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Adapting the Multifamily Group Model to the Veterans Affairs System: The REACH Program

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The Oklahoma City Veterans Affairs (VA) Medical Center modified an evidence-based model of family psychoeducation (the multifamily group model; McFarlane, 2002) and implemented it for the first time in a VA setting and with veterans living with posttraumatic stress disorder (PTSD). Named the REACH Program (Reaching out to Educate and Assist Caring, Healthy Families), the 3-phase program begins with 4 weekly "joining sessions" with the individual veteran and his/her family focused on rapport building, assessment, and goal setting. Phase II consists of 6 weekly diagnosis-specific educational/support sessions for cohorts of 4 to 6 veterans and their families. In Phase III, veterans/families attend 6 monthly multifamily groups to support the maintenance of gains. This article describes the rationale for modifying the original Multifamily Group Program (MFG) for a unique setting (the VA) and the needs of families of veterans in a new diagnostic group (PTSD). The changes to the MFG curriculum are specifically described, and details of the new REACH intervention are explained. Attendance, retention, and satisfaction data for 2 diagnostic cohorts, PTSD and affective disorders, are also presented.

Keywords: family psychoeducation, PTSD, affective disorders, family therapy, multifamily group

The family environment has been recognized as a significant factor in the course of serious mental illness (SMI) since the early research on expressed emotion (Brown, Monck, Carstairs, & Wing, 1962). Families play a major role in consumers' lives, because 40% to 65% of adults with SMI live with their families (Solomon & Draine, 1995). Because high levels of expressed emotion in the family predict relapse in schizophrenia (Wearden, Tarrier, Barrowclough, Zastowny, & Rahill, 2000) and impede progress in treatment for clients with other disorders such as posttraumatic stress disorder (PTSD; Tarrier, Sommerfield, & Pilgrim, 1999), a variety of family interventions have been developed to reduce the critical family atmosphere and improve functioning. Although most family programs have targeted schizophrenia, newer programs target other mental illnesses as well (McFarlane, 2002; Miklowitz & Goldstein, 1997).

When added to standard pharmacotherapy and case management for schizophrenia, family psychoeducation (FPE) is associated with reduced rates of relapse, remission of residual psychotic symptoms, enhanced social and family functioning, and financial savings because of decreased need for hospitalization (Pfammatter, Junghan, & Brenner, 2006; Pharaoh, Mari, Rathbone, & Wong, 2006). The finding of decreased relapse rates is robust across

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cultures (Magliano et al., 2006; Zhang, Wang, Li, & Phillips, 1994). FPE participants have also experienced a significant reduction in negative symptoms of schizophrenia (Dyck et al., 2000). In addition, family members participating in FPE report less burden, burnout, psychosomatic difficulty, and distress, as well as greater effectiveness in helping their loved one (Cuijpers & Stam, 2000; Hazel et al., 2004).

Use of family interventions is strongly recommended in several practice guidelines, including the Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations (Lehman et al., 2004; Lehman, Steinwachs & Survey Co-Investigators of the PORT Project, 1998), the American Psychiatric Association's best practice guidelines (American Psychiatric Association, 2004), and numerous expert consensus guidelines (e.g., Weiden, Scheifler, McEvoy, Frances, & Ross, 1999). The President's New Freedom Commission Report on Mental Health (2003) recommends that mental health services focus on recovery and consumer/family needs and interests, while the newly released Uniform Mental Health Services package (U.S. Department of Veterans Affairs, 2008) requires all VA medical centers to provide family education or family psychoeducation for veterans living with SMI or PTSD.

Nevertheless, few families receive FPE or any other family service. Nationally, less than 10% of families of outpatients with schizophrenia receive services (Lehman et al., 1998). An informal survey conducted in 2003 found that none of the VA medical centers offered evidence-based family psychoeducation programs (McCutcheon, 2003). To increase provision of recovery-oriented services, the VA's Office of Mental Health Services funded 37 initiatives between 2005 and 2008 to implement family psychoeducation programs (personal communication, Susan McCutcheon, May 22, 2008). The Oklahoma City Veterans Affairs Medical Center (OKC VA) was one of three sites to receive support to implement FPE in the first round (2005) of funding. This article describes the process of selecting and adapting an evidence-based FPE program for implementation in a VA setting and presents participation, retention, and satisfaction data for initial participants in two diagnostic cohorts, PTSD and affective disorders.

Context for Implementation of Family Psychoeducation Services

The OKC VA Family Mental Health Program began over 30 years ago with providing couples/family therapy. It expanded in 1999 with the creation of the Support And Family Education (SAFE) Program (Sherman, 2003), a curriculum of educational/support workshops for family members of veterans living with SMI or PTSD (available for free download at w3.ouhsc.edu/safeprogram). Veterans do not attend SAFE Program sessions. Over 300 family members have attended this program to date, and 3- and 5-year program evaluation and satisfaction data are very positive (Sherman, 2003, 2006). Nonetheless, over the 10 years that the SAFE Program has been available, it has become clear that educating and supporting family members is necessary but not sufficient. The funding from VA Central Office allowed us to develop and implement a more intensive treatment option involving both veterans and families.

Preference Assessment and Model Selection

Initial Focus Groups

To enhance the probability of successful program implementation, site-specific data were gathered to examine veteran and family preferences regarding family involvement. Two focus groups (one with veterans with SMI or PTSD and one with family members) were conducted at the OKC VA; six veterans and seven family members participated. Their perspectives were elicited using open-ended questions such as, "What types of things do family members of veterans receiving mental health services need from VA mental health staff?" and "Thinking about your role as a family member of someone who has mental illness, what do you need to take care of yourself in this difficult role?" (Questions are available from first author.)

Both veteran and family participants expressed a desire for family involvement in treatment, believing it would help families better understand veterans and their mental illnesses. Veterans thought that family members should be invited to participate through the veteran (rather than a direct invitation to families). Both veteran and family participants wanted both individual family and multi-family group sessions, and preferred late afternoon and evening appointments.

Program Selection

Upon review of the evidence-based FPE programs, we selected the Multifamily Group Program (MFG; McFarlane, 2002) model because (1) it has been proven effective in a variety of SMIs, not only with schizophrenia; (2) it delivers the bulk of sessions to small groups of families (groups can be more efficient, provide more support for family members, and be associated with lower relapse rates than single family interventions (McFarlane, Link, Dushay, Marchal, & Crilly, 1995; McFarlane, Lukens, Link, Dushay, Deakins, & Newmark, et al., 1995); and (3) McFarlane's model has a detailed toolkit and manual that facilitate mastery of the program and fidelity to the model. The MFG model has been applied in a variety of settings (e.g., public hospitals, community mental health centers) resulting in lower relapse rates for consumers (Dyck, Hendryz, Short, Voss, & McFarlane, 2002) and better physical health for family members when compared with control groups (McFarlane, 2002). However, the model had not been implemented or tested in the VA.

We named our program REACH (Reaching out to Educate and Assist Caring, Healthy Families). This article focuses on two of our diagnostic cohorts, affective disorders (major depression and bipolar disorder) and PTSD. Although the MFG model was originally created for schizophrenia, it has been successfully applied in the private sector to bipolar disorder (Moltz & Newmark, 2002) and major depression (Keitner et al., 2002). Although there is no published research on the MFG model with PTSD, McFarlane (its creator and our consultant) expressed support for such an application, noting that the FPE model is based on a "trauma perspective" (e.g., serious mental illness can be conceptualized as a trauma, significantly affecting both the consumer and his/her family), so its theoretical underpinnings appear relevant for PTSD.

Some adaptations to the model were needed because of our diagnostic groups, our focus group findings, and the nature of the veteran population (including unique aspects of the military cul-

ture and the high proportion of veterans with PTSD or affective disorders whose closest family member is an intimate partner rather than someone from their family of origin as has been the norm with schizophrenia). We describe our adaptation of the MFG model below and present initial data for two of the diagnostic groups, PTSD and affective disorders.

Modification of the MFG Model for REACH

Table 1 compares the components of the MFG model and REACH. All program modifications (as well as the rationale for the changes) were discussed with our consultants before we initiated the intervention. Both REACH and MFG are 9-month programs comprised of three phases. We made only minor changes to the MFG Phase I, which consists of single-family joining sessions focusing on rapport building, assessment, exploration, and strengthening of social support networks, problem-solving around specific concerns, review of coping skills, and goal setting. Although veterans may attend Phase I sessions in the original MFG model, both veterans and family members attend all four Phase I sessions in REACH. In addition, for the many intimate partner dyads enrolled in REACH, clinicians routinely dedicate time during Phase I to assessing and strengthening the relationship. For example, families are asked to bring a photo album to highlight good memories, strengthen bonds, and celebrate strengths.

In the MFG model, Phase II is a 1-day workshop comprised of providing education in a relaxed group environment, enhancing rapport, and facilitating communication among families and providers. Mental health providers present didactic material on the etiology of mental illness, treatment options, common family reactions, family guidelines for illness management (adapted from Anderson, Reiss, & Hogarty, 1986), and problem-solving skills. Providers create a collegial atmosphere, avoid pressuring anyone to participate, encourage questions, and instill hope.

We made several modifications to Phase II. First, both veterans and family members routinely attend REACH Phase II, whereas MFG Phase II was designed primarily for families (although consumers may attend). Providing information to both members of the dyad is thought to increase the likelihood of dialogue and decrease misconceptions about the disorder and the treatment process. Furthermore, in-class discussions/activities prompt dyads to continue discussions between sessions, thus promoting open communication. Second, rather than presenting program content through a day-long workshop, REACH offers six weekly classes (see Table 2 for a summary of class content and activities; a detailed curriculum is available upon request). We find that more families are able to attend 75-min classes than a 6- to 8-hr class. In addition, REACH classes are held in the evenings to minimize conflict with work schedules. Although total workshop hours are similar in the two approaches, we are able to impart more information and skills over a 6-week period than could be absorbed in a single day. Weekly classes give participants time to rehearse new skills between sessions and complete homework. The weekly format also allows families to begin to build cross-family connections early into the program, which can increase social support and facilitate retention. Third, each Phase II REACH session includes a 15-min break-out session during which veterans meet with one of the two cofacilitating psychologists while families meet with the other; these small-group sessions provide the opportunity to give and receive support from others in similar situations. Participants sometimes feel freer to openly discuss interpersonal challenges in break-out sessions because their family member is not present. After the break-out sessions, participants reassemble for a joint 20-min session to practice skills (e.g., via role-plays) and plan for the week ahead (including homework). Fourth, because of the difficulties many families living with affective disorders and PTSD have with anger, we teach conflict disengagement and anger management skills. Emphasis is placed throughout on both the veteran's and family member's needs (rather than on those of the veteran alone), encouraging both parties to support one another.

Table 1
Comparison of Multifamily Group (MFG) Model and Reaching out to Educate and Assist Caring, Healthy Families (REACH) Program

Phase	MFG model	REACH program
I	Joining sessions Three weekly 60-min home or clinic-based meetings with family (consumer not always present or seen separately for shorter time)	Joining sessions Four weekly clinic-based 50-min sessions with veteran and family (both attend every session)
II	One-day psychoeducational workshop Six to eight hours of lectures and discussion to 4–7 families (consumers usually do not participate) Topics include survival skills for managing serious mental illness (SMI) and family guidelines Taught by Phase III facilitators and a psychiatrist who explains the biological basis of the illness and medication issues	Six weekly classes Seventy-five–minute cofacilitated evening classes for 4–6 family/veteran dyads Classes include 15-min break-out sessions for veterans/family members Inclusion of anger management, a topic not covered in original model Facilitated by two REACH psychologists, one of whom also provides the Phase I and III sessions
III	MFGs Ninety-minute biweekly groups Primary focus on problem solving Typically same group members Attend MFGs for 2+ years	Diagnosis-specific multifamily groups Ninety-minute monthly groups Various topics are covered, including but not limited to problem solving Group members rotate in and out Graduation after 6 months of MFGs

Table 2
Topics and Major Content of Reaching Out To Educate and Assist Caring, Healthy Families (REACH) Phase II Sessions

Session	Title	Session content and activities
1	PTSD and its impact on the family[a]	Major symptoms of PTSD; treatment options; instillation of hope; effects of trauma on relationships
2	Managing anger effectively	Effects of chronic anger on self and relationship; coping strategies; time-out process
3	Communication skills	Rationale for improving communication skills; "I" messages; "softened-start up" technique (Gottman & Silver, 2000); role plays
4	Creating a low-stress environment and minimizing crises	Importance of minimizing stress and strong emotions in home; specific tips on stress management; creation of crisis plan including review of red flags for possible problems
5	Depression and its impact on the family	Major symptoms of depression and their effects on relationships; treatment options; dealing with suicidality; coping skills; role play of communicating how to be helpful when other is depressed
6	Problem-solving skills	Normalize common problems in families; tips on how to approach problems; education and rehearsal of problem-solving process

Note. PTSD = posttraumatic stress disorder.
[a] For Affective Disorders cohort, Class 1 (above) is replaced with "What causes mental illness?" which reviews the biopsychosocial model and the diathesis-stress model.

MFG Phase III consists of 75-min multifamily group sessions dedicated to problem solving. Group cohesion develops and strengthens over time as families support one another through illness-specific and general life challenges. We made two primary adaptations to MFG Phase III. First, although REACH Phase III focuses on problem solving, we include more varied activities (e.g., role plays, in-class exercises) to complement and expand participants' skills. Second, rather than attending closed MFG groups biweekly for 2 or more years (as in the original MFG model for schizophrenia), REACH participants attend monthly classes for only 6 months, and new Phase II graduates may join each month. For veterans with PTSD and affective disorders, indefinite participation raises clinical concerns about reinforcing "stuckness" and reliance on treatment/providers. Less frequent (monthly) classes encourage participants to practice program skills on their own and to move toward more independent functioning.

In REACH, upon completion of Phase III, each family has a graduation interview with the psychologist who provided their Phase I sessions. The psychologist celebrates the family's success, reviews progress on originally defined goals, and discusses any remaining needs and other treatment options that could be useful.

Eligibility Criteria and Recruitment

To participate in the REACH Program, veterans must (1) be active in mental health treatment at the OKC VA; (2) have a chart diagnosis of PTSD (from any form of trauma, not combat-specific), bipolar disorder, or major depressive disorder; and (3) have a family member living within 90 miles of the hospital. The family member may be anyone in the veteran's support system, regardless of relationship. Veterans who are acutely dangerous to themselves or others or have an active substance abuse problem (defined as using any illicit drug in the past month or drinking more than 14 alcoholic beverages per week) are not invited to participate in REACH.

Veterans are recruited from the OKC VA psychiatric inpatient unit, outpatient mental health clinic, and outpatient PTSD program. Given the well-known challenges of engaging families in treatment and failure of such strategies as phone and mail invitations (Sherman, Faruque, & Foley, 2005), we use an intensive engagement strategy. Prior to a veteran's routinely scheduled psychiatric appointment, he/she completes (in the waiting room) a checklist of goals that could be addressed in REACH. The provider then discusses the program and its possible benefits during the appointment. If the veteran is open to learning more about REACH, an "on-call" REACH psychologist comes to the clinic immediately and engages in a brief motivational-interviewing session with the veteran (and accompanying family if present) to explore the "fit" for the program, address concerns, identify an appropriate family member, and schedule a next appointment (see Sherman et al., 2009, for details of the engagement procedure).

REACH Project Experience in Year 1

Participation and Retention

During Year 1, approximately 1,300 veterans with chart diagnoses of PTSD or an affective disorder were approached (see Table 3). Approximately one third met with a REACH psychologist to learn more about the program. About one fourth of veterans who met with a REACH provider both enrolled in the program and completed Phase I. As discussed in detail elsewhere (Sherman et al., 2009), these engagement rates are higher than any others in the published literature. Veterans and their families have to overcome numerous potential barriers (e.g., stigma, travel distance, childcare, work schedules, etc) to engage in a family program.

In Year 1, 116 veteran/family member dyads participated in REACH (attended at least one Phase I session), including 58 PTSD cohort dyads and 58 affective disorder dyads (see Table 4). Most veterans were male, White, and 50 years of age or older. A majority had a high school degree (30%) or some college (47%). Over 80% were married or living as if they were married. Usually (80%), the family member accompanying the veteran in REACH was a spouse.

Within-phase retention was quite high across cohorts, as 89% of those who began Phase I completed it and 95% of those who began Phase II completed it. Attrition between the beginning of Phase I and the beginning of Phase II was approximately 30%. We do not yet have enough

Table 3
Attendance and Retention

	PTSD		Affective disorders		Total	
Veteran participation	*n*	%	*n*	%	*n*	%
Veterans approached	594		703		1,297	
Met with REACH	202	34	206	29	408	32
Phase I participants	58	29	58	28	116	28
Phase I completers	52	90	51	88	103	89
Phase II participants	39	75	35	69	74	72
Phase II completers	38	97	32	91	70	95

Note. PTSD = posttraumatic stress disorder; REACH = Reaching out to Educate and Assist Caring, Healthy Families.

data from Phase III to calculate completion rates. Given the long-term nature of the REACH Program and the well-known challenge of maintaining families in treatment, we reminded participants about appointments by sending appointment letters and calling them the day before each appointment. We also gave attendance awards (e.g., REACH Project mugs, pens) to veterans/families at the end of Phase II and III.

Fidelity

To maximize fidelity to the MFG model, REACH psychologists were trained and received ongoing consultation by William McFarlane, the MFG program's creator (McFarlane, 2002). Fidelity of FPE Program implementation during REACH Year 1 was

Table 4
Demographic Characteristics of Veteran Participants

	PTSD		Affective disorder		Total sample	
Characteristic	*n*	%	*n*	%	*n*	%
Diagnosis	58	50	58	50	116	
Gender						
Male	57	98	46	79	103	89
Female	1	2	12	21	13	11
Age (years)						
20–29	3	5	3	5	6	5
30–39	8	14	15	26	23	20
40–49	2	3	11	19	13	11
50–59	20	35	17	29	37	32
60+	25	43	12	21	37	32
Ethnicity						
White	50	86	50	86	100	86
African American	3	5	6	10	9	8
Hispanic	4	7	1	2	4	5
Native American	1	2	1	2	2	2
Marital status						
Never married	3	5	3	5	6	5
Married/living as married	49	85	45	78	94	81
Widowed	0	0	1	2	1	1
Divorced	5	9	7	12	12	10
Separated	1	2	2	3	3	3
Education						
Less than high school diploma	4	7	2	4	5	6
High school diploma/GED	16	28	19	33	30	35
Some college	25	43	29	50	47	54
College graduate	10	17	6	10	14	16
Postgraduate	3	5	2	4	4	5
Relationship of family participant to veteran						
Spouse	49	85	43	76	93	80
Parent	4	7	6	10	10	9
Child	2	4	2	4	4	3
Sibling	1	2	1	2	2	2
Other	2	4	6	9	7	6

Note. PTSD = posttraumatic stress disorder.

assessed by an independent psychologist who was not involved with the intervention. Assessment followed McFarlane's protocol and procedures for completion of the Family Psychoeducation Fidelity Scale (*www.mentalhealth.samhsa.gov*). Each of the 12 items in this measure is rated using a 5-point Likert scale ranging from 1 (*not implemented*) to 5 (*fully implemented*); item-scores are summed to generate a total score ranging from 12 to 60. The 12 items address concordance with criteria for adequacy of program management, program duration, session frequency, session content, and session delivery format(s). Data for item rating are derived from review of the program curriculum and related documents, chart review, observation of joining and multi-family group sessions, and semistructured interviews with participants and with specified program personnel (program director and clinicians).

To complete the Family Psychoeducation Fidelity Scale for REACH, the independent psychologist reviewed the REACH curriculum and workbook for participants; reviewed charts for 10 randomly selected veteran participants; conducted individual interviews with the program director (first author), three REACH clinicians, one veteran and two family participants from separate families; reviewed audiotapes of joining sessions, and observed two multifamily group sessions. To ensure standardized data collection and the comparability of the REACH scale score, the independent psychologist used checklists, semistructured interview questions and interview probes included in the Fidelity protocol. In its first year of operation, REACH met criteria for a score of 5 (*fully implemented*) on each of the 12 items, for a total score of 60.

Program Satisfaction

Satisfaction with REACH was assessed anonymously at the end of each phase by veterans (Phase I, $n = 38$; Phase II, $n = 69$) and families (Phase I, $n = 45$; Phase II, $n = 70$). The satisfaction measure (introduced 3 months into the project and available from first author) consists of 10 items, including 5 quantitative items (on 4-point Likert-scale) and 5 open-ended questions.

Responses to the five quantitative items are shown, by phase, in Table 5. Almost all participants reported being *very satisfied* (60%) or *mostly satisfied* (39%) with REACH services. Almost all described the quality of their mental health care in REACH as *excellent* (60%) or *good* (37%). Participants indicated that REACH helped them deal more effectively with problems *a great deal* (47%) or *somewhat* (51%). Almost all participants (99%) indicated that they would refer a friend in need of similar help to REACH. The levels of satisfaction were not statistically significantly different by diagnosis or by veteran/family member status.

The open-ended questions asked what participants found most and least helpful about REACH. Participants liked learning about the diagnosis (e.g., "better understanding of my illness and how to deal with it better"), improving their understanding of each other

Table 5
Satisfaction Data From Veteran and Family Member Participants

Variable	Phase I ($n = 83$)		Phase II ($n = 139$)		Total ($n = 222$)	
	n	%	*n*	%	*n*	%
How would you rate the quality of mental health care you received in the REACH Project?						
Excellent	55	66	79	57	134	60
Good	27	32	56	40	83	37
Fair	1	1	4	3	5	2
Poor	0	0	0	0	0	0
If a friend were in need of similar help, would you recommend the REACH Project to him/her?						
Yes, definitely	61	74	97	70	158	71
Yes, I think so	21	25	42	30	63	28
No, I don't think so	1	1	0	0	1	1
No, definitely not	0	0	0	0	0	0
Has the REACH Project helped you to deal more effectively with your problems?						
Yes, it helped a great deal	33	40	71	51	104	47
Yes, it helped somewhat	48	58	65	47	113	51
No, it really didn't help	2	2	3	2	5	2
No, it seemed to make things worse	0	0	0	0	0	0
How satisfied were you with services received in REACH?						
Very satisfied	50	60	83	60	133	60
Mostly satisfied	33	40	53	38	86	39
Indifferent or mildly dissatisfied	0	0	3	2	3	1
Quite dissatisfied	0	0	0	0	0	0
Overall, how satisfied are you with your therapist(s)?						
Very satisfied	75	90	114	82	189	85
Mostly satisfied	8	10	24	17	32	14
Indifferent or mildly dissatisfied	0	0	1	1	1	1
Quite dissatisfied	0	0	0	0	0	0

Note. REACH = Reaching out to Educate and Assist Caring, Healthy Families.

(e.g., "this allowed my wife and I to be on the same page"), and discovering they were not alone (e.g., "getting to know other people going through the same issues"). When asked what they liked least about REACH, 50% ($n = 108$) did not answer or wrote "nothing." The most common complaint was that Phase II classes were too short ($n = 25$, 12%), followed by having to travel to the hospital ($n = 12$, 6%) and too few individual family sessions ($n = 9$, 4%). In response to the expressed desire for longer sessions, in Year 2 we lengthened Phase III classes from 75 to 90 min.

Conclusions

This project demonstrates the feasibility of adapting the evidence-based MFG model to a new setting and a new diagnosis. The VA system is moving toward greater family involvement in the care of veterans living with SMI and PTSD. Given the considerable resources being invested in nationwide implementation of family services, it is essential to carefully describe the modifications to existing programs required, the rationale for changes, the experience of participants, and the satisfaction associated with various family interventions. This article is to our knowledge the first such description for any of the VA-funded family psychoeducation projects.

As discussed in detail elsewhere (Sherman et al., 2009), our intensive engagement strategy was quite effective. Almost one third of approached veterans met with the REACH team to learn about the program, and 28% went on to participate in the project. These figures are higher than any others reported in the literature.

The high within-phase retention rates (89% for Phase I, 95% for Phase II) and positive satisfaction data during Year 1 of REACH for both the affective disorder and PTSD cohorts are noteworthy. The modifications described above, particularly the six-class structure of Phase II and the inclusion of new topics relevant to veterans (e.g., anger management), functioned well. Veterans and families also responded well to the interactive approaches (e.g., role plays, homework) we added to supplement the problem-solving procedure that forms the basis of the multifamily group sessions. Comparison of REACH satisfaction and retention rates to those of other programs has proven difficult. Despite consultation with national experts and a thorough literature review, we were unable to find any comparable assessment of satisfaction. Although our retention rates are considerably higher than those published previously on multifamily groups (Dyck et al., 2000; McFarlane, Lukens, et al., 1995), that would be expected given the shorter duration of our program and diagnostic differences among program participants.

The applicability of family models to PTSD is important in light of the high prevalence of PTSD among veterans (Magruder & Yeager, 2007). Furthermore, because veterans returning from Iraq and Afghanistan are at risk for PTSD (Tanielian et al., 2008), the need for family services is likely to grow.

Research is currently underway evaluating changes in veteran and family member functioning across all phases of the REACH intervention. If REACH proves effective in improving veteran and/or family functioning and maintaining these gains, it will be important to test its acceptability and effectiveness with other populations of veterans/families with PTSD or affective disorders. The external validity of this project is limited because of a somewhat homogenous sample (older, White, non–substance-abusing male veterans) and data collected from one site. Future research will need to examine and evaluate the necessary modifications of the REACH program for various groups (e.g., different ethnic groups, rural populations, different practice settings, veterans returning from Iraq and Afghanistan).

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