Trauma Focus Group Therapy for Combat-Related PTSD: An Update

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Individual cognitive–behavioral therapy involving directed exposure to memories of traumatic events has been found to be effective in treating posttraumatic stress disorder. In this article, we present updated information on an alternative group form of exposure therapy: manualized trauma-focus group therapy (TFGT), designed as an efficient means of conducting directed exposure. We describe the cognitive–behavioral and developmental models from which the approach was derived, present an overview of session topics and a case illustration, provide guidelines for referring individuals to TFGT, and offer suggestions for future research. © 2002 Wiley Periodicals, Inc. J Clin Psychol/In Session 58: 907–918, 2002.

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Posttraumatic stress disorder (PTSD) is a relatively "new" disorder, having formally been introduced into the psychiatric diagnostic system in 1980. However, specific psychiatric syndromes had been described much earlier in association with the combat-related problems found among veterans of the two world wars. In contrast to the more narrowly defined concept of "shell shock" generated during World War I, detailed case histories of many World War II veterans described a wider variety of psychological problems following combat. Recent studies of PTSD epidemiology have shown that the disorder is prevalent among those exposed to other traumas ranging from childhood physical and sexual abuse or assaults in adults, deadly forms of community violence, natural disasters, and motor-vehicle accidents. Even so, chronic PTSD among combat veterans remains one of the largest clinical concerns. Paradoxically, there are relatively few controlled studies of psychosocial treatments for combat-related PTSD, whether administered in either individual or group formats.

Trauma-Focus Group Therapy

The primary objective of trauma-focus group therapy (TFGT) for combat-related PTSD is to enhance members' control of chronic symptoms of PTSD. Improving self-control and quality of life is seen as taking precedence over immediate symptom reduction as the longer-term outcome. Emphasizing this objective takes into account the intractable nature of chronic PTSD insofar as life-long risk for symptom exacerbation is concerned. However, the approach challenges patients to adopt realistic goals of living fuller lives while managing risks of periodic symptom exacerbation.

TFGT emphasizes systematic prolonged exposure and cognitive restructuring applied to each individual's combat-related traumatic experience, as well as relapse prevention training to enhance members' coping skills for maintaining control over specific PTSD and related symptoms. Our cognitive–behavioral model of TFGT is set in a developmental perspective, taking into account important relationships and experiences occurring across the life span (over pre-military, war-zone, and post-military time frames) for group members who are now in middle adulthood (Gusman et al., 1996). Thus, our model features an autobiographical emphasis that combines both individual narrative construction and the group concept of having others bear witness through nonjudgmental receiving of members' public recounting of their significant life experiences. Relapse-prevention planning is a final core component of TFGT, mobilizing coping resources to be used in predictable high-risk situations to maintain treatment gains between sessions and after TFGT is completed.

From a cognitive–behavioral perspective prolonged, repeated imaginal exposure to significant traumatic memories is necessary to reduce trauma-related fears and to accomplish desensitization to related cues (reminders of the trauma). Prolonged exposure also is useful in correcting faulty perceptions of danger that may develop through generalization (spreading to similar situations) of fears derived from traumatic experiences. In our TFGT procedures, we address the need for repeated exposures to combat-related traumatic memories by devoting one third of all sessions to individualized focus work on war-zone combat experiences. This extensive exposure element, along with its related cognitive restructuring (guided rethinking about the cause and meaning of the trauma), is the core TFGT treatment component.

Mowrer's (1960) two-factor theory often is used to explain the origin and persistence of symptoms of PTSD, such that the initial trauma reaction becomes a conditioned emotional response (classical conditioning), and subsequent avoidance responses are motivated by fear and reinforced by fear reduction (operant conditioning). Additionally, our

cognitive–behavioral conceptualization of PTSD (Foy, 1992) is an interactional model that is used to account for the interplay of trauma characteristics (agent), personal factors (host), and other factors (environment) in the development of acute or chronic PTSD. Such a model allows for individual differences on other important factors, such as prior trauma exposure, social support, or cognitive attributions about the cause and meaning of the trauma (Foa & Meadows, 1997) to be incorporated in case conceptualization.

Session Design and Clinical Sequence

There are six group members and two group facilitators in each War-Trauma Focus Group. Each session is organized to include five core elements: Check-in; Review of homework; Specific topics; Assignment of homework; and Checkout. The initial Check-in provides an opportunity for members to state how they are feeling, identify any special current problems or concerns, and generally establish their readiness to engage in the group. During the Review of homework, each member reports on weekly assigned tasks and outcomes, while group leaders reinforce homework compliance, shape performance as necessary, identify and problem-solve obstacles to homework completion, and collect homework forms. The majority of group time then is allocated to the Specific topic(s) that is the focus of the session (see below). During Assignment of homework, leaders explain the homework task(s), provide a rationale for the homework, answer questions, and explore potential obstacles to completion. Finally, in the Checkout, members report on their reactions to the group session. In addition, as necessary, group leaders may use the Checkout to assist members in planning for the following week, take steps to calm distressed members, or reinforce individual change.

Homework is considered a crucial part of the treatment described here. In each weekly session, homework tasks are assigned to bridge the gap between group therapy sessions and the daily lives of the members. The goal is to help them better cope with PTSD in their home environments.

There is one group meeting each week. War-zone focus sessions are planned for 2-h duration; other meetings last 90 min. As outlined here, the group meets weekly for 30 sessions, or about seven months, then monthly for another five months. Sessions take place according to the schedule shown in Table 1.

As noted above, there are three general types of sessions. Introductory sessions have several goals: to provide education about PTSD and the treatment process, teach and reinforce basic coping skills, prepare members for their upcoming task of re-experiencing their traumatic memories, and provide group facilitators and other members with additional background information about each participant. Preparation for therapeutic exposure is accomplished by setting clear group rules and structure, building member cohesion, discussing realistic expectations for outcome, presenting a clear rationale for exposure treatment, and teaching and supporting coping skills to be employed consciously during the war-zone focus section of treatment. War-zone Focus sessions begin with trauma-scene identification and proceed to systematic exposure to key aspects of trauma memories. They are intended to reduce fears of memories of traumatic experiences, improve perceived self-control of memories and accompanying negative emotions, and strengthen adaptive coping responses under conditions of distress. Finally, Relapse-Prevention and Termination sessions focus on planning for anticipated difficulties in post-discharge living, identifying individual risk scenarios and positive responses, continued practicing of coping skills, providing a period for consolidation of experiences during exposure, and preparing members for group termination.

Table 1
Schedule of Sessions

	Introductory Sessions
Session 1	Introductions, structure, and group rules
Session 2	PTSD education
Session 3	Coping resources
Session 4	Negative and positive coping
Session 5	PTSD symptoms and self-control
Sessions 6–7	Premilitary autobiographies
Session 8	Pre-war-zone military autobiographies
	Warzone Focus Sessions
Sessions 9–10	War-zone trauma scene identification/coping review
Sessions 11–22	War-zone trauma exposure and cognitive restructuring
	Relapse Prevention and Termination
Session 23	Integrating trauma: The three-way mirror
Sessions 24	Improving social support
Sessions 25–26	Anger management
Session 27–28	Risk situations and coping strategies
Sessions 29	Behavioral contracting
Session 30	Transitioning to monthly sessions
Booster sessions (5)	Integration of traumatic experience and relapse prevention

Specific content for each session mirrors these goals. PTSD Education (Session 2), for example, provides members with a chance to describe their own trauma symptoms and the personal impact of those symptoms. Group facilitators have the opportunity to provide didactic education and clarify misperceptions about PTSD. Coping Resources (Session 3) introduces the concept of coping by encouraging members to conduct a personal inventory of current coping resources, identifying personal strengths, and noting areas in need of development. Negative and Positive Coping (Session 4) continues this theme by examining negative coping behaviors used in the past (e.g., alcohol consumption, social isolation, anger, and violence) and their consequences, as well as positive alternatives (e.g., finding support from significant others, practicing relaxation). PTSD Symptoms and Self-Control (Session 5) emphasizes the importance of responding positively to symptoms, for instance, taking action to manage arousal, control attention, and enlisting social support.

Pre-military Autobiographies (Sessions 6 and 7) provide members with a chance to explore briefly, in a structured way, their childhood and adolescence to help establish their identities before experiencing combat trauma. Key developmental themes that are related to early life coping and response to trauma are reviewed. These include relationships with family members and peers, religious and cultural background, and pre-war traumatic experiences. Pre-War-zone Military Autobiographies (Session 8) presents members with a similar opportunity to examine early attitudes toward military life and war, as well as ways in which basic military training affected their responses to war traumas.

War-zone Trauma Scene-Identification/Coping Review (Sessions 9 and 10) is designed to help each member select the trauma scene that he will review during his personal trauma-focus work. Members are encouraged to select scenes that are especially distressing, related to current symptomatology or vivid imagery, and associated with fear as the predominant affect. War-zone Trauma Exposure and Cognitive Restructuring (Sessions 11–22) are conducted by focusing upon one member at a time to ensure a minimum of 30 min of exposure to his important trauma-related reminders, as well as to prevent cognitive

avoidance. In their narratives of their trauma scenes, members emphasize their sensory perceptions, thoughts, and emotional reactions that occurred during the incident. During recounting of the traumatic experience, minimal prompts are given by the facilitators, as the therapeutic objective is to encourage the member to assume responsibility for "self-exposure." Overall, the task might be conceptualized best as "supported remembering."

After the member describes his traumatic experience, cognitive distortions are identified and challenged. In turn, each member is allocated one session for this work; after each has had a turn, the process is repeated so members can be exposed to the material a second time in-group. Following the initial in-session exposure, the member is asked to begin an extra-group self-exposure process as homework. The purpose of the exposure homework is to increase the number of times trauma scenes are re-experienced (exposure "dose") to ensure that fears are reduced effectively. He is given a cassette recording of his trauma narrative and the related cognitive restructuring, asked to listen to the recording at least once during the next week, note distress levels, and report on coping skills used to manage resultant distress.

Originally, traumatic events may have been so intense that they overwhelmed the member's capacity to comprehend them accurately (Foa & Meadows, 1997). The simple sequence of events in the scene often is not even clear to the survivor. Thus, many survivors draw inaccurate inferences from the events; often, these involve misperceptions about culpability for the tragic outcome. Accordingly, the goal of the self-exposure process is to access painful memories but to prevent overwhelming negative emotion. Facilitators focus attention on key trauma reminders, help prevent avoidance, and assist with management of distress as necessary (Ruzek et al., in press). In the cognitive restructuring phase following the member's narrative account of his scene, facilitators and other group members assist the member by carefully and systematically evaluating the "data" supporting the inferences and beliefs the member holds about his scene.

Integrating Trauma. The Three-Way Mirror (Session 23) is designed to aid the transition of the group from trauma-focus work to a current-day perspective in which integration of traumatic experiences and relapse prevention are emphasized. The mirror metaphor is used to represent each member's life in developmental perspective: pre-military, military, and post-military/current timeframes. Improving Social Support (Session 24) focuses on helping veterans recognize the importance of support from significant others for relapse prevention, reviewing current key relationships, identifying problems in these relationships, and developing (and implementing as homework) action plans for improving them.

Anger Management (Sessions 25 and 26), as the name indicates, directs members' attention to the links between their past traumatic experiences and current anger and the negative consequences of anger in their present lives. It also helps them to identify positive anger-control strategies, generate individualized plans, and practice some of these strategies in session and as homework. In Risk Situations and Coping Strategies (Sessions 27 and 28), members complete structured exercises to identify personal high-risk situations and specify steps for constructive coping. They also prepare personalized "emergency cards" that they carry with them to prompt more effective coping in emergencies. Behavioral Contracting (Session 29) cements this process of relapse-prevention planning by formalizing each member's commitment to coping in a written contract. In Transitioning to Monthly Sessions (Session 30), members review lessons learned, develop implications for the future, and discuss feelings about moving from weekly to monthly meetings. The five Booster Sessions are designed to continue the work of trauma integration and relapse prevention within the group while members are weaned gradually from their

dependence upon the group. Troubleshooting difficulties that members encounter in keeping their rehabilitation contracts are primary activities within these sessions.

To summarize, the primary treatment elements employed in TFGT include PTSD education, prolonged exposure, cognitive restructuring, coping skills, and relapse-prevention training. Groups are structured so that leaders follow a detailed treatment manual and group members follow instructions in their workbooks for completing weekly homework assignments.

Case Illustration

Presenting Problem/Client Description

Mark is a 48-year-old divorced male, service-connected Vietnam veteran, referred by his VA case manager for cognitive–behavioral assessment and treatment of his chronic combat-related PTSD symptoms. His pre-military social history was unremarkable in that there was no reported abuse, no indications of severe family dysfunction, and indications of positive school adjustment through his timely completion of high school. He served in the Marines, with training as a rifleman and supply clerk. His tour of Vietnam duty included several instances in which his unit was exposed to heavy combat and suffered casualties, although Mark himself was not wounded.

After Mark's discharge from military service, he was employed as a stock clerk in a succession of entry-level jobs, several of which he eventually walked away from after disputes with supervisors. He has a history of two prior marriages, each of which produced one child with whom he has intermittent contact. He is currently in a cohabitation relationship that began about two years ago. Mark has a history of three brief psychiatric hospitalizations, and he has had two extensive attempts at individual psychotherapy on an outpatient basis. He also has a previous history of alcohol abuse, but he has been sober for approximately two years and attends AA meetings on a monthly basis. Mark has been maintained on antidepressant medication from which there has been modest improvement in mood, but no change in his PTSD symptoms. At the time of his referral, he had just left his job of 8 months as a warehouse worker after a disagreement with his supervisor and was reporting increased discomfort being around other people, combat-related nightmares, and unresolved strife with his cohabitating partner.

Case Formulation

Despite Mark's positive pre-military history, his post-combat adjustment has been marginal, suggesting that profound life experiences and changes in his coping capabilities occurred during his period of military service. Although his specific traumatic experiences in combat have not been identified yet, it appears that his primary PTSD features include both re-experiencing and avoidant symptoms in the form of recurring nightmares and disrupted interpersonal relationships indicative of social isolation and mistrust. In view of his history of insignificant gains following his two previous attempts at individual therapy and his specific interpersonal difficulties, TFGT was recommended to Mark as a new form of combat-related PTSD therapy that possibly could help him achieve improvements.

Course of Treatment

Over the course of 7 months, Mark participated as a member of a VA-sponsored TFGT that included five other combat veterans and two professional co-facilitators. His group met weekly for 7 months and then moved to once a month for booster sessions and

transitioning out of the group. For each session, one of the co-facilitators made an outline of the topics to be covered on a flipchart in the group-therapy room so that members could refer to the session agenda as the group sessions unfolded. Although it made him somewhat uncomfortable at first, Mark and the other members soon became accustomed to the videotaping of each session. He agreed to the taping on the condition of confidentiality and that the tapes would be used for teaching purposes and to provide feedback to the facilitators for their performances in managing each group session.

It had been many years since Mark and the other members had been assigned school homework. However, he found that doing the weekly assignments prescribed in his own Member's Workbook made it easier for him to prepare for and follow along with weekly session topics. He also noticed that the co-facilitators had a similar requirement to follow the session guides contained in their leaders' manuals.

Thus far, Mark's response to treatment was positive. He attended sessions as scheduled and completed homework assignments on all except one occasion. Because he had been prone to social isolation, it especially was noteworthy that he related well to other members of the group and appeared well motivated to begin his war-zone-trauma work.

The thirteenth session was devoted to supporting Mark as he reviewed his specific combat-related trauma in detail ("exposure") and then reconsidered his assumptions and beliefs about the event for accuracy ("cognitive restructuring"), using feedback and observations from both other group members and the facilitators. The excerpt below occurred about 70 minutes into the two-hour session and presents the initial work on cognitive restructuring, after Mark completed his first round of exposure to the event. Before Mark's 45–minute exposure, each member first had participated in check-in and had handed in his homework. The cognitive restructuring began with a reminder about the process to the group.

FACILITATOR 1: I really appreciate how hard it was for you to tell us about that event, and I can see how sad and angry it makes you. Where are you on the anxiety scale (which ranges from 0 to 10)?

MARK: Ten.

At this point, he was sweating profusely, wiping his forehead, and his legs were shaking. Thus, it was clear that Mark's physiological arousal matched his subjective assessment of very high distress. Because the goal is to keep arousal below overwhelming levels to facilitate the cognitive restructuring work, the facilitator provides a prompt for Mark to use one of his coping skills to reduce his distress.

FACILITATOR 1: It might help you get a bit calmer if you focus on your breathing . . . (*pause*). I want to remind everybody about what we are going to do now that Mark has finished describing his trauma. While Mark was telling us about it, Sandy (*the other group facilitator*) was listing each "key point"—each point in which an action was taken (or could have been taken) to influence the tragic outcome in this event—on the flipchart. Now, in the cognitive restructuring, we want to help Mark be sure that he has an accurate understanding of the events that happened and hasn't made any erroneous assumptions about what could be controlled and who (or what) was responsible for the tragedy. We also want to be sure we discriminate between information he knew *at the time of the event* and things he has considered or figured out much later. Now, Mark will need your feedback to be sure he considers each of these issues carefully and thoroughly. We will look at each one of the key points and try to figure out how foreseeable and controllable it was that this action would lead to the tragic outcome. Everybody got that?

Let me briefly summarize the scene. You were two weeks in country—a new sergeant. You were a supply sergeant, and on this day you had the assignment of cleaning up outside the perimeter of the base after the unit faced some contact. Three of you hiked a mile or so outside the base camp to do the job. Nobody expected a problem, and you were new in country, so you were following their lead. You asked once about safety because you thought you might find live ammunition, but the corporal with a special-weapons certification said, "It was a piece of cake," and not to worry. The corporal told you to go out about 500 yards and start to clean up. You were surprised because it seemed unusual to you and maybe dangerous, so you asked him if he was sure. He said yes, and you followed his instruction. No one else thought there was any danger, so you weren't too worried. The other guy had a box of blasting caps in the left pocket of his shirt. As the three of you were cleaning up the area, you were cleaning up some casings, you had a second thought about safety, and then you heard a "pop"—not an explosion—and you couldn't see or hear anything. You thought you had tripped a mine and were dead. And then you looked around and saw that the other guys were badly injured and screaming. You didn't have any way to help them, so you quickly ran back to the base camp for help.

Now, look at the first key point Sandy wrote up there.

FACILITATOR 2: You used the words "negligent" and "guilt." Those are two predominant thoughts and feelings you have?

MARK: Negligence. . . . There are decisions that were made that could have changed the outcome, and I had a hand in them.

FACILITATOR 2: And that's where the guilt comes in.

MARK: Yeah.

FACILITATOR 2: You feel guilty you didn't question the corporal . . . didn't let him know you were uncomfortable with the mission.

MARK: Right.

JACK (*another member*): And you were what? Two weeks in country? And you were reluctant to question an order? I don't see why you need to beat yourself up for that . . .

FACILITATOR 1: I can hear you being supportive . . . but let's make sure that Mark gets a chance to air all his concerns before we give him input.

FACILITATOR 2: So there was also guilt because you hadn't overridden the decision and after the explosion you realized you weren't a medic or corpsman so you couldn't help the men who were hurt.

MARK: Right. I didn't even have a first-aid kit.

FACILITATOR 2: And no radio?

MARK: Right.

FACILITATOR 2: And you couldn't run fast enough to get help? Did I get that piece right here on the board? Is that what you think?

MARK: Yeah . . . I couldn't do anything right. The events pointed to my own ineptitude. I felt very responsible. I was in charge, the senior person technically, even though I was new. . . .

FACILITATOR 2: Can I ask some of your peers here how the evidence fits with your feelings?

FRANK (*another member*): When you went and visited the wounded men in the hospital, did you feel guilty then? Did they act like you were to blame?

MARK: I always felt so bad. . . . I came out scot-free and they were in bad shape.

JACK: You know, when I was in Vietnam, we always paid attention to the experienced guys, even if they were lower in rank—the guys who had two or three tours—they knew the score. If I were new in country, even if I was in charge, I would have listened to more-experienced people. That's all you had. You don't want to feel like a baby. You want assurance. I wouldn't want to question experience.

FACILITATOR 2: No matter what the rank?

JACK: Right. They knew. I would never question experience.

FRANK: How could you not defer to them? How would you back it up? At least you asked the question. You did bring it up. How is that negligence? You asked the right question of the expert.

Here, pointed confrontation of Mark's assumption about his responsibility for the incident is offered by other group members. The inconsistencies in his assumption, when viewed against other common knowledge about the circumstances of war, are being made without judgment toward Mark, offering him an opportunity to consider revising his assumption.

CHRIS (*another member*): I don't know. It could have been a blasting cap; you said the guy's arm was blown off. Not a mine. A blasting cap.

JACK: That's what it sounds like to me. A mine would be the legs—but a blasting cap?? Trouble—the arm.

FACILITATOR 1: Mark, did you ever give any thought to the idea that it may have been a blasting cap and not the mine? A blasting cap would have taken off the arm.

FACILITATOR 2: And then when everybody jumped, it might have tripped the mine.

FRANK: I remember in weapons school, they used to have us set the blasting caps and crimp them behind our backs because they were so sensitive. If they went off, they were so powerful you could lose a finger—but not your face, if it was behind you. They are so sensitive—sounds like an old one that someone set off by mistake.

CHRIS: And that was the "pop" you heard. Not an explosion. A pop.

JACK: That's right. Time sequence would have been instantaneous.

FACILITATOR 2: Mark, let me summarize. A group of your peers thinks a blasting cap probably caused the arm injuries, and then someone tripped the mine. Now, what about the guilt. You talked about how you could have pushed it further about safety, but that's kind of moot if the blasting cap set it off. Now, on the board—the first-aid kit, the radio—how does that fit?

MARK: Well, I have to admit that I wasn't prepared. I was the senior person. I should have had all those things.

FACILITATOR 2: So, 48-year-old Mark knows he should have been prepared. How old were you then? Twenty-two?

MARK: Twenty-one.

FACILITATOR 2: So 21-year-old Mark should have had your wisdom?

FACILITATOR 1: Was it predictable?

MARK: Predictable? I can't run from the fact that I knew that there was danger there.

FACILITATOR 2: The day that you got off the plane you knew there was danger there. I mean—you had a specially trained corporal who thought it was safe; he had done it numerous times—cleaning up the perimeter was standard operating procedure at most places.

FACILITATOR 1: Did you know it was going to happen?

CHRIS: They were all short. When I served, one of the responsibilities of the corporal and sergeants was to break in the new guys. If it had gone up for a disciplinary action, it

may have been him who got the Article 15. Not you. He's the one who should have known. He's the one with the time. He gave you bum information the first few weeks—wrong information. No radio?

FRANK: I keep thinking, with the extent of the injuries, I am not sure a radio or first-aid kit would have helped. You can bleed to death in one minute from a major artery. He lost his shoulder and arm. . . . Even if you called for a dust-off, I don't think that they could have gotten there in time.

MARK: I guess I just do—I keep repeating—you didn't keep the guys safe, you didn't have a radio, you didn't have a first-aid kit, you weren't ready . . .

FACILITATOR 2: But you have a medic here telling you it wouldn't have made any difference if you had had that stuff.

CHRIS: Eye wash. Now how would that have helped? A first-aid kit? You would have wasted valuable time. As it was, you got out of there and ran for help. You didn't delay.

FACILITATOR 1: Chris brings up a good point. And as I asked before, did anyone notice anything that made this predictable? That Mark would have known it was going to happen? (*silence*) That he could have controlled it?

JACK: I keep thinking he did the right thing. He pulled a guy from danger and got help as quick as he could under tremendous strain.

FRANK: If you were in an explosion that killed someone, it is amazing to me that you had the presence of mind to get help. A lot of guys are just shocked or run the wrong way—into the woods.

FACILITATOR 2: What about the most important point on the board—you lived and they died. As the group has said, the event was not predictable or controllable, and maybe you have come to believe that. So are you responsible? You are two weeks in country, it doesn't feel right to you, you try to tell them, we have two other members here who say that the first thing you learn is to trust and listen to the more-experienced people.

MARK: What they told us over and over on arrival in country, if you want to stay alive, you listen to the experienced guys.

FACILITATOR 2: And you did exactly what you were told. And in spite of that, they died. And if they had lived, and you had died, would you condemn them to be tormented like you have been? Would you have wanted them to suffer the way you have over the last 25 years.

MARK: No. It's a price which you pay, and you pay and pay and pay, it's too harsh of a sentence—a life sentence.

FACILITATOR 1: What did you learn today?

MARK: That there are many ways of looking at what happened. That maybe I am not responsible. That I too am human.

FACILITATOR 1: How are you feeling now?

MARK: I was afraid of judgment. That my peers would judge me. But I didn't hear that. And it was gratifying.

FACILITATOR 2: In fact, you heard experienced people supporting you and offering other plausible explanations for the events that had nothing to do with Mark. It was an accident. Where are you on that 0-to-10-anxiety scale?

MARK: About a 7 or so; down a little.

As can be seen, there were two key aspects of the cognitive restructuring in the session: (1) clarifying the exact sequence of events during the trauma, and (2) ascertaining whether the events were predictable or controllable. While Mark clearly believed himself culpable for the injuries of his companions, the data do not necessarily support

his assumption of guilt according to other experienced members' observations. Thus, tension between his evaluations and those of respected others prompted him to begin reconsidering his self-appraisal of responsibility. A drop in his rated anxiety level accompanied this "cognitive shift." This therapeutic work continued in Mark's second round of trauma focus six weeks later.

Outcome and Prognosis

Mark attended every session except one, and he completed almost all of his homework assignments. After years of avoidance (shutting out thoughts about the trauma), he did find listening to the taped narrative of his trauma very stressful (experiencing anxiety levels of 9 or 10 during each exercise). He reported a significant increase in sleep difficulties and nightmares intermittently during the 8 weeks of focused-trauma work. As the trauma-focus component of the treatment was drawing to a close, he spontaneously played the tape for his girlfriend so that "she could understand what (he) might have done wrong and why (he) was so screwed up." She was very supportive about the experience and this greatly relieved his tension. At that point, Mark decided to go back to his boss, inform him that he had been working on some personal issues, and ask for his job back. The supervisor agreed to rehire him on a probationary status. At the conclusion of the treatment, Mark opted to transition to an anger-management class at the Vet Center in order to "get more control of my wicked temper." While he still met diagnostic criteria for PTSD, his symptom severity had declined approximately 25%. He reported that he had found the TFGT content "somewhat helpful," but was especially appreciative of the feedback from his peers and for the opportunity to bond with other veterans.

Clinical Issues and Summary

There are several active treatment components in the current form of TFGT. These include education about PTSD, coping/relapse-prevention skills training, personal autobiography, prolonged-exposure therapy, cognitive restructuring, and group cohesion. The extent to which these treatment components are essential, individually or collectively, for positive TFGT outcomes is unknown. Thus, an important area for future research on TFGT is identifying essential treatment elements. Additionally, future research needs to identify essential client characteristics for efficient matching.

In terms of the clinical needs of thousands of veterans suffering from chronic combat-related PTSD, it appears that TFGT may be considered a potentially beneficial alternative for those individuals who have been unable to benefit from traditional, individual forms of trauma therapy or support groups. While empirically based criteria for matching individual clients to either group or individual forms of trauma-processing therapy presently do not exist, we recently have published rationally based guidelines (Foy et al., 2000).

Indications for TFGT include: acceptance of the rationale for trauma-exposure work; willingness to disclose personal traumatic experiences; ability to establish interpersonal trust with other group members and leaders; previous group experience, including 12-step groups; completion of a preparatory course of individual therapy; not actively suicidal or homicidal; willing to abide by rules of group confidentiality; not severely paranoid or sociopathic; and stable living arrangements. Contraindications include: active psychosis; severe organicity or limited cognitive capacity; litigation or compensation-seeking pending.

At present, data analysis from a recently completed, multisite controlled-treatment trial of TFGT is underway (Schnurr, Friedman, Lavori, & Hsieh, 2001). Final results of

that study will be available in the near future. In the meantime, there is encouraging data from our developmental work on TFGT showing that more individuals were able to complete the intensive trauma-exposure therapy in the group format than would have been anticipated with individual therapy.

Recent revisions of the leaders' treatment manual and members' workbook have been made based upon our extensive experience in conducting the cooperative study. In addition, there are current studies underway with adaptations of TFGT for other groups, such as homeless women and war-exposed Bosnian adolescents. Glynn and associates (1999) have shown that manualized individual therapy (including exposure and cognitive restructuring) can be combined successfully with behavioral family therapy. Accordingly, another possibility for the future might be to combine TFGT with family therapy for those individuals where family issues are salient.

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