Journal of Depression and Anxiety
ISSN: 2167-1044

Faber and Gray, J Depress Anxiety 2012, 1:4
DOI: 10.4172/2167-1044.1000121

Research Article Open Access

Evaluation of a Program Designed to Facilitate Understanding of Veterans' Post-Combat Adjustment and Reintegration: Pilot Study of Faber Post-Trauma Model

D. C. Faber[1] and Matt J Gray[1]*

[1]*Faber Groupsynergy, llc, University of Wyoming, Laramie, WY 82071-3415, USA*

Abstract

The present investigation was designed to evaluate a psychoeducational intervention designed to increase understanding and awareness of adjustment and reintegration issues experienced by combat veterans following deployment. The specific issues addressed by this intervention are broader in scope than formal psychopathology or disorders experienced by a minority of combatants. Instead, the domain of difficulties covered pertains to many or most individuals returning from combat. Specifically, difficulties with emotion regulation, social functioning, planfulness and stress management among other concerns were delineated. Military and civilian attendees (N = 100) of two separate presentations of this model were asked to report on familiarity and understanding of reintegration difficulties incurred by homecoming combat veterans. Analyses indicated that relative to pre-intervention scores, attendees reported significantly greater understanding of numerous aspects of the post deployment experience and effect sizes were generally large (i.e., Cohen's d's were generally in excess of .8 at the item level and aggregate scale pre-post change = 1.04) [1].

Approximately 10-20% of the two million U.S. troops who have served in the wars in Afghanistan and Iraq experience significant mental health difficulties including PTSD, depression, and anxiety (e.g., Hoge CW et al. [2] and Hoge CW et al. [3]). Because PTSD and other mental and behavioral health problems among veterans of war are pernicious and disabling (e.g., Dohrenwend et al. and Prigerson et al. [4,5]), a major public health challenge is to identify ways to intervene as soon as feasible to prevent spiraling dysfunction, suffering, premature discharge, and chronic problems [6]. Certainly, a number of evidence-based approaches for treating formal disorders emanating from combat have been developed and are being disseminated. While this is certainly encouraging, less attention has been devoted to describing broader post-deployment issues and concerns among returning Veterans. Because the great majority of Veterans do not experience formal psychopathology, it is important to consider whether conventional treatment development approaches adequately address more normative reintegration difficulties that might be experienced by a broader spectrum of military personnel.

Encouragingly, a number of recent interventions have been developed to acquaint community members and community mental health service providers about Veterans' needs and available resources and to increase connectivity between VA and community providers (e.g., Straits-Troster et al. [7]). Unfortunately, the great majority of such programs maintain a focus on formal psychological disorders such as PTSD, depression and substance dependence. Certainly these are important considerations and continued efforts to address these undertreated issues among returning Veterans are laudable. However, reintegration to civilian life after lengthy and/or repeated deployments can be very challenging and fraught with problems regardless of whether one has a formal disorder or not. Moreover, concerned family members, significant others and community members often lack a substantive understanding of combat, the deployment experience and changes in priorities and functioning that often occur when a combatant returns to civilian life. Indeed, researchers have observed social functioning difficulties that can occur when veterans transition back into civilian contexts [8] and others have noted difficulties finding meaning and purpose to their lives after completing military service [9]. Finally, Sayer NA et al. [10] identified a number of reintegration difficulties endorsed by veterans with and without PTSD, confirming that the historical, singular focus on psychopathology and combat stress injuries may not adequately address all of the substantive needs that returning service members have.

To address this relative void, an informational model was developed to describe more normative post-deployment difficulties encountered by many Veterans seeking to reintegrate into civilian life. The Faber Post-Trauma Model (FPTM) was developed by the first author – an Operation Enduring Freedom (OEF) Veteran based on his personal experiences and consultations with other returning combat veterans. The model (described in more detail below) was designed to normalize and elucidate post-deployment difficulties for returning Veterans as well as Veterans' friends, family members and concerned community members. Though the content is certainly relevant for those who may be experiencing combat-related pathology (e.g., PTSD), it seeks to address pervasive difficulties experienced by returning Veterans and to ease transition back into civilian life. The present study was designed to provide initial, pilot data for the degree to which attendees of an overview of the FPTM obtained greater understanding of the plight of returning combat Veterans.

Method

Participants

Participants included all attendees (N = 100) at either of two

***Corresponding author:** Matt J Gray, PhD, Associate Professor of Psychology and Director of Clinical Training Psychology Department, 1000 E. University Ave – Department 3415,University of Wyoming, Laramie, WY 82071-3415, USA, Tel: (307)766-2927; E-mail: gray@uwyo.edu

Received May 23, 2012; **Accepted** June 23, 2012; **Published** June 25, 2012

Citation: Faber DC, Gray MJ (2012) Evaluation of a Program Designed to Facilitate Understanding of Veterans' Post-Combat Adjustment and Reintegration: Pilot Study of Faber Post-Trauma Model. J Depress Anxiety 1:121. doi:10.4172/2167-1044.1000121

presentations who agreed to complete anonymous pre-presentation and post-presentation surveys about their knowledge of Veterans' experiences with homecoming and reintegration. The first presentation was delivered to the Wyoming National Guard, but partners, spouses, friends and community members were also invited to attend. Commanding officers informed all Guard personnel about the presentation electronically and provided information about date, location, time and foci. All interested personnel and families were encouraged to attend. The second presentation was delivered at the University of Wyoming. Faculty, staff and student list servs and the university website were used to announce the presentation and fliers were posted on campus and at various businesses in town. Although this particular audience largely consisted of students, faculty members and civilian community members, Veterans and military personnel were in attendance as well. More specifically, 27% of respondents were in the National Guard, 15% were in other branches of the military, 13% were military spouses or partners, 12% were military family members, 7% were friends of military personnel, and the remaining participants did not endorse a military affiliation or relationship to military personnel. The mean age of the sample was 45.8 (SD = 14.35), and 51% were male and 49% were female. In terms of ethnicity, 7% were Hispanic or Latino, with the remainder being non-Latino. In terms of race, 84% reported being Caucasian, 4% were American Indian or Alaskan Native, and the remaining participants reported being of another race (8%) or did not report racial status (4%).

Measures

In addition to the demographics measure, each participant completed a brief 10-item inventory designed to evaluate the knowledge of attendees with respect to core aspects of Veterans' post-combat adjustment and reintegration experience. Items were rationally derived based on content of the model and information to be presented as well as reintegration difficulties commonly encountered by Veterans and their families as gleaned from the aforementioned empirical literature. Though there is conceptual overlap between some of the items (e.g. emotional and psychological functioning), care was exercised to ensure that items were not functionally equivalent. No two items exhibited a stronger correlation than r = .75, indicating that no more than 56% of an item's variance could be accounted for by any other single item. Further, content provided in the presentation helped to conceptually delineate psychological and emotional functioning. Specifically, using 5-point Likert-type scaling, the measure inquired about respondents' knowledge of Veterans' emotional functioning, psychological functioning, social functioning, relationship with significant others, post-combat changes in life priorities, difficulties with future orientation and planning, mental health needs, suicidality, available mental health approaches, and likelihood of getting treatment if needed of assisting Veterans in accessing services. These domains reflected the core content of the Faber Post-Trauma Model designed to convey information about Veterans' reintegration and post-combat adjustment. The measure appears to be quite reliable as the internal consistency was very high (Cronbach's alpha = .93 at pre-intervention, .94 at post-intervention collection periods).

Procedure

Before and after each presentation of the Faber Post-Trauma Model (described in more detail below), audience members were given the measures indicated above. There were no measures of psychological distress administered because it was deemed likely that a substantial portion of the audience would be community members or friends and family members of Veterans as opposed to Veterans and military personnel themselves. This was indeed the case as slight majorities were civilians. The focus of the present study was to evaluate whether knowledge of reintegration and adjustment issues increased as a result of hearing the presentation. Accordingly a pre-post design was used to evaluate overall and item-level increases in knowledge of these issues.

Faber post-trauma model

Though most formal efforts to elucidate returning Veterans' experiences have focused on formal psychopathology (e.g. PTSD, substance abuse, etc.), the intent behind this model is to explicate factors that are common to most veterans independent of any formal disorders they may be experiencing. In that sense then, it attempts to reach a broader audience than those requiring formal treatment or warranting a formal diagnosis, and it attempts to speak to broader readjustment issues and concerns than is often the case. Although it is impossible to delineate the model in extensive detail given the space constraints of this manuscript, more detailed information is available upon request from the first author. The model was developed by the first author who served a combined 20 years in the United States Army and Wyoming National Guard. The model was informed by personal experiences in, and returning from combat, including service in Afghanistan for which he received the Bronze Star and Combat Action Badge. The psychoeducational intervention presented to each of the two groups lasted approximately 90 minutes and addressed the content summarized below.

In essence, the FPTM seeks to describe commonly experienced but seldom-discussed aspects of the returning combat Veteran's experience in five domains. First, a core assumption is that that returning Veterans are present-focused and not necessarily relegated to thought processes dominated by past events. While it is true that formal PTSD is characterized by intrusive recollections of past traumatic events, this is not the totality of their cognitive experience. Further, for those who do not formally have PTSD, there is no reason to believe that past-focused cognitions would be any more relevant for returning Veterans than for civilians. The FPTM holds that many if not most difficulties experienced are related to difficulties connecting with others and meeting demands of a society that has not been deployed.

Second, it is noted that Veterans have concentrated emotional intensity and that they are affectively focused. This stands in contrast to antiquated and unsubstantiated notions that traumatized populations are "emotionally numb". Though the model addresses broader issues than those pertaining solely to PTSD populations, it is worth noting that PTSD by definition is a fear and anxiety-based disorder, is highly comorbid with depression, and includes increased anger and irritability as a defining symptom. It appears then that at least where negative emotionality is concerned, emotions are certainly not numb but if anything are accentuated [11]. Further, there is some evidence to suggest that apparent instances of "emotional numbing" in PTSD are not the result of dampened emotional experience but instead are the result of intentional efforts to conceal or withhold emotion in certain contexts. This concentrated emotional intensity is manifest in extreme displays of emotion – often negative affect – by returning combatants.

Third, transitioning from a "fight-or-flight" context characterized by more survival-oriented brain functioning (e.g. more amygdalar activation) to a civilian context where future orientation, planfulness and delayed gratification are more optimal strategies can be a significant challenge for returning veterans. In theatre, it is necessary to respond rapidly to immediate circumstances for one's very survival, and long-

range planning can actually be a liability in the context of combat. In civilian life the optimal strategies for adaptive functioning are often exactly the opposite – i.e., one must inhibit acting on immediate needs and impulses and instead plan for longer term outcomes. This is true in occupational and social contexts. Accordingly, the third main focus of the FTPM is a metaphorical frontal lobe transformation, where higher level cognitive processes and strategies can be impaired as a function of chronic exposure to combat where immediate survival focus is essential. Importantly, although changes in frontal lobe activity such as the anterior cingulate cortex have been implicated in PTSD – e.g., Sayer NA et al. [10] – the FPTM is designed to address reintegration difficulties for a broader population of returning Veterans, not just those with PTSD. Accordingly, it does not allege or suggest that the majority of returning Veterans have formal structural or functional frontal lobe deficits or damage.

Fourth, living after accepting death addresses the fundamental change in priorities and motivation for daily tasks once an individual has confronted and accepted their own death or the death of others and survived. While this re-prioritization can be beneficial in that individuals may be less likely to worry about minutiae or comparatively minor stressors, it can also create problems when readjusting to civilian life as a Veteran may experience apathy and exhibit a failure to respond to expectations of others in social and vocational settings because they are deemed to be unimportant. This component of the model seeks then to instill an appreciation for advantages of living after accepting one's death (i.e., being less concerned about objectively minor stressors) while simultaneously acknowledging that optimal functioning post-deployment requires accountability and engagement in social and vocational contexts.

Finally, the FPTM makes a distinction between psychological trauma and stress such that individuals do not catastrophize or accentuate emotional responses to the later by virtue of having a trauma history. Concrete suggestions for responding more effectively to mundane stressors (e.g. leaving the situation, taking a walk, etc.) are provided in order to illuminate behavioral choices that can de-escalate a stressful situation. The FPTM is not designed to be "curative" for those with severe combat-related psychopathology or distress and is not a therapeutic approach per se. Instead, it is an educational tool designed to educate Veterans, supportive others and community members about common difficulties encountered by Veterans when reintegrating after deployment. Those who have more severe distress are given contact information for mental health professionals and services available locally.

Results

To evaluate whether attendees' understanding of Veterans' reintegration experiences improved as a function of attending an overview of the FPTM, t-tests were conducted for each item to evaluate self-reported change from baseline to post-presentation. Similarly, all 10 items were aggregated for a total score to evaluate overall increase in understanding of post-combat adjustment and re-integration. Cohen's d effect size analyses were also conducted for each item and the aggregate scale changes from pre-presentation to post-presentation to depict magnitude of change.

As depicted in Table 1, all items reflected significant increases in understanding as a result of the presentation. At the individual item level, effect sizes were all in the medium to large range (Cohen's d's ranging from .44 to 1.18) with the majority of effect sizes exceeding conventional standards for a large effect (d = .8; Cohen, 1988). The smallest effect, though still medium in magnitude was increased likelihood of seeking mental health services (or facilitating that for Veterans if the respondent was a friend or significant other) if the event that distress was significant. In terms of the overall increase in understanding of Veterans post-deployment adjustment and reintegration experiences, the total scale change from pre to post was statistically significant and the effect size was large (d = 1.04). The overwhelming majority of respondents (79%) reported increases in knowledge that were moderate in size (d = .50) or larger. There were no significant differences between military and non-military personnel in terms of their reported change in understanding as a result of this intervention (Cohen's d = 1.01 and 1.06, respectively).

Item	Pre	Post	t	d
Veterans' emotional functioning	3.01	3.69	6.29**	.87
Veterans'psychological functioning	2.90	3.64	6.80**	.94
Veterans' social functioning	3.02	3.72	6.27**	.85
Relationships with significant others	3.12	3.67	4.96**	.68
Changing priorities post-combat	2.92	3.78	7.28**	1.00
Future-orientation and planning	2.82	3.80	8.62**	1.18
Mental health needs	3.00	3.56	4.91**	.68
Suicidal thoughts of some veterans	2.94	3.57	5.48**	.76
Traditional mental health services	2.77	3.46	5.76**	.78
Inclination to seek services if needed	3.68	4.05	2.09*	.44
Overall change (aggregate of items)	26.49	32.88	7.48**	1.04

*$p < .05$; **$p < .01$

Table 1: Pre to Post Change in Self-Reported Knowledge of Veterans' Adjustment and Reintegration Difficulties (N = 100).

Discussion

Though preliminary, these findings demonstrate that Veterans, friends and significant others, and community members came away from the presentations with an enhanced understanding of common difficulties that Veterans encounter when reconnecting with civilian life after combat. The greatest increases in understanding pertained to Veterans' changing priorities after combat and difficulties that Veterans encounter with respect to future-orientation and planning abilities following combat. These domains are particularly noteworthy as they are relevant to aspects of the combat experience that often go unaddressed by conventional psychopathology models of combat stress. Specifically, confronting and accepting one's death in the context of combat can significantly alter appraisals of normative stressors and responsiveness to expectations in vocational and social contexts.

The smallest change – though still significant – pertained to inclination to seek services in the event of significant distress. This is to be expected given that the FPTM is not designed to be an introduction to therapy and generally focuses on common reintegration difficulties as opposed to focusing on psychological disorder per se. Further, inspection of pre and post presentation means demonstrates that respondents were generally quite receptive to seeking such services as needed, so it would be difficult to characterize this as a limitation of the model in an absolute sense.

Although these initial findings provide preliminary support for the FPTM, the study is not without limitations. The study relied exclusively on self-report survey data and lacked a control group. Because the outcome of interest is perceptions of one's own understanding of Veterans' experiences, a self-report approach is most viable. Nevertheless, future studies should include follow-up assessments to discern whether perceptions of increased understanding of Veterans' reintegration experiences are maintained over time relative to individuals not exposed

to this model. Additionally, because both presentations were open to any and all interested individuals, it is not clear how representative the present samples are (for either military or non-military attendees) and how they may differ from individuals not electing to attend. This study was also reliant on a measure of understanding of Veterans' reintegration difficulties that was designed expressly for the present study and has not seen prior use. Although we would like to have used a validated and established measure, we were unable to find one in the published literature which focused on and adequately represented the intended domain. Although more extensive psychometric properties would be ideal, the very high internal consistency, lack of excessive empirical overlap among items and sensitivity to intended change provide preliminary, if suboptimal, evidence of its psychometric acceptability. Further, this study was not designed to evaluate whether enhanced understanding of such experiences translates into more functional outcomes for Veterans or enhanced support for Veterans by significant others. Future, longitudinal studies will need to evaluate the functional impact of exposure to the FPTM in effecting such outcomes. We are in the process of beginning such studies at present. Until such studies are complete, however, the present findings from a diverse group of individuals who are concerned about Veterans' reintegration suggest that the FPTM facilitates understanding and awareness of challenges experienced by Veterans returning home after combat.

References

1. Cohen J (1988) Statistical Power Analysis for the Behavioral Sciences. (2ndedn), Hillsdale, NJ: Lawrence Erlbaum Associates.
2. Hoge CW, Auchterlonie JL, Milliken CS (2006) Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 295: 1023-1032.
3. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, et al. (2004) Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Engl J Med 351:13-22.
4. Dohrenwend BP, Turner JB, Turse NA, Adams BG, Koenen KC, et al. (2006) The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods. Science 313: 979-982.
5. Prigerson HG, Maciejewski PK, Rosenheck RA (2001) Combat trauma: trauma with highest risk of delayed onset and unresolved posttraumatic stress disorder symptoms, unemployment, and abuse among men. J Nerv Ment Dis 189: 99-108.
6. http://www.istss.org/AM/Template.cfm?Section=PTSDTreatmentGuidelines&Template=/CM/ContentDisplay.cfm&ContentID=2323
7. Straits-Tröster KA, Brancu M, Bob G, Sheryl P, Charlotte W, et al. (2011) Developing community capacity to treat post-deployment mental health problems: A public health initiative. 3: 283-291.
8. Shea MT, Vujanovic AA, Mansfield AK, Sevin E, Liu F (2010) Posttraumatic stress disorder symptoms and functional impairment among OEF and OIF National Guard and Reserve veterans. J Trauma Stress 23: 100-107.
9. Bowling UB, Sherman MD (2008) Welcoming them home: Supporting service members and their families in navigating the tasks of reintegration. Professional Psychology Research and Practice 39: 451-458.
10. Sayer NA, Frazier P, Orazem RJ, Murdoch M, Gravely A, et al. (2011) Military to civilian questionnaire: a measure of postdeployment community reintegration difficulty among veterans using Department of Veterans Affairs medical care. J Trauma Stress 24: 660-670.
11. Litz BT, Gray MJ (2002) Emotional Numbing in Posttraumatic Stress Disorder: Current and Future Research Directions. Aust N Z J Psychiatry 36: 198-204.