A Field Test of Group Based Exposure Therapy With 102 Veterans With War-Related Posttraumatic Stress Disorder

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Group-based exposure therapy (GBET) was field-tested with 102 veterans with war-related posttraumatic stress disorder (PTSD). Nine to 11 patients attended 3 hours of group therapy per day twice weekly for 16–18 weeks. Stress management and a minimum of 60 hours of exposure was included (3 hours of within-group war-trauma presentations per patient, 30 hours of listening to recordings of patient's own war-trauma presentations and 27 hours of hearing other patients' war-trauma presentations). Analysis of assessments conducted by treating clinicians pre-, post- and 6-month posttreatment suggests that GBET produced clinically significant and lasting reductions in PTSD symptoms for most patients on both clinician symptom ratings (6-month posttreatment effect size $\delta = 1.22$) and self-report measures with only three dropouts.

The International Society of Traumatic Stress Studies (ISTSS) practice guidelines indicate that there is more empirical support for exposure therapy than for any other posttraumatic stress disorder (PTSD) treatment (Rothbaum, Meadows, Resick, & Foy, 2000). A recent survey suggests that exposure therapy is rarely used in the U.S. Department of Veterans Affairs (VA) system despite its treating large numbers of war veterans with PTSD (Rosen et al., 2004). The failure to adopt evidence-based therapies may explain why studies have generally failed to support the efficacy of VA PTSD treatment (Zadecki, 1999). Exposure therapy for PTSD requires repeated and prolonged confronting of traumatic experiences with the goal of facilitating the emotional processing of the experience (Foa & Kozak, 1986). Although war veterans have been found to be more difficult to treat than other PTSD populations, four controlled studies provide support for exposure therapy with war veterans, although the effects have been small (Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001).

This is a study of an ongoing specialized VA PTSD program that has made extensive use of exposure therapy for over 4 years using a new model called group-based exposure therapy.
Group-Based Exposure Therapy (GBET). Group Based Exposure Therapy combines elements of the Transcend Program (Donovan, Padin-Rivera, & Kowaiw, 2001), trauma-focused group therapy (TFGT; Schnurr et al. 2003), and an Australian PTSD program (Humphreys, Westerink, Giarrantano, & Brooks, 1999) with techniques developed over the past decade within this specialized VA PTSD outpatient clinic.

Indirect evidence of benefit from this treatment program was found in two previous studies. Both reviewed the computerized medical records of 90 of its patients during the 4 months before, the 4 months of, and the 4 months after intensive PTSD group treatment. Fifteen patients in this sample received GBET and the rest were in cohorts that received similar treatment without the use of recordings of patients’ war-related trauma presentations (see below). One of these studies examined pain ratings collected during pretreatment, in pain ratings both during and after intensive group treatment for those patients with chronic pain (Shipherd et al., 2007). The other study found a significant reduction in primary care visits during and after intensive group treatment for patients rated as high utilizers of primary care (Keyes et al., 2004). The present study focuses on the impact of GBET on PTSD symptoms.

**Method**

The clinical staff at the Atlanta VA Medical Center’s Posttraumatic Stress Disorder Clinical Team (PCT) developed GBET with the goal of improving its treatment outcomes after a previous study failed to find efficacy for its group therapy program. To determine the efficacy of this new model, the first 10 cohorts to receive GBET were assessed prior to treatment, immediately posttreatment, and 6-months posttreatment. Assessments were conducted by PCT clinical staff in this unfunded program evaluation study.

**Participants**

All patients in this field test were referred for specialized PTSD treatment between January 17, 2003 and April 27, 2005 from the Atlanta VA Medical Center. There were 791 referrals during this period. All referrals were sent a letter that described GBET and asked him or her to call the clinic to set up a screening appointment. If the patient did not call within one month PCT staff attempted to reach him or her by telephone. Fifty-two percent of referred patients (412) either did not receive the letter due to wrong addresses or did not respond to the letter and could not be reached by telephone. Three hundred seventy-nine patients were contacted. Two hundred eighty-two of these patients expressed a desire to participate in GBET treatment. Of these, 107 did not meet diagnostic criteria for documented war-related PTSD as a primary diagnosis and 56 were excluded due to active substance abuse or dependence. One hundred nineteen were offered GBET (42% of those who expressed an interest). One hundred two of these patients participated in this open trial, 13 were treated in later cohorts, and 4 did not start GBET treatment due to unexpected changes in their ability to participate. It is noteworthy that there was a large increase, over 200% compared to the year before, in referrals for specialized PTSD treatment in the months following the start of the Iraq war (March 2003). This seemed to be due to many war veterans having a temporary increase in PTSD-like symptoms in response to viewing the television coverage of the war. As a result, there were many more inappropriate referrals during this period than usual. Figure 1 summarizes the flow of patients from referral to GBET.

All patients in the first 10 cohorts volunteered to participate in the study. The study was conducted at the Atlanta VA Medical Center, was approved by the Institutional Review Board of Emory University, overseen by the Atlanta VA Medical Center’s Research and Development Committee, and all patients gave written informed consent. The study included 93 (91%) Vietnam veterans, 4 (4%) Gulf War veterans, 2 (2%) Iraq War (OIF) veterans, 1 Korean War veteran (1%), 1 (1%) veteran who came under enemy fire and saw a close friend die during an incident near the Korean DMZ in 1967, and 1 (1%) veteran who came under enemy fire and was nearly killed in a natural disaster during a peace-keeping mission in the 1990s. All were male except one Vietnam veteran who was a nurse. Fifty-three were African American, 45 were White, and 4 were Hispanic. The average age at the start of GBET was 54 (SD = 6) and the ages ranged from 33 to 78. There were three dropouts. One patient came only to the GBET orientation meeting, another dropped out in the second week of treatment after being confronted about not doing his homework, and the third dropped out in the last month of the program after completing his trauma work. The latter patient indicated that he left the program because he felt significantly better, had a transportation problem, and believed he no longer needed the group. All dropouts were Vietnam veterans. The goal was to have 10 patients per cohort. Due to concerns about possible attrition, there were four groups of 11 patients. No one dropped out of these groups so they were extended to 18 weeks to include the additional patient presentations (see below). Two groups had a potential member not start GBET due to a last-minute family emergency or health problem so there were two groups of nine. The other four groups each had 10 group members.

A review of VA computerized medical records indicated that 92% had received previous VA treatment for at least one other, non-PTSD, Axis I psychiatric disorder and 37% had been treated for two or more other psychiatric disorders. The most common comorbid psychiatric conditions were substance abuse/dependence disorders (78%) and depression (48%). Most of these patients also had received VA treatment for at least three significant co-morbid medical conditions and 27% had been treated for four or more such disorders. Table 1 lists common comorbid disorders for which this sample had received VA treatment. Seventy-four percent of these patients had received treatment in the Medical.
Table 1. Common VA-Treated Comorbid Disorders in This Sample

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>61</td>
</tr>
<tr>
<td>Respiratory disorders</td>
<td>47</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>45</td>
</tr>
<tr>
<td>Arthritis</td>
<td>36</td>
</tr>
<tr>
<td>Diabetes</td>
<td>30</td>
</tr>
<tr>
<td>Heart disease</td>
<td>18</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior substance use disorder</td>
<td>78</td>
</tr>
<tr>
<td>Depression disorders</td>
<td>48</td>
</tr>
</tbody>
</table>

Center’s Mental Health Clinic for at least 6 months prior to GBET (Mdn = 12 months). Only two patients in this sample had not been treated by a Mental Health Clinic psychiatrist prior to GBET.

Measures

Screening for GBET consisted of two interviews, first with a PCT nonphysician clinician and then with a PCT psychiatrist. All patients were required to pass a urine drug screen before the second interview was scheduled.

The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995) was administered in the first interview and during the two posttreatment assessments. This structured clinical interview measures the frequency and intensity of 17 symptoms as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994) over the period of the last month. The second interview with a PCT psychiatrist included a psychosocial, military, and psychiatric history; a mental status exam; and a review of all comorbid conditions and current medications.

Prior to the first interview and to both posttreatment interviews, patients were asked to fill out the Mississippi Scale for Combat-Related Posttraumatic Stress Disorder-Revised (Mississippi-R; Betemps, Baker, & Dewleen, 2004). The Mississippi-R consists of 39 statements (such as “The people who know me best are afraid of me.”) and patients are asked to rate how they feel about each statement on a scale from 1 (not at all true) to 5 (completely true). The Burns PTSD scale (Burns, 2002) was administered on the first and last day of group therapy and at the 6-month posttreatment assessment. The Burns PTSD scale consists of 10 statements (such as “Upsetting memories of a traumatic event that come into your mind over and over.”) and asked patients to rate how much they have experienced the symptoms included in each statement during the past week on a 0 (not at all) to 4 (extremely) scale. The Burns PTSD scale is face valid and was found to have high reliability (α = .90) in an earlier study of 77 veterans from this PCT program (Burns, 2002).

Inclusion criteria included war-related PTSD, as measured by the CAPS and the self-report measures, documentation of war exposure with a DD214 or other confirming documents, a minimum of 6 months of sobriety for patients who reported substance abuse histories and passing a drug urinalysis test. Patients with...
active psychosis, significant cognitive impairment, active substance abuse/dependence, subsevere PTSD symptoms (a CAPS below 50), and/or an inability to make a firm commitment to treatment were excluded.

**Treatment**

Group-based exposure therapy is a manualized (Lorenz et al., 2006) outpatient program in which patients attend 3 hours of group therapy per day twice weekly for 16–18 weeks (depending on group size). Group-based exposure therapy is comprised of three phases: a didactic training and group-building phase, an exposure therapy phase, and a grief/guilt and relapse prevention phase.

The first 4–5 weeks of therapy have a twofold goal of teaching stress management skills and building group cohesion. It begins with a sponsoring alumni group providing lunch and discussing the value of participating in the program with the new cohort. The next two GBET days include didactic presentations about the symptoms of PTSD, breathing retraining, instruction in thought-stopping, grounding techniques, and information about how irrational thoughts affect emotions. Similar to an Australian PTSD program (Humphreys et al., 1999), there is an emphasis on how avoidance maintains PTSD symptoms. Next, each group member is required to make 30-minute presentations to the group concerning his or her premilitary and prewar military histories. These presentations were adapted from the manual of a VA substance abuse and PTSD residential treatment program called Transcend (Donovan et al., 2001). Patients are also required to telephone other group members and ask assigned questions that they later report on during group therapy. The questions, such as, “What was your first car and how did you get it?” are designed to be conversation openers. Many of these patients seem to have an almost phobic avoidance of the telephone and this exercise seems to promote spontaneous phone calls between group members for the rest of the program. It is our impression that more phone calls leads to greater group cohesion which, in turn, may increase tolerance for the exposure therapy. Frequent between-group member contact is encouraged throughout GBET to combat social isolation, increase emotional support, normalize experience, and build a sense of community. A primary goal of this phase of treatment is to create a “we can get through this by sticking together” atmosphere for when the exposure therapy phase begins.

The second phase lasts 8–9 weeks. It starts with the sponsoring GBET alumni group receiving a lunch provided by the new cohort, and discussing how exposure therapy affected them. This was designed to reassure the patients that the next phase is worthwhile and contributes to a sense of community. Outlines (adapted from the Transcend manual) are provided for the first war-trauma presentation and each patient has up to 2 1/2 hours to present to the group. This outline includes arrival in the war zone, attitude towards commanding officers, substance use in the war zone, first combat exposure, first kill (when appropriate), and most stressful combat experiences. Patients were instructed to write their presentation prior to presenting. Patients were also instructed not to attempt to present a complete history of their war experiences, but to focus on describing the events that come back to haunt them most often in the form of reexperiencing symptoms. During the session following a patient’s first war-trauma presentation (on the next GBET group day), he or she is interviewed about his or her homecoming experience. The goal is to create a narrative that includes a beginning (arrival in war zone), middle (war traumas), and end (return to family). These presentations and the homecoming stories are recorded onto audiocassettes and group members are required to listen to recordings of their own presentations at least 10 times between groups. This technique was adapted from TFGT (Schnurr et al., 2001). During this period, the first hour of each GBET day is also used to check in with patients concerning their responses to the war-trauma presentations. This gives the staff an opportunity to deal with any negative responses to treatment, to evaluate how often patients are listening to their presentation tapes, and to encourage those who find it difficult to write their presentations or listen to their tapes. After the first session, there is a break during which a nonpresenting patient provides lunch. This prevents the interruption of having to leave the room to get lunch, contributes to the sense of community, and creates more time for war-trauma presentations. Each patient has his or her day for presenting about his or her war experiences and his or her day to provide the lunch for another patient’s presentation. Once each patient has completed his or her first war-trauma presentation, he or she makes a 1-hour presentation about his or her most traumatic war experiences, which is also recorded and listened to at least 10 times. As before, patients are given an outline ahead of time and are expected to write their presentations prior to presenting. Patients generally present in the same order as before. During this period, the first hour is again used for monitoring patient progress and dealing with any treatment-related issues. There are two 1-hour war-trauma presentations per day. During both types of war-trauma presentations other group members are encouraged to ask questions and provide feedback. This peer input often appears to be invaluable. Patients experience 60 or more hours of exposure during GBET (3 or more hours of their own war-trauma presentations, 30 or more hours listening to recordings of their own war-trauma presentations, and 27 or more hours of hearing other patients’ war-trauma presentations). It is noteworthy that almost all patients reported listening to recordings of their war-trauma presentations more than the required 10 times.

The final 3 weeks of GBET address grief, guilt, and relapse prevention. It includes an imagined funeral for a fallen comrade, a healing ceremony facilitated by a chaplain, a surprise welcome home party/lunch given by the sponsoring alumni group, and recorded feedback from group members to each other. There is an emphasis on expressing war-related grief, which often seems to
produce reductions in war-related guilt. On graduation day, the patients are given a certificate of completion and a gold-colored medal pin that has PCT stamped on it. They are encouraged to wear the pin and talk to others wearing these pins to increase the sense of community. In addition, there was an ongoing monthly support group for the significant others of past and current GBET participants.

Psychotropic Medications

Patients’ VA computerized medical charts were reviewed for the 4 months prior to the first GBET assessment, the period during GBET, and the 6 months post-GBET to investigate the role of psychotropic medications. Seventy-three percent of patients had active prescriptions for at least one psychotropic medication prior to GBET versus 100% during GBET and 99% post-GBET. During the 4 months prior to GBET 56% of these patients were prescribed selective serotonin reuptake inhibitors (SSRIs) and 44% were prescribed non-SSRI antidepressants: Note some patients were prescribed both concurrently. Fifty-six percent of the patients remained on the same psychotropic medication(s) during GBET as they had been prescribed for at least 4 months prior to GBET, while 40% had a psychiatric medication discontinued and/or added, most commonly antidepressants. Ten percent of these patients had an SSRI and 20% had a non-SSRI antidepressant added during GBET.

RESULTS

Of the 102 patients who enrolled in GBET treatment, 99 completed GBET treatment, 98 completed the posttreatment assessment that included the CAPS, and 93 completed the 6-month follow-up assessment. One of these patients was eliminated from the analysis after a series of mini-strokes compromised his ability to respond to the scales. The primary dependent variables were the patients’ scores on the three CAPS subscales and their total CAPS scores; additional analyses utilized the Burns and the Mississippi-R score as outcome variables. Means, standard errors, and standardized effect sizes (δ; Raudenbush & Lui, 2001) for differences between posttreatment and 6-month follow-up versus pretreatment are given in Table 2.

Data were analyzed separately for the three CAPS subscales and the total score. Mixed model regression analyses, also called multilevel analysis, were used to account for the repeated measurements across time (pretreatment, posttreatment, and 6-month follow-up), the random effect of cohort, and because of the missing data (Hsieh, 1988). There was a significant effect of time on all three CAPS subscales: reexperiencing, $F(2, 272) = 63.42, p < .001$; avoidance numbing, $F(2, 272) = 63.50, p < .001$; physiological reactivity, $F(2, 272) = 58.79, p < .001$; and on the total CAPS score, $F(2, 272) = 85.65, p < .001$. On the total CAPS score and all three CAPS subscales, patients scored significantly lower at posttreatment assessment than at baseline [all $t$s (272) $> 9.40$, $p s < .001$] and at 6-month follow-up than at baseline [all $t$s (272) $> 8.09$, $p s < .001$]. There were no significant differences between posttreatment assessment and 6-month follow-up scores on any subscale or the CAPS total scores (all $t$s $< 1$), indicating that patients maintained their posttreatment gains, $t$s $< 1.35$, ns effect sizes $δ$s $< .13$.

Eighty-one percent of patients (76 of 94) with valid total CAPS scores at pretest and posttest showed a clinically significant improvement, defined as a reduction of 10 or more points on the total CAPS score, indicating that patients maintained their posttreatment gains, $t$s $< 1.35$. Following a series of mini-strokes compromised his ability to respond to the scales. The primary dependent variables were the patients’ scores on the three CAPS subscales and their total CAPS scores; additional analyses utilized the Burns and the Mississippi-R score as outcome variables. Means, standard errors, and standardized effect sizes (δ; Raudenbush & Lui, 2001) for differences between posttreatment and 6-month follow-up versus pretreatment are given in Table 2.

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### Table 2. Clinician-Administered PTSD Scale (CAPS) and Self-Report Results: Least Squares Means and Effect Sizes From Intention to Treat Analysis

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretreatment</th>
<th>Posttreatment</th>
<th>Pretreatment Posttreatment Effect size</th>
<th>6-Months</th>
<th>6-Months Posttreatment Effect size</th>
<th>Pretreatment 6-Months Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CAPS</td>
<td>90.68 1.63</td>
<td>62.74 2.46</td>
<td>1.20</td>
<td>61.99 2.55</td>
<td>1.22</td>
<td></td>
</tr>
<tr>
<td>Caps reexperiencing</td>
<td>24.89 0.83</td>
<td>17.33 0.98</td>
<td>0.95</td>
<td>16.48 0.94</td>
<td>1.16</td>
<td></td>
</tr>
<tr>
<td>Avoidance Numbing Caps</td>
<td>36.27 0.93</td>
<td>23.47 1.22</td>
<td>1.02</td>
<td>22.90 0.84</td>
<td>1.04</td>
<td></td>
</tr>
<tr>
<td>Physiological reactivity</td>
<td>29.52 0.50</td>
<td>21.83 0.76</td>
<td>1.05</td>
<td>22.44 0.84</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>Burns PTSD</td>
<td>28.49 0.77</td>
<td>18.91 0.99</td>
<td>1.10</td>
<td>21.75 0.96</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>Mississippi-R total score</td>
<td>147.97 2.27</td>
<td>136 2.34</td>
<td>0.64</td>
<td>137.29 2.32</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Mississippi-R Item-10</td>
<td>2.45 0.13</td>
<td>1.73 0.13</td>
<td>0.61</td>
<td>1.89 0.13</td>
<td>0.49</td>
<td></td>
</tr>
</tbody>
</table>

Note. PTSD = Posttraumatic stress disorder. $Ns$ range from 99 to 76. $N$s for each analysis are given in the text. All posttreatment and 6-month values are significant at $p < .0001$ versus pretreatment values.
in the analysis). A similar 81% of the 90 patients with baseline and follow-up data had a clinically significant improvement when comparing baseline to 6-month follow-up assessments (73 of 90). This suggests that GBET produced clinically significant and lasting reductions in PTSD symptoms for the majority of patients. Note that the CAPS outcomes on 15 of these patients are mentioned in an earlier study of PTSD and chronic pain (Shipperd et al., 2007).

Additional information about the potential effects of GBET on the symptoms of PTSD comes from the Burns PTSD scale and the Mississippi-R self-report measures. We analyzed the Burns, the Mississippi-R total score, and question 10 of the Mississippi-R using a mixed model analysis. Question 10 (“Lately, I have felt like killing myself.”) from the Mississippi-R was analyzed separately to investigate the impact of GBET on suicidal ideation. There was a significant effect of time in all three analyses, Burns: $F(2, 258) = 45.25, p < .001$, Mississippi total and question 10: $F(2, 248) = 11.20, 11.76$, respectively, $p < .001$, and again patients scored significantly lower at posttreatment and follow-up than at pretreatment on the Burns PTSD scale, $t(160) = 8.52, 7.34$, respectively, $p < .001$, and on the two Mississippi measures, total score: $t(230) = 3.65, 3.39$, respectively, $p < .01$, respectively; question 10: $t(200) = 4.60, 3.61$, $p < .01$, respectively. Although there was no significant difference between the posttreatment and the follow-up assessments on the Mississippi-R measures there were significantly higher scores on the Burns PTSD scale at 6 months posttreatment than at posttreatment, $t(155) = 2.06$, $p < .05$, although the effect size was small, $\delta = .23$. At posttreatment, there were 76 and 87 completed Mississippi-R and Burns PTSD scales, respectively. There were 77 completed scales of each self-report measure at 6-month posttreatment. These results support those of the CAPS, suggesting GBET produced significant and lasting reduction of PTSD symptoms and in suicidal ideation.

**DISCUSSION**

The primary goal of this study was to investigate if a new treatment model developed within a specialized VA PTSD program fulfilled the mission of reducing PTSD symptoms. Analysis of assessments conducted prior to treatment, posttreatment, and 6-months posttreatment suggest that GBET produced clinically significant and lasting reductions in PTSD symptoms for the majority of veterans treated for war-related PTSD in this program. Significant symptom reductions were found in all three symptoms clusters and on both clinician ratings and self-report measures. Large effect sizes were found on the clinician ratings of total PTSD symptoms and medium-to-large effect sizes were found on PTSD self-report measures on both posttreatment and 6-month posttreatment assessments. Medium effect sizes were also found on question 10 of the Mississippi-R at posttreatment and 6-month posttreatment, suggesting that GBET reduces suicidal ideation. The greatest strength of this study is that it was conducted in an ongoing specialized VA PTSD program by VA clinicians who would have provided these patients the same treatment had there been no study. It is also noteworthy that group formats have been favored in the VA system and may be more efficient than individual psychotherapy.

Caution should be used in interpreting these unusual outcomes for several reasons. First, all posttreatment assessments were conducted by treating clinicians. Unintended rater bias or the patients’ desires to please their therapists may have had a significant impact. Second, there was no effort to measure the interrater reliability of assessments or treatment fidelity. Third, although more than 40% of the patients who expressed an interest in GBET received this treatment, these patients may have been more motivated than the typical VA PTSD patient. Patients had to undergo two evaluations, pass a drug screen, report at least 6 months of sobriety (if they reported a substance abuse history), provide documentation of war-related trauma, and make a firm commitment to treatment prior to acceptance into GBET. In addition, most of these patients first heard about GBET from another patient who highly recommended it. This may have led to a self-selection bias. In addition, there is no comparison group so it cannot be determined what effects treatment as usual or a nonexposure-based treatment of similar intensity would have had on a control group of patients.

A primary disadvantage of real-world studies like this one is that the impact of the different therapeutic components cannot be determined. For example, further investigation would be necessary to determine the effects of each phase of treatment and of psychotropic medication. Although it may seem reasonable to assume many of these patients had already gotten most of the benefit of psychotropic medications prior to starting GBET, we do not have enough evidence to conclude this and the impact of GBET on medication compliance was not measured.

One of the significant differences between GBET and some of the other group models for treating war-related PTSD, such as TFGT, is the “dose” of exposure therapy. The largest and most rigorous study to examine the use of exposure therapy within a group with war veterans utilized TFGT and failed to find clinically significant reductions in PTSD symptoms for the majority of patients (Schnurr et al., 2001). Group-based exposure therapy has a minimum of 60 hours of exposure therapy (see above) compared to TFGT’s 40 hours (4 hours of within-group war trauma presentations per patient, 16 hours of listening to recordings of one of the patients own presentations, and 20 hours of hearing other patients war trauma presentations). It also may be noteworthy that the number of exposures to a patients’ own traumatic experiences in GBET (22 or more) is more similar to the number of exposures typically used in individual exposure therapy (35 or more; Foa, Hembree, & Dancu, 2002) than in TFGT (10). Perhaps the higher does of exposure therapy contributed to the differences in treatment outcomes between GBET and TFGT.

Some PTSD experts have advised against conducting exposure therapy in a group due to the risk of “secondary traumatization” (Resick & Schnake, 1996). In both posttreatment assessments,
patients were asked if they experienced any lasting negative effects from hearing about the traumatic war events of other group members. Although many patients indicated that hearing others' traumatic experiences evoked painful recall of what happened to them and brought back war memories that they had forgotten, none reported any lasting negative effects and many indicated that this process helped them put their own experience into better perspective. It seemed that conducting the exposure in the group often helped normalize experiences and gave the other patients opportunities to provide critical information that the staff did not have. For example, in most of these cohorts a third or more of the patients froze the first time they were under fire. Learning how common this was helped reduce the shame and guilt that many patients had felt for decades. In addition, other patients sometimes provided input about weapons or tactics that helped the presenting patient come to a better understanding of what had happened to him or her. It is noteworthy that many patients began recalling positive experiences they had during the war as they desensitized to their negative experiences. It was our impression that the vicarious exposure of hearing about others' war experiences was of real benefit to the majority of these multitraumatized patients. Consistent with emotional processing theory (Foa & Kozak, 1986), it was our impression that the more complete a veteran's memory of his or her war experiences the better, and hearing about others' war experiences leads to more complete memories.

Although some VA clinicians have indicated to us that they do not use exposure therapy due to concerns about possible increases in suicide ideation, hospitalizations, and in dropout rates, we found the opposite to be true. Self-reported suicidal urges, as measured by question ten on the Mississippi-R, were significantly less after GBET and, as of this writing, none of the 205 patients who have started GBET became suicidal during GBET, had a psychiatric hospitalization due to GBET, or dropped out during the exposure phase of the program. In addition, the overall dropout rate continues to remain low (4%) in this ongoing program. This may be largely due to the high level of group cohesion created in the first phase of GBET that fosters positive peer pressure to stay with the program and complete assignments.

It is important to note that all patients in this study were in the process of trying to establish, increase, or maintain VA service-connected disability payments for PTSD. Although patients were informed that program evaluation assessments would not affect their disability claims, it was clear that some patients did not believe this. This may have led to some patients exaggerating their symptoms during posttreatment assessments. In addition, although this open trial's outcomes are unusual for a war-veteran population, similar and often better outcomes have been reported in studies of exposure therapy with other PTSD populations (Rothbaum et al., 2000).

Part of the impetus for the development of GBET was an earlier study of this PCT's group therapy program that failed to find efficacy. The previous program was less structured and had a greater “here and now” focus. It included the same number of hours of treatment on the same schedule as GBET, and the treatment was provided by most of the same staff. The primary difference between the previous group therapy program and GBET is the systematic use of a high level of exposure therapy. It is our impression that we have been achieving the best treatment outcomes in our PCT's 13-year history with GBET.

Finally, although it is encouraging that the close to 80% of patients in this sample appear to have made clinically significant and lasting reductions in PTSD symptoms after GBET, an average 6-month posttreatment CAPS score of 61.99 suggests that many patients still had significant PTSD symptoms. These limited findings are significant primarily because of the paucity of published reports of similar or better outcomes from the more than 140 other VA Medical Centers' specialized PTSD programs and 206 Vet Centers. Although far from a cure, GBET may represent a step forward in the treatment of chronic war-related PTSD in the VA system.

REFERENCES


