sensitive to the need for support of the person undergoing the exposure to traumatic memories, to stay together between sessions and on weekends, and to prevent one another from isolating. These reminders form a regular part of the closing minutes of each group session.

Each of the three sessions during a given exposure week has a different focus. Session one covers pre-war and pre-military experience, session two is concerned with induction and training, and session three focuses on experiences in country and the initial return home. (See the Appendix for a listing of possible questions and issues which can be raised in regard to each of these time periods).

In these exposure sessions, the therapists attempt to achieve the process and objectives described by Rozynko and Dondershine (1991):

> "The goal is to help the patient reconstruct his experience as completely and as accurately as possible. The therapist listens for inconsistencies and gaps and watches for micro-displays of discordant or dissociated affect. When any of these become apparent the patient is asked to fill in missing data or an attempt is made to probe for missing feelings. Strong emotions are vented, dissociated "truths" are reclaimed, and there is a final telling which may be sad but which no longer terrifies or overwhelms. The goal is reached when the story is emotionally and cognitively complete and congruent" (p. 159).

Through the telling of the story, therapists hope to enable the patient to "link up" his pre-military, training, and war experiences and to facilitate an outcome similar to that described by Lindy (1988):

> "As a result of the working through of trauma and the activation of mourning, we hoped that patient would have reclaimed some of his disavowed affect, given personal meaning to the absurd catastrophe, and regained psychic continuity with his own past" (p. xxvi).

Group leaders have two broad goals in these sessions: to direct each patient through a process of remembering, in which he focuses and elaborates on the circumstances surrounding the traumatic events, as well as the thoughts, feelings, and behaviors prior to, during, and immediately following them; and to facilitate a process of reappraisal and reinterpretation by helping the veteran reconceptualize the experiences, challenging irrational understandings, introducing or reinforcing constructive perspectives, and strengthening perceptions of improved coping ability.

Final Week

In the final week of the group, leaders help participants to strengthen their new understandings, by asking them to identify new insights, rehearse constructive attitudes, and think about implications for the future. Each participant is asked to go up to the blackboard (inscribed with a four-sided mirror), identify the periods of important personal change, and describe how he changed

throughout his life course. This act of "putting it all together" involves seeing and articulating the changes wrought by their important life transition points; identifying and affirming the positive aspects of the coping skills used at these points in time (and describing how they may have led to unintended negative consequences, and how they continue to be used or misused in daily life today); identifying central beliefs which were created or strengthened by the traumatic experiences, challenging those which are inaccurate or counterproductive, and affirming those which are helpful; and focusing attention on the future application of the changed understanding. Group discussions center around these themes.

Another vehicle for this integration effort is the autobiography, which has been begun earlier in treatment in an "autobiography group". Previously, patients have been instructed to delay writing about their military experience until after they are assigned to do so in the Focus Group. After completing their focus session, they are assigned to write the final chapters of their autobiography (military experiences and life after the return home), making reference to the issues outlined above.

While the content of group discussions during the final week will arise out of the previous weeks of group experience, it may be useful to include an exploration of the positive effects of exposure to war traumas. Wilson (1988) noted that "among the many attributes common to survivors are: honesty, integrity, sensitivity, acceptance of others, concern with justice and equality, nonmaterialistic world view, inner strength, spirituality, and the profound awareness of the basics in life" (p. 272). An acknowledgement and assessment of these benefits may help furnish the veteran with additional aids in the process of integrating his memories and improving his orientation to the future.

It is also important to address issues related to the breakup of the group. Members should be asked to express their thoughts and feelings about the war trauma focus group experience and about ending the group. They can be encouraged to take the view that the end of the group is the beginning of their work of learning to cope more effectively with emotions and life problems.

Guiding Principles for Implementation of Exposure Sessions

The following paragraphs summarize the major principles which guide therapists as they implement the remembering of trauma:

1) Encourage elaboration of participants' beliefs and feelings

A. Adopt a "client-centered" approach to elaboration of meaning during the recounting of traumatic events. That is, encourage the person to elaborate on his or her statements, by asking for clarification and probing for his or her interpretation of events. "Enrich the context" of memory retrieval by asking questions about details of places and events (e.g. "Where were the doors on the helicopter?"). As the person says more, retrieval of the meanings and feelings associated with the events will become more likely.

B. Remind participants to describe both thoughts and feelings during the description of traumatic events. Start with general questions which allow him or her to use their own words: "What's going on right now?" or "where are you sitting right now?". Then ask more pointed questions, such as "What're you remembering?", "What feelings are you having, if any?", or "Are you connected to us in the room?". Whenever possible, give out information which lets them know why you are asking the question: "I saw a look on your face which made me think you were having some strong feelings about that". Reflect emotional content to in order to increase the emotionality of the account.

2) Discuss fears regarding emotional and social consequences of disclosure

A. Fear of emotional expression and loss of control. Many participants tell their stories with flat emotional expression, impoverishment of detail during the recounting of memories, omission of clearly salient upsetting elements, minimization of the events themselves, and/or language which does not fit the actualities of the event (e.g. "He left us" versus "He was blown apart"). Often, these styles of describing traumatic events reflect a fear of experiencing emotions or of losing control. Fears of not being able to stop crying, not getting support to process emotions, of going crazy or "going off" and becoming violent are quite common. The therapist can speak directly to these concerns and give realistic reassurance regarding them. They can be addressed in the first week of the group, and again in various

sessions as reactions to the sessions are discussed. Such reassurances are appropriate in that these groups are extremely unlikely to lead to violence, precipitate psychotic episodes, etc. Some of these issues can also be addressed through humor: "We've never lost anybody yet!".

Many people regard expression of feelings as a sign of weakness. Men may see such expression as unmasculine. If "How were you feeling?" elicits little emotion, "What were you thinking?" can be sometimes be asked to get at the same material without obvious emphasis on emotions.

B. Fear of responses of other group members. Detail and emotionality of trauma stories are also influenced by social factors. For example, some participants may skip over details or hide the intensity of their emotions out of a lack of trust or liking for other group members. Others may be concerned about the social acceptability of their actions and expect negative responses to them. In the past, potential listeners may have not wanted to hear their stories, or they may have encountered real or imagined condemnation by others. In order not to push the listener away, details of accounts may be omitted or modified. Such issues of trust, liking, and actual and expected reactions of listeners should be discussed in the first preparatory week, and raised regularly during the exposure sessions as part of the process of "checking in" with members at the start of group and discussing reactions to each session towards their close.

To summarize these rules for elaboration of beliefs, feelings, fears:

Anticipate and discuss blocks to open disclosure;

"Enrich the context" by asking for details of events;

Reflect emotional content;

Ask for elaboration of interpretations of actions and events.

3) Discuss emotional and cognitive reactions to the traumatic stories

A. Accept expressions of emotion as normal, acceptable, and non-debilitating. Take care not to invalidate feelings by minimizing them. Attempt to "normalize" feelings by treating them as appropriate and

manageable. Enquire about others who begin crying or appear to be experiencing other strong emotions during the story of another.

B. Challenge fears of loss of emotional control by reframing crying as the gaining of emotional control: the person can now have normal emotions and connect his emotions to real events. In the past, he/she has been controlled by the suppressed emotions, and pushed to avoid reminders of trauma, to avoid expression of other desirable emotions (e.g. related to intimacy, social enjoyment, appropriate grieving), to lie to himself and others about the personal significance of events ("It don't mean nothing"). Now he or she can have more control over his emotions by allowing the experience of genuine feelings and thoughts that have been previously avoided.

When a participant experiences anxiety, the therapist can check out the cognitions of the individual (e.g. fears about heart attack) , offer reassurance about those concerns, and continue on with the session. Anger can be treated as a way of coping with other more uncomfortable negative emotions such as grief, fear, and so on.

C. Cotherapists monitor group members for signs of "tuning out" or dissociation. Those who do so can be brought back to the present by asking "Are you having trouble relating to what _____ was saying?" or "Can we help you?". Members can be encouraged to contract with the therapist to tell him or her if he is starting to "trip out".

Conflict between group members may be discussed and then explored as part of a larger pattern: "How is this like other things that you've done before?".

4) Identify negative cognitions

As a general rule, the accounts of trauma lead therapists to identify negative, distorted interpretations of the events which perpetuate distress and may prevent working-through and recovery. After the event has been described, then, these interpretations are identified and challenged in various ways.

A. Feelings (e.g. of guilt, shame, anger, depression, sadness) should be labeled and then explored in terms of their cognitive content. Strong emotions are hints as to the presence of important "hot cognitions", cognitions which may be linked to serious misinterpretations of the events themselves. Therefore, strong feelings should be labeled

("What feeling are you having right now?"; "You seem very sad") and then explored in terms of their cognitive content ("What are you thinking right now?"; "What are you saying to yourself about what happened?"). The aim is to help the participant identify what he is saying to himself about the event that leads him to feel that particular emotion.

B. Explore perceived culpability, predictability, and controllability of past traumatic events. Key problematic interpretations may be more easily identified if the therapists keep in mind the following questions - regarding culpability, predictability, and controllability - as they listen to the retelling of trauma:

Culpability:	Is there an assumption of responsibility or personal blame under conditions where these are unwarranted by circumstances? Is there a related inappropriate blaming of others for traumatic events or their outcomes?
Predictability:	Was the event foreseeable or predictable, under the circumstances prevailing at the time, and does the person have an accurate understanding of this?
Controllability:	Was the event controllable at the time: does the individual have a realistic interpretation of controllability? Was there anything that anyone could have done under the circumstances to make events turn out differently?

These questions are important because inappropriate self- or other-blame help to cause the feelings of guilt and anger which are common among our participants and which may operate to help maintain distress, depression, and PTSD symptomatology. Judgements of predictability and controllability of the past traumatic events are integral to blame, guilt, and anger.

5) Challenge negative cognitions

The challenging of problematic beliefs and attitudes can be done in several ways.

A. Therapists may directly challenge the validity of trauma-related conclusions (while acknowledging how painful that belief has been to the person across the years). One direct approach to the exploration and challenging of negative trauma-related meanings may be roughly described in terms of the following steps (to be used in a flexible, not mechanical, manner):

A. Therapist describes the belief:

"You feel that you made the wrong decision in the field and therefore caused the death of three of your buddies, that you are responsible for their deaths and cannot be forgiven".

B. Therapist checks with the person to ensure that he accepts the description:

"Have I got that right? Is that how you see it?".

C. Therapist describes aspects of the event itself that don't fit with the belief, and checks for acceptance of his/her description:

"You agree that your reasons for making the decision were reasonable given the information you had at the time? And your decision was "backed up" by your superior in the field? And that if you had made the other choice available at the time, you might have suffered other deaths?".

D. Therapist asks the group member how the evidence fits with the belief:

"So, you made a decision which was understandable given what you knew at the time, and which was backed up by others. How does that fit with your blaming yourself for making a bad decision which led to the deaths of your buddies?"

B. Use group feedback to provide more positive alternative interpretations of events, and to help persuade about the reasonableness of alternative interpretations. The group members may be asked for their opinions, to help provide evidence for other, more benevolent interpretations of the event: "John has just described what happened in the field and feels that he made a bad

decision and caused the deaths of his buddies. He feels responsible for their deaths and blames himself. What do you all think about what he has said?".

C. Use the following questions to encourage a different, more constructive, point of view, by asking the member "If this had happened to your buddy, what would you say to him?" or "What would you think of him?", and "What would your buddy have wanted you to do?". Or, "If you had died instead of him, would you have wanted him to blame himself for your death?". Similarly, ask the participant "what would you say to your eighteen year old son if he came to you and told you what you've just told us?".

D. Williams (1987) listed some useful ways to help those suffering from "survivor guilt" realize that they did the best they could under the circumstances:

> Encourage them to review their behavior in light of their current age and development, now that they understand that life is not fair and that bad things may happen to good people, instead of from their earlier, adolescent moral stance in which the world and its issues are seen in black and white terms;
>
> Draw their attention to the limited time during which decisions were taken, the amount of experience they had in such decision-making situations, and the amount of information they had at the time. (It may be helpful to make the comparison with the split seconds during which police officers have to decide whether to draw their guns and whether to fire);
>
> Investigate whether others shared some of the responsibility for decisions, by direct action or the approval of action;
>
> Identify as many positive aspects as possible of the person's behavior during the trauma; and
>
> Encourage the view that "As long as you are alive, the memory of the victim remains". (That is, the veteran himself is one positive testament to the significance of fallen buddies, and he can choose to take care of himself, become active in veterans' causes, aid in the recovery of others, and otherwise revere the memory of those who were killed).

In addition, it may be useful to draw attention to the overall stress and confusion of the warzone itself, and the impact on decision-making.

E. Gently challenge negative statements, recasting them into more constructive ones. In the face of negative experiences, find ways of identifying positive aspects of that experience ("Sometimes some good things come out or even the worst tragedies; was there anything positive that you got from that experience?). Find meaning in tragedy, and dignify it. Suggest that changes made now will result in a better future.

F. Redefine and restate character self-blame in words of behavioral self-blame: When a member says "I was an incompetent leader and I let my people down", his comment can be gently restated by the therapist as "You made a wrong decision when you ordered your men in that direction - you made a mistake that day", if that is appropriate to the circumstances. Redefine "I'm an evil person" as "I did actions which violated who I am". When challenging these statements, take the opportunity to redefine the purposes of the group and help explain what you are doing: "One of our aims in this group is to check out our labels and look at them from other perspectives".

6) Distinguish between the time of past trauma ("then"), and now

Draw attention to the differences between a situation now in which the group member is having strong feelings and the situation in which he originally had those feelings. Distinguish between feelings conditioned in life-threatening situations and feelings now. Stress that levels of fear and anger appropriate to combat are not appropriate to heated interpersonal conflicts, and that it is possible for participants to be very angry without "losing it" or doing other extreme behavior. Identify rules of life brought home from the war, that are inappropriate to civilian life. Warzone survival values and coping responses, while helpful during the war, often caused problems upon return home.

7) Reframe symptoms by saying that they are part of a natural effort at coping with traumatic events

For example, Briere (1992) suggested encouragement of the view that flashbacks are not signs of being crazy, but represent "the

mind's attempt to heal itself by reexposing the survivor to small, "handle-able" chunks of painful memory" (p. 127).

8) Encourage personal responsibility for change

A. Distinguish between current responsibility for constructive life change and responsibility for past traumatic events and negative emotional reactions to them. This therapeutic message is concerned with the idea that veterans may have had limited responsibility for events of the war due to lack of influence regarding the conduct of the war, lack of control over the behavior of others, the stress and confusion of combat, limited availability of information, and so on. Similarly, they cannot be held responsible and blamed for their emotional reactions to the war and their ensuing PTSD symptoms. But, they are responsible for taking action towards recovery from PTSD and towards improvement of their current relationships and problems. This idea can be discussed in the group and therapy itself can be presented as a taking control of current circumstances and taking responsibility for change.

B. In line with such thinking, therapists should challenge any language used by group members which suggests that they may be assuming the role of "victim" in their present situation (e.g. minimization of current responsibility). Challenge inappropriate blaming of past events for present problems and challenge an inappropriate sense of entitlement derived from previous victimization experiences. Validate feelings, but indicate that the individual is responsible for doing whatever is necessary to get out of the victim role and associated feeling states.

C. Look for ways to allow participants to make public committment to constructive change and to particular constructive actions. Ask them if they "want to live like that anymore". When a member says that he wants something different, ask questions to have him elaborate on his desires and intentions, and ask him what he is willing to do to change things and how he plans to go about bringing the changes about.

D. Encourage the attitude that self-maintenance is the responsibility of each individual. Remind group members not to become dependent upon always being in a supportive environment. Instead, they should be encouraged to take responsibility for their own maintenance plan and living circumstances.

Patient Materials

No special patient materials are used in this group.

Homework Assignments

Patients have two assignments related to their participation in the war trauma focus group. As they continue the practice, established previously in the program, of keeping a journal, they are encouraged to make entries related to group participation. And they are asked to finish their autobiography, adding material related to Vietnam and the return home.

Expected Outcomes

The expected benefits of war trauma group participation are to some extent those of combat-related PTSD treatment in general. They are related both to ability to understand and manage PTSD symptoms, and to ability to cope with ongoing life stressors.

Coping with PTSD Symptoms

One goal of the group described here is the reduction of some types of PTSD symptoms. Specifically, it is expected that some symptoms of reexperiencing (e.g. distressing trauma-related recollections and dreams, reliving experiences, and distress upon exposure to trauma cues), avoidance (of trauma-related thoughts and feelings or activities and situations), and arousal (e.g. difficulty sleeping, irritability or anger outbursts, difficulty concentrating, physiological reactivity upon exposure to cues) will become less severe as a result of group participation.

However, these symptoms, even if they improve, will not disappear, and a second goal of the group is therefore that the graduate should be able to better understand his physiological responses to certain combat-related stimuli, realizing that they are triggering an old fear, but one which is no longer a scary, dark secret. He should leave the group expecting to feel sad or afraid sometimes, and knowing that he is entitled to feel this way, that his reactions are understandable responses to trauma. He should have reframed his ongoing self-therapeutic task: "What I have to do is to manage my emotions and PTSD symptoms"; and he should have accepted responsibility for his

self-management role: "I can't let my feelings get so raw that I begin to behave in a self-destructive manner". In the past he may have seen himself as an "ignorant victim"; now he can no longer do so.

He should have accepted that he can't erase his trauma or the associated PTSD symptoms, but that he can understand them, give meaning to them, struggle with them. He should feel more confident in his ability to cope with his symptoms without letting them disrupt his life.

These expected improvements in coping abilities are similar to the changes in coping confidence and in the experience of traumatic memories observed by Lindy in his work with those who developed PTSD as a result of their Vietnam combat experiences (1988):

> "During the course of treatment, we were able to observe how this coping changed; how the veteran became more and more confident that the expression of layers of emotion and meaning connected with the memories was indeed useful; how sharing them with another individual was effective", and "The veteran was no longer enmeshed in a reenactment with a loss of reality testing, but rather was reacting to a memory of something that occurred years ago" (p. 329);
>
> "Once the veteran had fully remembered his experience, had gained a new perspective on it, and had told his story, he changed. While still unable to trust his environment, he could now trust his therapist and a few people close to him. While still experiencing intrusions from his war experiences, he now had better ways to manage them. While still subject to rageful impulses, he was now less fearful of losing control. He explained that he had found a spark which connected him to his own past and enabled him to look forward, albeit cautiously, to the future" (p. 325).

Coping with Ongoing Life Stressors

There are at least three ways in which the war trauma focus group experience is expected to improve ability to manage stress unrelated to traumatic experiences of war. First, it may be assumed that current life problems have been experienced as more emotionally intense due to their interaction with symptoms of PTSD. That is, a person who is having the hyperarousal and reexperiencing

symptoms associated with PTSD may be expected to react to additional life stressors with greater-than-normal intensity. To the extent that PTSD symptoms are reduced and abilities for coping with them are strengthened, there may be a related improvement in ability to manage current problems. Second, the experience of participating in the focus group itself may be considered a kind of stress management learning opportunity. In order to complete the group, the individual must tolerate strong emotions in self and others, and the experience of managing these feelings should contribute to an increased self-perception of ability to manage stress. Third, the understanding (gained in part through focus group participation) of how his problems developed, his significant events and turning points, his typical behaviors under stress, and his usual coping mechanisms should help in dealing with current stresses.

The war trauma focus group experience should also enable the participant to better distinguish current events and stresses from those related to trauma. As the person is better able to contemplate rather than avoid his traumatic memories as well as sources of current upset, they should be more easily discriminated from one another. Thus, it is expected that the patient will have improved his ability to ask himself: "Is this my combat stuff or am I using my wartime experiences to allow myself to continue with my old patterns?".

Measurement of Outcomes

The expected outcomes are described above in a general way, but they may also be framed in more measurable terms for purposes of group evaluation. Because war trauma focus groups have yet to receive formal evaluation, it is not clear which questionnaires may best be used to assess change in participants. The following measures may be tentatively recommended for clinical and program evaluation purposes, in that they are relevant to war trauma focus group outcome, easy to administer, and can be used to evaluate the impact of the group:

> Mississippi Scale for Combat-Related PTSD (Keane, Caddell, and Taylor, 1988): A 35-item self-report scale which measures a range of symptoms derived from DSMIIIR criteria.
>
> Impact of Event Scale (Horowitz, Wilner, and Alvarez, 1979): This is a 15-item questionnaire that measures the frequency of

PTSD symptoms of cognitive intrusion (e.g. of thoughts, feelings, images) and avoidance (e.g. emotional numbing, avoidance of trauma-related thoughts).

Beck Depression Inventory (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961): A 21-item self-report questionnaire which has been widely used in research on depression.

In the Outpatient Setting

While this type of group is most often conducted in an inpatient setting, it may also be used to advantage with selected outpatients. We suggest that it only be employed in the context of a treatment program structured in phases. A substantial preparatory phase of non-trauma-focused individual and group therapy may be used for two purposes: as an opportunity to strengthen coping skills which will be necessary during war trauma group participation, and as an opportunity for assessment of motivation and readiness for trauma work. In the earlier treatment phase, ongoing clinical observation can supplement a more formal assessment of the clinical advantages and disadvantages of a focus on war zone trauma. Selection factors will include time abstinent from substance use, psychiatric severity, social support, current life stressors, and therapeutic relationship and compliance. Education and practice in relaxation, stress management, communication skills, and the like can help patients develop an ability to cope with the feelings which may emerge in the second phase.

In the outpatient setting, therapists are more likely to be confronted with veterans who miss appointments. In discussing forms of avoidance of strong emotion during flooding treatment, Foy (1992) indicated that "the most obvious avoidant behavior is engaging in nonemergency "no-shows" for scheduled sessions after agreeing to undertake the procedure" and suggested that it be handled "by renegotiating the contract with the veteran to begin flooding only when he informs the therapist that he is now ready to begin" (p. 59). His suggestion may be useful in the group context outlined here.

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Appendix A: Some Questions and Issues for Exploration

Pre-Military Period

Family structure
Relationship with mother, father, siblings
School experiences
Peer relationships
Relationships with opposite sex
Alcohol and drug use in family
Physical and sexual abuse
Losses and traumatic experiences
Ethnic, religious characteristics of family
Interrace relationships
Troubles with the law
General views of society and war

Military Training Period

Induction experiences
Expectations of military training
Basic training
Advanced training
Duty before Vietnam
Leave before Vietnam: length, location, relationships with family and friends

Look for:

Traumatic experiences
New insights about self and others
Development of new skills
Confidence, lack of confidence
Relationships with authorities, esp DI
Information about the coming war experience
Friendships and relationships with others
Spouse and family relations
Alcohol and drug use

Military/Combat Period

What were your expectations of Vietnam?

Transportation and arrival:

How did you get there (air, sea; commercial or military)?
Thoughts and feelings during the journey (e.g. about being killed or wounded; about family, spouses, friends)?
Who was with you during the trip?
What route did you take?
What were your first impressions of the country?
What sights, sounds, smells did you experience upon arrival?
What was the weather like?
Did you see or hear shooting?
Did you meet any veterans on their way home?

Being the "fucking new guy":

What was your unit assignment and job?
How did the men in your unit treat you?
Were you given any orientation or additional training?
Did you witness any firefights or traumatic events during that time?

Thoughts and feelings associated with combat:

I'm afraid of dying, being maimed, being captured
I'm afraid of letting others down
I did something wrong and others died
I got out of the assignment and my replacement was killed
I was a coward
I lost all my morals
My old self died there
What's the meaning of all this?
I did terrible things
I'll become just like these other guys
I killed women, children, civilians

The Return Home

Hospital experiences
Arrival and welcome, lack of welcome
Family and social relationships upon return
Disclosure/non-disclosure of war experiences
Reactions of others to disclosure

Appendix B

The "Dear America: Letters Home from Vietnam" videotape may be ordered through your local video store: Warner Home Video, Catalogue #90207.