

THEORETICAL AND PRACTICAL FOUNDATIONS
OF AN INPATIENT POST-TRAUMATIC STRESS DISORDER
AND ALCOHOLISM TREATMENT PROGRAM

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This article describes the structure and process of the first inpatient program in the Department of Veterans Affairs for the treatment of post-traumatic stress disorder (PTSD) and alcoholism. The therapeutic community setting utilizes lifespan developmental and social learning models to provide patients with 1) a framework for understanding what has happened to them; 2) tools for more effective coping in the future; 3) an arena to experience the discomfort of their previous coping mechanisms; and 4) the anxiety/pleasure of creating and practicing a new and more effective repertoire of skills. The program is divided into three phases, roughly equivalent to Prochaska & DiClemente's (1982) Stages of Change. Phase I focuses on solidifying motivation for change through assessment, education, and some

interpersonal work. Phase II represents the action stage and incorporates exposure-based therapy in a developmental framework to address trauma issues. Additionally, the second section of the program pushes deeper into understanding and modifying the patient's interpersonal behavior. Finally, Phase III emphasizes maintenance and generalization of their learning; modified relapse prevention training provides the cornerstone of this final segment.

As early as 1983, numerous small sample studies and clinical reports documented the problem of co-occurring conditions among patients with post-traumatic stress disorder (PTSD) resulting from combat experiences (Abueg et al., 1987; Green, Grace & Gleser, 1989; Sierles et al., 1983). The National Vietnam Veterans Readjustment Study (NVVRS) (Kulka et al., 1990) replicated these initial reports with population-based estimates. Of nearly 479,000 veterans estimated to have a diagnosis of PTSD as a consequence of the Vietnam war, 25% currently carry the diagnosis of alcohol abuse or dependence. Nearly 75% of PTSD sufferers in the NVVRS had a lifetime diagnosis of alcoholism. A recent survey suggested similar rates of the alcohol diagnosis with

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PTSD (Rosenheck & Massari, 1990). Full diagnostic workups in outpatient and inpatient settings have yielded estimates in the range of 42% to 80% (Abueg et al., 1987; Jellinek & Williams, 1984; Keane & Wolfe, 1989).

While these relationships are co-relational only, they do present a new and complex challenge to mental health treatment. The aim of this article is to describe one model of inpatient treatment for veterans who suffer from post-traumatic stress disorder (PTSD) and concurrent alcohol abuse or dependence. The origins of the program, the first of its kind in the Department of Veterans Affairs, will be presented along with a conceptual model and its practical implications for the conduct of therapy. The structure and dynamics of the program *will* also be discussed in detail.

Origins of the Program

The progression of our work has proceeded in four stages. First, an enhanced protocol was developed and implemented with forty patients *through* a year-long pilot period that augmented the existing PTSD program (Berman et al., 1982). Secondly, after the initial anecdotal successes were observed, grant funding was obtained to study formally the treatment outcome effects of a specialized protocol with PTSD/alcoholics (Abueg & Kriegler, 1988). Preliminary results of the outcome study led to a proposal for the first inpatient unit anywhere in the VA (Medical Center) nationally devoted to the treatment of the PTSD-substance abuser. Funding was granted in the fall of 1988 for continued refinement of a 30-bed inpatient unit for the dually diagnosed, and analyses of data from follow-up to the outcome study.

In the two-group outcome study (Abueg et al., 1989; Abueg et al., in press), 44 patients received enhanced relapse prevention training (ERPT), which attended to the interaction of addiction with PTSD symptoms and themes; 44 matched control subjects did not receive (the specific ERPT treatment) such treatment. ERPT was shown significantly to forestall the first return to drinking at 6-month follow-up. Although this initial result demonstrated an impact of the intervention, 9-month follow-up data began to show a convergence of relapse rates between groups. A second important finding was a significant suppression of the severity of relapse in the experimental group through 9-month follow-up, which replicates other studies regarding improved drinking status as a result of relapse prevention training. Significant positive co-relations were obtained between

drinking status (average number of drinks consumed) and scores on a measure of PTSD severity at follow-up. Hence, reduced drinking is associated with fewer reported PTSD symptoms.

Need for Concurrent Treatment

A growing literature on the dually diagnosed has begun to draw attention to problems in existing conceptualizations (Brower, Blow & Beresford, 1989; Carey, 1991), meaning the acquisition and maintenance of the addiction among individuals with psychopathology may be substantially different from those without serious psychopathology (Meyer, 1985). Within the anxiety disorders in particular, differential findings regarding onset and maintenance of alcoholism have been found across the phobias, panic disorder, and agoraphobia (Kushner, Sher & Beitman, 1990). In the specific area of PTSD and co-occurring substance abuse, Abueg & Fairbank's (1991) review suggests the need for additional model building based upon four main arguments: 1) the biological and psychological interaction of the disorders; 2) the high relapse rates in alcoholism and PTSD; 3) convergent impairment of the dual disorder; and 4) cost-effectiveness.

Briefly describing Abueg & Fairbank's (1991) statements, the interaction argument reflects preliminary evidence of etiological and current symptom interactions in PTSD and substance abuse. Although the etiological findings are less clear than maintenance data, which disorder precedes the other in time may have important **treatment** implications (e.g., Davidson et al., 1990). Two findings are clear in the maintenance of PTSD and substance abuse: anxiety potentiates the urge to drink and use drugs, and chronic alcohol or drug use can exacerbate PTSD symptoms (Jellinek & Williams, 1984; Schnitt & Nocks, 1983).

The relapse rates and convergent impairment arguments are related. These refer to the severity of symptomatology of both PTSD and chronic alcoholism or substance dependence, which may lead to poorer outcomes in treatment – greater resistance to change, higher dropout rates, and higher relapse rates (Meyer, 1985; Woody et al., 1985). The last argument, cost effectiveness, is a logical proposition awaiting empirical test. It seems reasonable, however, to explore whether resources can be more efficiently utilized through the concurrent, integrative treatment of the dually diagnosed.

Convergence of Three Conceptual Paradigms

The Menlo Park PTSD/Alcohol Program is conceptually based on three central theoretical

paradigms: social learning theory, the life-span developmental model, and the therapeutic community or milieu psychiatry. Although psychopharmacology plays an important role in stabilization in the PTSD/Alcohol Program, it does not occupy a central place in the fundamental understanding of what factors can potentiate change in an individual.

Social learning theory (Bandura, 1978, 1982) is a comprehensive theoretical paradigm that accounts for behavior from a social and cognitive-behavioral perspective. Central to Bandura's theory is the construct of self-efficacy. Self-efficacy, or the confidence to engage in a particular behavior, accounts for a significant amount of explanatory variance in the prediction of future behavior. Although conditioning and learning influences are paramount in the theory, self-perceptions of competence weigh heavily in a person's ability to overcome, for example, a trauma-based disorder. Biological influences are acknowledged, but again, using this model, they are not central to understanding the individual's behavior.

The strength of this theory in practical application to combat veterans with multiple diagnoses is how a number of important models can be subsumed within a broad, multivariate social learning theory. Examples of models fully consistent with social learning theory are two-factor conditioning models of traumatic avoidance conditioning (e.g., Fairbank & Brown, 1988; Solomon, Kamin & Wynne, 1954); self-regulatory cognitive models (Meichenbaum, 1977); and relapse prevention (Marlatt & Gordon, 1985). Special attention is paid in the Menlo Park milieu to a model fully compatible with social learning called the process of change model (DiClemente & Prochaska, 1982; McConaughy et al., 1989; Prochaska & DiClemente, 1983). The model advances that change in therapy, especially commitment to not being on alcohol or drugs, is a predictable process marked by stages: pre-contemplation, contemplation, action and maintenance/relapse. After observing these stages clinically in our patients, we chose to capitalize on the ongoing process of change by attempting to match phases of the program and treatment elements to patient motivation and level of competency.

The life-span developmental model incorporates a number of sources, including some that have explicitly broached the idea that trauma occurs in the context of a person's life (Erikson, 1950; van der Kolk, 1985): that is, the impact of that trauma on the individual is determined largely

by the current developmental stage of life and life tasks facing the individual. Erikson (1950) observed how early adulthood role conflicts became "frozen in time" for a World War II veteran with PTSD who went into combat as young man. Similar obstacles to maturation have been repeatedly observed by clinicians working with Vietnam war veterans, victims who on average faced their traumas at age 19.

The therapeutic community approach draws heavily from the British model of milieu therapy (Jones, 1963). The emphasis of the inpatient program since its inception in 1978 has been on personal responsibility in the context of an interdependent milieu (Berman, Price & Gusman, 1982). The model encourages self-disclosure of vulnerability and defensive coping in the context of group and unit activities. The governance of the program relies heavily but not wholly on the participation of the group members; increased support and accountability results from clear contingencies placed on undesirable behavior. Verbal or physical threats, for example, are grounds for discharge; at the same time, however, patients have ample opportunities through the day to identify and appropriately express rageful feelings. From a behavioral perspective, the therapeutic community therefore provides a high "density" of interventions delivered by peers as well as clinical staff, and it is therefore an arguably powerful treatment tool for the disenfranchised Vietnam veteran.

Overall Structure and Dynamics of the Program

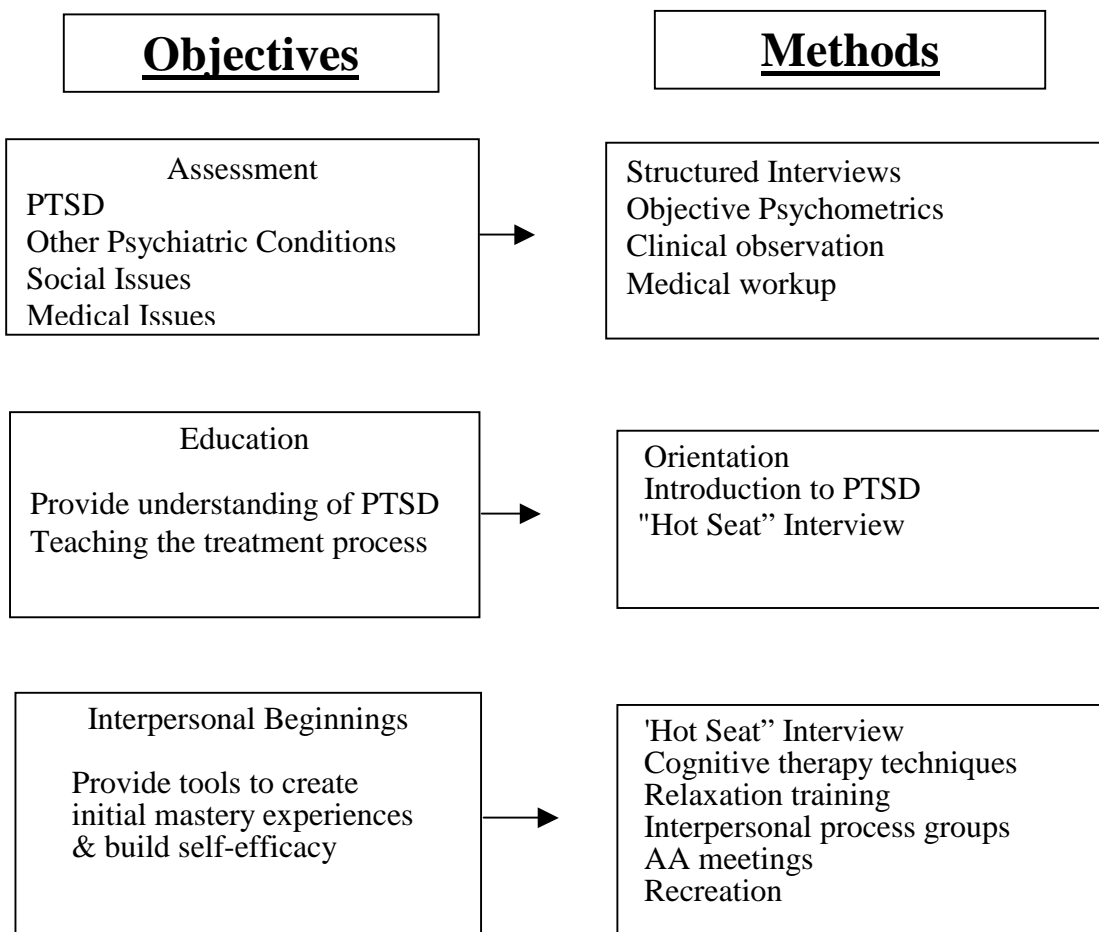
The PTSD/Alcohol Program is a 30-bed voluntary inpatient ward that receives nationwide referrals. The average length of stay is 3 to 4 months, divided into three phases that are generally equivalent to the stages of change in the model described by Prochaska & DiClemente (1983). Furthermore, there is a heavy emphasis on coping. This is a population that has had twenty years of avoidant and self-defeating coping that has reinforced a negative set of beliefs about the self and the world, possibly explaining why a noteworthy percentage of PTSD-Alcoholics meet criteria for Axis II disorders (Kulka et al., 1990). Treatment therefore incorporates assessment, education, skill-building, and interpersonal psychotherapy, and it occurs in group and milieu settings. The program activities are designed to enable the veterans to understand their current patterns of behavior, learn alternative strategies, and practice these behaviors in a safe environment.

Once residents become available to this learning process, they are then generally ready to utilize exposure-based therapy to re-visit their combat experiences, and incorporate relapse prevention training to prepare for future challenges.

Phase I: Assessment, Education, and Interpersonal Beginnings

Phase I focuses on Contemplation/Motivation and then the beginning of the Action Stage. As seen in Figure 1, this 4-5 week period uses educational and experiential activities to accomplish the following objectives: establish a therapeutic alliance, promote a sense of common past experience and present purpose, create opportunities for learning new coping strategies,

and build greater self-efficacy. Furthermore, each patient receives a comprehensive medical and psychological assessment, with special attention to the interaction among problem areas. The educational component begins with the "Orientation" and "Introduction to PTSD and Treatment" groups that teach how the program functions, normalize fears about treatment, and differentiate PTSD from everyday stress. There are also groups that explain the relationship between PTSD and substance abuse, as well as describe the physiological consequences of substance abuse. Residents generally find that these groups help dispel doubts about whether they belong in the program, and also provide



some hope that they are in a place where change occurs. In social learning terms, this period of treatment aims to increase positive outcome expectations for therapy and a sense of personal responsibility and control (Bandura, 1982); therefore, this aspect/ethic of the program may indeed be one of the most potent and enduring components of treatment.

The experiential side of the program uses a weekly introductory ritual to begin to identify avoidant strategies, distortions in perceptions of self and others, and reasons for being in the program. Each new resident stands before the community and is questioned by the program director about the road that led him to the program and his motivations for treatment. This "hot seat" clinical interview usually brings forth the resident's methods of coping that will impede his growth in the program. The interview often also provides the first experience of being emotionally vulnerable before others and succeeding. Consequently, the veteran's avoidant defenses begin to be penetrated, and he can start acquiring a sense of competence in interpersonal situations.

Additionally, cognitive therapy techniques are introduced early in the resident's stay as a model to help the patient combat black-and-white thinking, personalization, over-generalization, and minimization (Beck & Emery, 1985). These efforts provide an immediate and concrete tool that community members can use to begin discriminating current life situations from those in combat. Such cognitive techniques additionally offer new skills to cope with emotional discomfort that in the past would have been handled impulsively through rage, hostility, withdrawal or other "acting out" behavior. Therefore, these groups further generate an increased sense of self-efficacy through modeling and successive approximations of instrumental coping.

Another crucial step in the commitment to treatment is taking responsibility for reducing the addiction to alcohol. A number of groups focus upon helping the patient understand the positive and negative consequences of alcohol and drug use. Once the patient becomes less defensive about the problem, he is able to review how using alcohol has affected his life. Equally important to this process is underscoring the potential gains of not drinking, and then building a new life that can be more satisfying and meaningful. Group therapy leaders consequently attempt to praise even the smallest signs of progress in the abstinence process.

Furthermore, the program recognizes that there is no single, current form of alcohol treatment that works for everyone (Miller & Hester, 1989). The inpatient program therefore offers a weekly Alcoholic Anonymous meeting, teaches specific skills such as assertiveness, gives formal relapse prevention training, and strongly recommends disulfiram use. These components support the milieu experience of learning to deal openly and honestly with others, and taking responsibility for one's behavior. Thus the program provides residents with regular exposure to a variety of interventions, so that they become informed consumers. As a result, prior to discharge, the veteran becomes an active agent in establishing, and then following, an individualized aftercare plan.

The program also incorporates a variety of behavioral activities to help manage stress. Residents receive training in progressive muscle relaxation and guided imagery, specific anger management techniques, such as time-outs and self-talk, and aerobic exercise. A local softball league team, a nationally recognized choral group, volleyball, and swimming provide further daily activities. By practicing some combination of techniques and activities, residents begin to acquire, or re-acquire, an increased sense of control over their environment. Moreover, they are taught that each of these strategies may help to reduce physiological as well as psychological cravings for alcohol (*cf.* Pomerleau et al., 1983).

Residents in the PTSD/Alcohol Program additionally have interpersonal process groups and community meetings to begin addressing the interpersonal here-and-now concerns of the residents. The process groups meet for an hour and a half, these times per week. Therapists in the group are active in challenging avoidant ways of coping, and use didactic and modeling techniques to teach members to deal with each other honestly and directly. Community meetings occur twice per week for the entire 30-bed dual diagnosis ward. These meetings are run by "ward officers," but are not only for conducting ward business. They are also a forum for discussing community-wide concerns, addressing conflicts between members who are not in process group together, saying good-bye to graduates, reviewing weekend passes, and conducting formal treatment reviews.

A formal treatment review occurs every 28 days and provides the resident and staff with valuable information. It represents an opportunity to

acknowledge successes publically, reinforce new behaviors, and provide corrective feedback; these activities therefore increase discriminative learning and generalization of new coping strategies. In the first part of the review itself, the resident stands before the community and evaluates his involvement on the following variables over the past month: expressing/showing his emotional discomfort, supporting others who are in distress, self-disclosing about significant past events, self-disclosing about significant present situations, giving other residents feedback, asking other residents for feedback, and applying feedback that he receives. In turn, the resident's process group, the other community members, and the staff vote on whether they see the resident participating in each of the above behaviors.

The second phase of the treatment review offers the resident the opportunity to describe his participation in the above domains. He is asked to articulate for the group the problem areas he has identified in the last month, the coping strategies he has used to address these issues, what behaviors have and have not been helpful, and the methods/defenses/old coping strategies that have interfered with incorporating new behaviors. Last, the floor is opened to the entire community to provide verbal feedback to the resident. Furthermore, as much as possible, the feedback comes from other residents, for this emphasizes an empowerment ethic that also supports the other members' sense of self-efficacy, and personal responsibility for their lives.

At the conclusion of the first month, the staff evaluates the data from the formal assessments, the treatment review, and their other clinical experiences with a new resident. The psychometric testing examines the presence, absence, and severity of his PTSD symptoms and other diagnoses. The treatment review and clinical observations provide the data to evaluate to what extent he has met the objectives of Phase 1. The seven process variables utilized in the treatment review organize the staff's thinking as treatment recommendations are formulated. With the ratings, our experience is that residents progressing satisfactorily are generally showing their discomfort, supporting other residents in distress, self-disclosing, and giving feedback. These behaviors are fairly ongoing, and on some occasions, affect-laden. Typically the resident, the majority of his process group, the majority of the staff, and some other community members endorse each of these items. The latter two variables, asking for and applying feedback, appear to require the

greatest risk and are not strong predictors of participation at this point.¹ Most residents move on to Phase II, but some are discharged to outpatient treatment, and some are held in Phase I a bit longer to further develop the best treatment plan. Thus, the data are combined to generate recommendations that are as individualized as possible. The bulk of the Action stage then begins as the veteran enters Phase II.

Phase II: Trauma Work, Interpersonal Development, and Skill Building

As residents become acclimated to the program, and their commitment and motivation solidify, they move increasingly into the Action phase, leading to a new set of treatment objectives and methods (see Figure 2). This includes the practice of cognitive therapy and problem solving skills learned in Phase I. Members begin using the antecedent-behavior-consequence (ABC) technique (e.g., Beck, 1973; Ellis, 1962) to deal with situations that arise in the program. When a problem arises, they define it operationally, generate alternative solutions, apply the chosen response, and evaluate the outcome. (D'Zurilla & Goldfried, 1971; Fairbank, 1989).

An important aspect of the program is that throughout his Phase II stay, the resident receives additional education and practice in building new skills. The process begins with didactic learning, followed by imaginal and/or role play work, and leads to application in present-day situations. Some of these, such as assertiveness training, teach coping methods for specific types of stressful situations. Others, like leisure education, assist the residents in developing more global strategies to reduce and/or manage stress. The tools provided by these activities are then incorporated into current situations as they arise during the resident's stay. As an example, most of the veterans in the program tend to view the world in dichotomous terms, and most have considerable difficulty managing ambiguity, intimacy, and interpersonal conflict. They tend to either get angry and act out, or "stuff" their feelings and withdraw. However, when lessons from assertiveness training are applied in process groups, residents who are angry with each other experience new and effective ways to achieve resolution. Although we have yet to empirically validate the long

¹Data on the usefulness of this system are currently being collected, and will be submitted for publication at a later date.

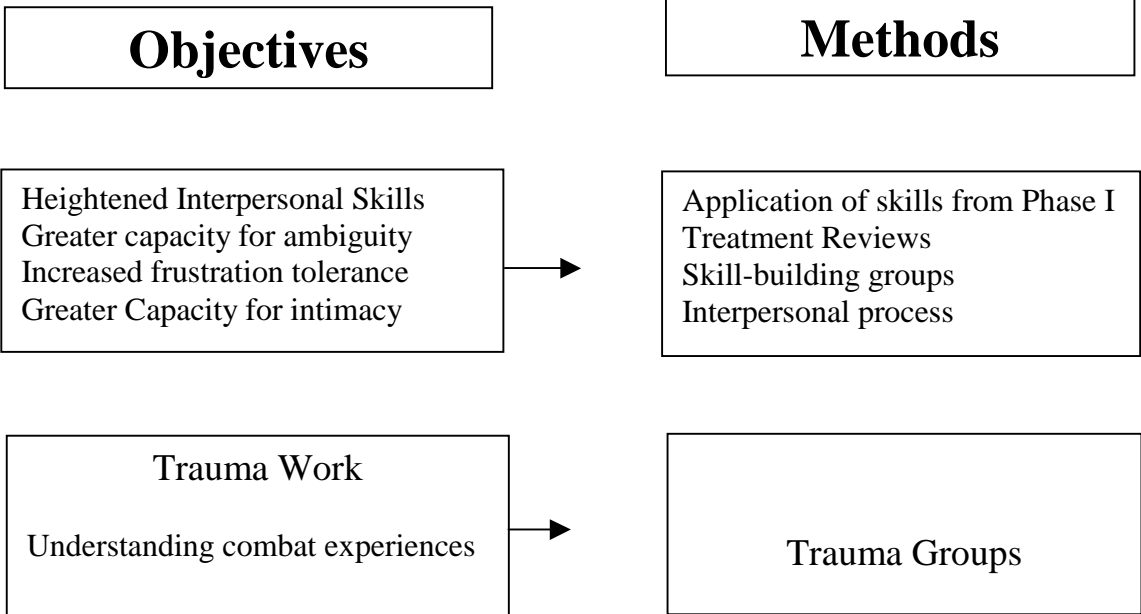


Figure 2

term usefulness of these skill-building components, residents consistently hail them as useful, because they are practical and the results are tangible.

When residents move to Phase II, most have just begun to practice taking responsibility for their behavior on the ward and communicating thoughts and feelings directly. The interpersonal focus continues and deepens as community members move into a smaller process group and a combat trauma group. These two groups are the settings for some very intensive work, and so tend to elicit strong avoidance behavior. Therapists therefore still must be active, particularly in the early stages of the groups to create a climate where residents assume full responsibility for their discomfort. One method that assists the process is having the same co-leaders in the two groups. The psychotherapy group is smaller than in Phase I, but still meets for an hour and a half, three times a week. The expectation of personal-responsibility and active participation, however, remains. In the first two weeks, the therapists are active in teaching and modeling communication skills, and also challenge the patient's strategies of avoiding interpersonal risks. Through modeling and gradual shaping of

self-disclosure skills, an increased confidence in tolerating affect emerges within the group. Consequently, each resident develops an adaptive, interpersonal feedback loop to help assess and guide his behavior.

For example, members often enter the program convinced the only ways to handle conflict are violence or total avoidance, yet in group they participate in conflict resolution and experience intimacy that does not prove emotionally or physically devastating. Such experiences can facilitate the extinction of previously learned cognitive, affective, and behavioral avoidance, particularly as these responses relate to the use of alcohol. Moreover, residents learn in group that these more direct methods to deal with strong feelings can actually strengthen relationships. The outcome is new and adaptive learning that heightens residents' sense of being an effective agent in their lives.

Exposure-based therapy in a developmental framework provides the structure for concurrent exploration of the intense, often overwhelming emotions related to their combat trauma (Rozytko & Dondershine, 1991). Initially, the residents

spend some time articulating their values, beliefs, and coping strategies prior to their military experience. The conceptual framework of the program involves deciphering the veteran's inter- and intrapersonal dynamics prior to the military, because they represent the foundation for how he managed the stress of combat. Then combat memories are carefully elicited. Intense feelings of anger, pain, fear, and guilt surface. Once these emotions are expressed and validated by the group, distortions and self-judgments about the events are challenged, and true grieving for lost comrades also can now begin. Veterans in this group also discover they are not alone, not "crazy," and that the tears do stop. The therapists actively support the efforts of the person in the room and in his attempts to cope successfully in combat. Sharing the great emotional intensity within this group thus assists the members in placing their combat experience in a new perspective, while also strengthening the bonds within the group. As a result of this process, and perhaps most importantly, they discover that they can again have hope for the future.

In addition to building positive experiences of self, the trauma group therapists have another crucial role. Most of the PTSD/Alcohol Program residents have a long history of coping with stress by using alcohol. During and after each person's debriefing, the therapists therefore articulate vulnerable areas or themes in the person's life. Typically, these themes originated in childhood and were amplified in combat. The case of Willie provides a good illustration. Willie grew up in an alcoholic family, and his father would come home drunk, and beat Willie for no apparent reason. Willie made sense of this by deciding whatever was wrong was his fault. At age 18, Willie decided to join the Marine Corps, and volunteered for Vietnam. While out on patrol, his buddy, Harry, was killed by a mine. Willie had let Harry walk point that day--therefore Harry's death was his fault. Therapy involves walking back through the incident to uncover the repressed feelings of helplessness and grief that Willie could not experience at the time. Moreover, the group then helps the veteran look at how he has cognitively held onto that incident, and challenges the irrational belief structure. Such exposure therapy, combined with cognitive restructuring that occurs in a group setting, further extinguishes the avoidant and self-destructive behaviors related to themes of intimacy, abandonment, and loss.

Obviously each resident's dynamic themes, or patterns, suggest the types of stressors that will appear in the future, and group members utilize this information in their relapse prevention learning. The formal enhanced relapse prevention training begins when the trauma group is about two-thirds completed. By that point, residents generally have a good idea of their themes, even if they have not completed their own "combat focus" yet. The group is based on Marlatt & Gordon's (1985) model, as modified by Abueg & Kriegler (1988). It meets three times a week for an hour and a half, and runs for five weeks. The early portion of the group focuses on education and assessment; members learn about the concepts of "lapse" and "relapse," and complete exercises to determine the types of situations where they are most vulnerable to drinking.

The completion of this work marks the decision point for movement from Phase II and the Action stage to Phase III and the Maintenance stage. The treatment review process is once again combined with clinical observations to update the resident's treatment plan. Within the structured environment of the inpatient setting, the expectation is that the resident has developed a solid feedback loop regarding his behavior, and has integrated a variety of new and adaptive coping mechanisms. The treatment review process should acknowledge these efforts in four ways: 1) that in the process ratings the resident will be credited, and credit himself, with asking for and applying feedback; 2) that the endorsement of these two process variables (as well as the other five) will not just be from his process group members and staff, but also from the vast majority of the remaining residents; 3) that the resident will be able to describe his feedback loop and coping skills, and 4) that the other residents and staff will also offer specific examples of the resident's behavior congruent with such a process. Based on this information, most of the residents move forward to Phase III. Those that do not meet the above criteria receive explicit recommendations, such as repeating an earlier activity or meeting individually with a staff member, to finish Phase II. Upon successful completion of the additional Phase II work, they too progress to Phase III.

Phase III: Relapse Prevention and Skill Practice and Generalization

With the completion of the trauma group and the first half of the relapse training, residents

move into the 2 to 6 week Phase III, whose goals and interventions are shown in Figure 3. The next segment of the relapse group involves learning progressive muscle relaxation. In this relaxed state, residents are visually guided through potential relapse situations to 1) help decrease the anxiety associated with experiencing these cues, and 2) to practice visually new behaviors that lead to a "successful" outcome, i.e., not drinking. Once members become facile in visual practice, the concluding sessions are devoted to role playing adaptive responses to each individual's high-risk situations. A unique characteristic of these techniques is the incorporation of the signs, symptoms, and themes of PTSD and trauma as high-risk cues. The anniversary of the death of a close friend, for

example, may continue to be a set-up for depression, isolation, and abusive drinking.

To solidify further new skills and coping strategies, residents in the latter portion of their inpatient stay take on additional responsibilities. Each functions as a role model and a community leader who orients newly admitted residents to the program. Additionally, a senior community member begins to reintegrate into the community through local volunteer work and/or work for pay, and uses weekend passes to practice his skills; the program then uses the process group in this phase to address issues that arise in the world outside the hospital. Finally, because the veteran faces the challenging task of moving from a structured therapeutic community to an unstructured outside world, he is

Objectives

Methods

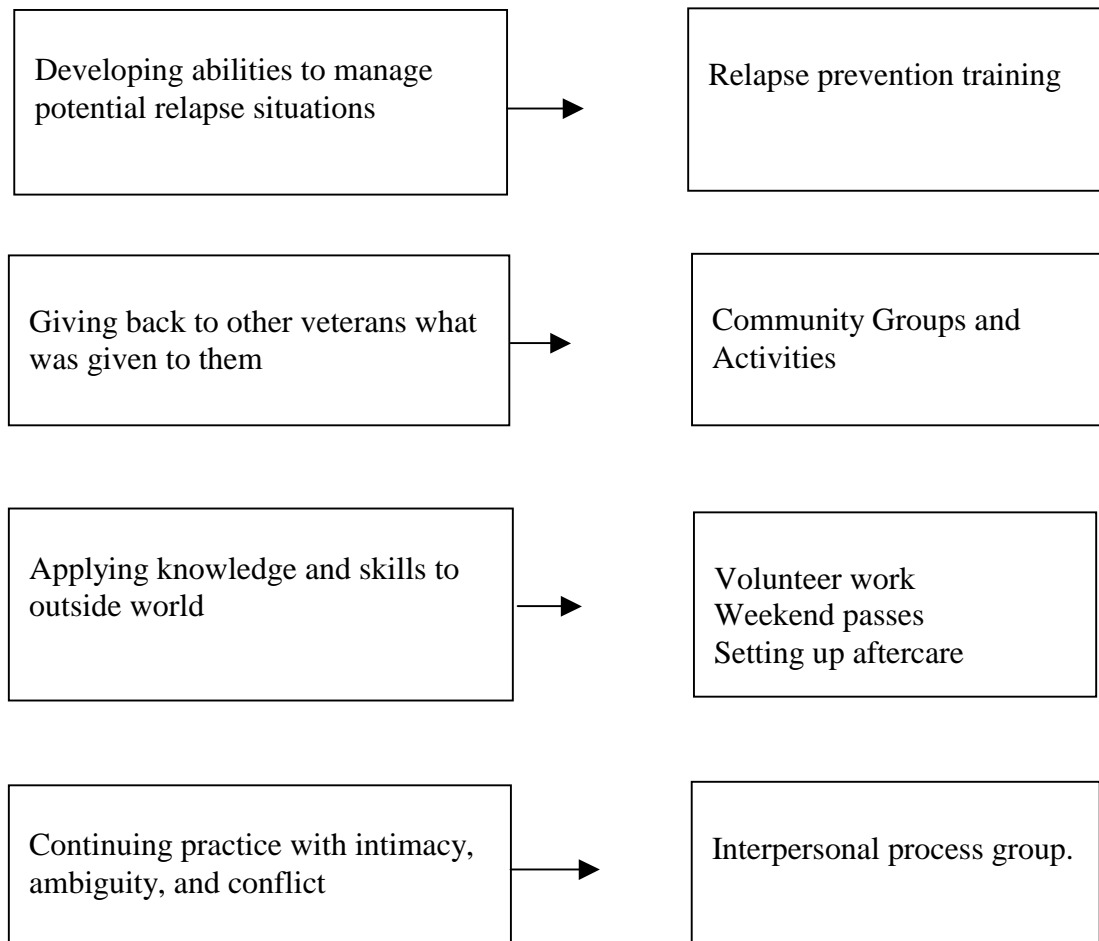


Figure 3

charged with creating an aftercare plan that articulates his resources, skills, potential problem areas, and further needs. This includes the gamut of practical issues from finances and education to support groups and family therapy. Staff then works with the resident to implement as much of the plan as possible prior to discharge.

Last, shortly before discharge, the program holds formal graduation ceremony for the outgoing group of residents. Most importantly, the veteran stands before the community and says goodbye. He has the opportunity to articulate, with all fellow residents and staff present, his program experiences for himself and others; the floor is then opened for community members to offer any words or gestures to the individual. The ceremony concludes with the presentation to the graduate of a lapel pin in the shape of Pegasus, the program symbol of growth and freedom. Residents regularly report that this is a difficult and meaningful experience for them because they have been unable for two decades to have a direct and heartfelt separation. Frequently there are tears, usually there are words of hope and feelings of accomplishment. and always there is modeling and inspiration for the new residents.

Summary

The consequences of all this inpatient work are captured by the four words on the banner that hangs in the program dayroom – *Humility, Trust, Integrity, and Pride*. While in the program, the veterans have a series of experiences that teaches them that there is a way to understand who they are, how they got where they are, and skills to help them get where they want to be in the future. By being willing to push beyond the ingrained defenses of anger, guilt, depression, and isolation the veterans learn, 1) that there are people who can understand them, and 2) that they are responsible for how they conduct their lives now and in the future. The outcome is a sense of humility and a sense of self-efficacy and control over their lives.

Additionally, the program continuously challenges the veterans to trust others by being emotionally vulnerable, something they have avoided for over twenty years--often through the use of alcohol. If they can lower their defenses, the veterans rediscover their capacity for forming an emotional bond with other people. Increased trust also allows them to walk slowly and carefully through their combat experiences and re-examine

how they made sense of what happened. This process further provides the opportunity to learn new and adaptive coping strategies; the relapse prevention work, for example, requires the development and implementation of new ways of dealing with high-risk drinking situations. "Trust" therefore is a symbol for heightened self-efficacy.

Integrity and pride fit tightly together. Integrity in the program requires direct, honest communication with others, with a heavy emphasis on the process of doing the right thing for the right reason. Actively and continually engaging in the program then spawns a new form of pride. This is not the angry, entitled pride the residents had on admission, but a calmer, more natural pride in being a person who has strengths, who is responsible for his choices, and who recognizes that what is important is being true to yourself and those that matter to you.

Therefore, with Humility, Trust, Integrity, and Pride, outcomes are still valued, but setbacks and stress are less likely to be perceived as personal attacks or create lasting doubts about self-worth. For example, maintaining abstinence and improved PTSD status is an ongoing process, not a single outcome. Relapses, or setbacks, are inevitable, and increasing progress might/should be observed over time (Institute of Medicine, 1990). The package thus is designed to help veterans develop, practice, generalize, and begin maintaining a set of adaptive coping tools, and most importantly, a sense of hope where there was none before.

Future Implications

As mentioned early on in the article, the evolution of this program has been strongly tied to program evaluation and theory driven research. Our current program development is directly informed by the results of these ongoing research efforts. For example, one of the cornerstone constructs of the program, relapse prevention for the dually diagnosed, has been the subject of at least two empirical studies. The first showed that a formal intervention aimed at teaching skills to avert relapse in PTSD and alcoholism had important impact on patients well beyond the treatment program, i.e., through one-year follow-up (Abueg et al., 1989; Abueg & Fairbank, 1992). Aside from the percentage of patients abstinent at 3-month follow-up being remarkably high (>60%), the average number of drinks per day was significantly suppressed among those patients

who did relapse and who received enhanced re-lapse prevention training. Moreover, improved drinking status among the specially treated group members maintained throughout the one-year follow-up.

Additional research was aimed at developing more powerful, enduring interventions which matched patient needs. One study, for example, examined the self-reported precipitants to alcohol relapse (Abueg, Chun & Lurie, 1990) among 107 PTSD-alcohol patients. Nearly 25% of the patients, in an open-ended question format, indicated that in fact PTSD related symptoms "led to a recent bout of heavy drinking." Equally interesting were findings that commonly implicated two other high-risk categories: depression, including isolation, sadness, and loneliness, and celebratory or positive social situations. The implications of these data were immediate in terms of providing greater focus in our program to enhanced relapse prevention training. Although we attend to PTSD symptoms as high-risk precipitants, balance must be maintained in addressing the isolation and other "set-up" situations identified by these preliminary data. Clinicians in our program stay abreast of these developments and assist in the iterative modifications of group treatment protocols.

One important conceptual strand of research is also under way. Now that we have evidence suggesting that a stage model can be successfully implemented for the multiple needs of addicted and traumatized veterans, we are faced with substantively linking process measures with long-term outcomes. For example, if a patient shows dramatic acquisition, maintenance, and generalization of social skills, does this bode well for long-term coping post-discharge? Our Center has recently received grant funding from the Department of Veterans Affairs to study the effects of the interventions described herein in a randomized clinical trial in the context of aftercare. Since most participants from this study will emerge from the PTSD-Alcohol Program, we will be able to carefully map the relationship between within-program changes with a host of personal, familial, and community adjustment variables. Our initial emphasis will be to evaluate the usefulness of the program for those who complete all three phases. In addition, future efforts will empirically assess the appropriateness of the decisions made during the treatment, such as discharge after the first phase or remaining in Phase II for additional treatment.

Our hope with empirically based program development is that we will be able to maximize our effectiveness with a traditionally undeserved population. Moreover, we hope the strength of this model is in the formal conceptual attention to client changes over time, and to filling in the gaps in our continuity of care to our war veterans.

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