A systematic review of the literature was conducted to examine empirical evidence about family-focused treatments (FFT) in the management of Veterans with post-traumatic stress disorder (PTSD).

The primary question guiding this systematic literature review was as follows: Are FFTs effective in managing symptoms of PTSD in Veterans? As the investigators initiated this review, the following aims also were considered:
- How do Veterans’ family members access services needed to manage PTSD?
- Are Veterans’ family members prepared to assist with the daily management of PTSD?
- What needs do family caregivers express when their Veteran member has PTSD?

Problem

Mental illness of any form can be challenging for any family. When a Veteran develops a mental health condition, family members need to be involved because they know the best ways to provide supportive care (National Alliance on Mental Illness [NAMI], 2013). Current care delivery models for PTSD often fail to incorporate family-focused care despite the availability of evidence-based family-focused programs for families of Veterans with any mental illnesses within the community at large.

When a previously well-functioning member returns after military deployment with avoidance behaviors, mood swings, and arousal symptoms, the family is unlikely to be equipped to manage these changes. Logistics and costs associated with the provision of needed forms of family-focused care must be weighed against long-term costs (e.g., substance abuse, homelessness, domestic violence, unemployment, suicide) and the long-term implications for a multi-person household over time need to be evaluated (Ohye et al., 2015). Addressing these concerns may require the commitment of a few researchers who complete longitudinal studies involving multiple family members and persons with PTSD to evaluate intervention effectiveness.

Significance

About 7%-8% of persons in the United States have PTSD at some point in their lives, or about 8 million adults in any given year (U.S. Department of Veterans Affairs [VA], 2018a). During the Vietnam War, about 15 of every 100 Veterans were diagnosed with PTSD. Rates have increased to 11-20 of every 100 Veterans serving in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom [OEF] (VA, 2018b).

Nurses must be more aware of the links between physical and mental health. Nurses can play important roles in encouraging and supporting family-focused treatments when Veterans present with symptoms of post-traumatic stress disorder (PTSD). Including families in treatments can influence PTSD symptoms and family relationship functioning positively.

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Background to the Problem

Research about caregiver roles and family relationships on Veterans with PTSD has been limited. Most studies that consider family relationships have focused largely on the challenges associated with multiple deployments and the effects of war on families (Creech, Hadley, & Borsari, 2014). Little is known about how families assist Veteran members with PTSD as they navigate care systems and follow treatment plans (American Public Health Association, 2014; Michigan Government Report, n.d.; Reisman, 2016; Tanielian & Jaycox, 2008). Clear understanding about the ways caregivers are prepared to assist or manage PTSD in daily life is lacking.

Much of the care focus has shifted to the surge of psychological health problems, specifically PTSD, identified in Veterans. At the height of OIF, OEF, and Operation New Dawn, a major question was, What is the impact of deployment on service members and families? The question later shifted to, What is the impact of treatments and programs on service members and families? (Flynn, 2014). These Veteran groups have faced the hazards of combat zones with increased survival rates and fewer casualties than in previous U.S. battles. Deployment lasts a particular amount of time that begins when a service member departs for a combat mission and ends when a stateside return occurs. However, the effects of multiple deployments and reintegration into the family have potential implications that can last years (Creech et al., 2014).

Veterans have endured multiple, longer deployments with shorter times at home with their family members. Over 2.2 million service members have deployed, leaving behind 1.1 million spouses and 2 million children under age 18 (Creech et al., 2014). By 2015, about 405,915 OEF/OIF Veterans were evaluated at Veteran healthcare facilities for PTSD following their deployment (VA, 2015). According to the American Psychiatric Association (APA, 2017), PTSD symptoms usually occur as intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions. These symptoms have been found to last longer than a few months and can disrupt multiple aspects of daily life.

Literature describes the scope of PTSD in Veterans linked with barriers, such as stigma to seeking care and gaps or challenges tied to care delivery (Institute of Medicine [IOM], 2014). Substance or alcohol use often are tied to PTSD concerns (Smith, Goldstein, & Grant, 2016). Varied treatments have been identified to manage PTSD, including cognitive behavioral therapy, eye movement desensitization and reprocessing, pharmacological treatments (e.g., antidepressants), and some trauma-focused forms of psychotherapy (VA, 2017a). It would be beneficial to know more about families and their caregiving roles, the effects of caregiving stress across the lifespan when a family member has PTSD, and which treatments best support family outcomes when a Veteran has PTSD. According to Bernardy (as cited in Reisman, 2016),

Shared decision-making has not been used widely, so we are trying to create a culture where providers meet with patients and discuss PTSD treatment options – the pros and cons of each – and then let patients and family members make the best decisions for their care. (p. 626)

This supports the claim that current care delivery models too often ignore family-focused care needs and the types of support members require. The paucity of family-focused research means little is known about the effectiveness of treatment interventions for military and Veteran families when PTSD is a concern. This lack of evidence suggests healthcare providers working with Veterans offer variable types or combinations of PTSD treatments that could result in military families receiving poor-quality psychological health care (IOM, 2014).

Definitions

The following definitions were used in this review:

Post-traumatic stress disorder (PTSD) is defined as a psychiatric disorder that can occur in persons who have experienced or witnessed traumatic events, such as natural disasters, serious accidents, terrorist acts, war/combat, rape, or other violent personal assaults (APA, 2017).

Methods of trauma-focused psychotherapy include the following:

- **Cognitive processing therapy.** Reframes thoughts about the trauma.
- **Prolonged exposure.** Faces negative thoughts and feelings to regain control.
- **Psychotherapy, medication therapies, and cognitive behavioral therapies** known to be effective, individualized, recommended treatments for Veterans with PTSD.

- **Cognitive behavior conjoint therapy (CBCT).** Identifies thoughts, feelings, and behaviors with the focus on targeting current symptoms and changing the thoughts, feelings, and behaviors.

- **Family-Focused Treatments (FFT).** Treatments for Veterans with PTSD that not only address Veterans’ needs but also include needs of family members.

Search Methods

The PRISMA-IPD (Preferred Reporting Items for Systematic Reviews and Meta-Analyses-Individual Participant Data) guidelines facilitate integrity, reporting of emerging issues, and exploration of variations of individual participant data for systematic reviews (Stewart et al., 2015). These guidelines provided a checklist for critical appraisal of published systematic reviews and the steps for this activity (Gray, Grove, & Sutherland, 2017). A search was conducted for peer-reviewed articles for 2000-2016 using Scopus, CINAHL, Medline, and PubMed. Search terms included caregivers, family, spouse, Veterans, technology, post-traumatic stress disorder, and PTSD.
The search included randomized controlled studies and quasi-experimental studies only. Descriptive studies, case studies, PTSD clinical guidelines, and any study testing individualized treatments for Veterans with PTSD were excluded. No authors or co-authors were contacted in search of pending studies and grey literature was not searched. Authors independently screened research and excluded any studies in which participants were non-American Veterans and any family-related rather than family-focused therapies were used. Also excluded were randomized controlled trials (RCTs) without FFT for Veterans and PTSD, studies on structural equation modeling, descriptive or correlational studies on active duty military personnel, and articles written in any language other than English. Six articles were retained. All articles selected by one author were reviewed by the second author, a consensus formed, and articles scrutinized for final results.

Results
In the last 16 years, only six of the 215 articles screened met the threshold for inclusion criteria and research questions. Five studies met the search criteria and one additional article from the reference section of one of the five articles provided the total of six articles for the review. None of the studies tested the feasibility or effectiveness of technology in delivery of any treatment or identified a framework for use of technology in treatment for PTSD. All six studies found FFT resulted in PTSD symptom improvements, but researchers did not measure PTSD symptoms the same way.

Three studies measured PTSD symptoms using both the Clinician-Administered PTSD (CAPS) and the PTSD Checklist (PCL) (Monson et al., 2012; Monson, Schnurr, Stevens, & Guthrie, 2004; Sautter, Glynn, Cretu, Senturk, & Vaught, 2015). Church and Brooks (2014) measured improvements in PTSD symptoms with the PCL. All four studies found improvement in PTSD symptoms. Because Fischer, Sherman, Han, and Owen (2013) used a 29-item self-report instrument for PTSD-related knowledge and behaviors developed exclusively for that study, no comparisons to changes in PTSD symptoms can be made to the other five studies. Participants’ knowledge about PTSD in the study by Fischer and co-authors did improve; researchers also measured empowerment, family problem solving, communication, relationship satisfaction, social support, coping self-efficacy, and quality of life. However, none of these outcomes were measured in the other five studies so no comparisons can be made. Monson and colleagues (2012) measured intimate relationship satisfaction with the Dyadic Adjustment Scale and also measured partner-rated PTSD symptoms and comorbid symptoms and adjustment. However, no other findings from the other articles in this review measured partner-rated PTSD symptoms or co-morbid symptoms so comparisons could not be drawn and conclusions could not be drawn from these findings alone.

Only one study used the Personal Beliefs and Reaction Scale-Modified and Trauma-Related Guilt Inventory as an outcome measure (MacDonald, Pukay-Martin, Wagner, Fredman, & Monson, 2016). Findings supported the value of couple-based intervention treatment for PTSD, not only for improved PTSD symptoms but also for improvement in trauma-related cognitions. Results also supported improvements in Veteran adjustment, attachment avoidance, and state anxiety. This was the only study in which Veterans’ partners showed significant reductions in attachment anxiety.

Fischer and co-authors (2013) found statistical significance in all measures; in particular, family members’ results for the Brief Symptom Inventory neared significance (p=0.054). Monson and colleagues (2004) exclusively used the Beck Depression Inventory and State Anxiety and Trait Anxiety. They found statistically significant improvements in results of both tools, as well as improvements in CAPS and partner PCL ratings of Veterans’ PTSD symptoms.

These findings provided additional evidence FFT improves not only PTSD symptoms, but also suggested cognitive behavior conjoint therapy improves symptoms of anxiety in partners and in trauma-related conditions.

Synthesis and Strength of the Findings
Six articles (see Table 1) were appraised for the level of research using the Johns Hopkins Nursing Evidence Based Practice Evidence Level and Quality Guide (Dearholt & Dang, 2012). Three of the six studies were appraised as Level I, with evidence based on experimental studies, RCTs, and systematic reviews of RCTs with or without meta-analysis (MacDonald et al., 2016; Monson et al., 2012; Sautter et al., 2015). The remaining three studies had Level II evidence (quasi-experimental studies, systematic reviews of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only with or without meta-analysis) (Church & Brooks, 2014; Fischer et al., 2013; Monson et al., 2004).

Discussion
Findings of the systematic literature review suggest families play key roles in treatment for Veterans with PTSD (Church & Brooks, 2014). Findings from use of CBCT with Veterans with PTSD indicated this treatment not only reduces Veterans’ PTSD symptoms, but also appears to reduce PTSD symptoms in partners. If PTSD symptoms are present in Veterans and their spouses who meet clinical criteria for PTSD, then FFT of Emotional Freedom Techniques (EFT), energy psychology, and energy modalities reduce stress and build resources. EFT appears not only to reduce PTSD symptoms, but also to improve family functioning as a result of improved symptoms and coping.
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<tr>
<th>Authors</th>
<th>Sample</th>
<th>Setting</th>
<th>Research Design</th>
<th>Measures</th>
<th>Intervention</th>
<th>Findings</th>
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| Church & Brooks, 2014 | Convenience sample of Veterans (n=109), average age 51  
Veteran spouses (n=109), average age 49  
Average 1.4 (1-3) deployments; average years of deployment 2.3 | Nonprofit rural retreat center in southwestern U.S. founded by VA and local government; programs are collaboration by local businesses, coaching organizations, Native American community | Level II quasi-experimental | PCL civilian and military versions | 7-day retreats included EFT, other EP methods to address PTSD symptoms, varied CAM modalities for stress reduction and resource building  
Interventions were delivered in group format and other CAM. | 83% of Veterans, 29% of spouses met clinical criteria for PTSD pre-intervention.  
Mean post-test PCL scores decreased to 41.8 (SE ± 1.2; p<0.001) for Veterans, with 28% continuing to meet the cutoff for clinical symptoms for PTSD. Spouses demonstrated substantial symptom reductions (M=28.7, SE ± 1.0; p<0.001), with 4% still clinical. A followup (n=63) found decreased PTSD symptom levels for spouses (p<0.003), with symptom reduction maintained for Veterans. |
| Fischer et al., 2013 | Veterans (n=100): 100% White males, average age 55.8  
Female spouses (n=96), average age 52.7 | Oklahoma City, OK, VAMC | Level II quasi-experimental | BSI; DAS-7; Rogers Empowerment Scale for Veterans; Koren empowerment scale for family; MSPSS; FPSC | REACH (adaptation of multifamily group psycho-education program tailored for Veterans with PTSD, their family members)  
REACH is a 9-month, three-phase program (four weekly 50-minute sessions involving Veteran, family member, REACH psychologist). | Results of each were statistically significant: PTSD self-report, Rogers empowerment scale, Koren empowerment scale for family, FPS.  
FPSC disappeared in Phase III and relationship satisfaction did not improve for dyads not distressed at baseline.  
Family members showed statistically significant improvements in MSPSS, GSI, anxiety scores as on relationship scores; neared significance on BSI scores. |

*continued on next page*
TABLE 1. (Continued)
Evidence Table

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<tr>
<th>Authors</th>
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<tr>
<td>MacDonald et al., 2016</td>
<td>Veterans (n=40) Partners (n=40) Mean age 37 75% female; 28% non-White; 68% couples cohabitating 40 couples (CBCT) 40 couples (WL)</td>
<td>Two sites: VAMC Boston, MA: psychology department-based clinical research center in Toronto, Ontario, Canada</td>
<td>Level I RCT</td>
<td>PBRS-M used to assess disruptions in beliefs concerning self-blame, safety, trust, control, esteem, intimacy. TRGI compared with waitlist; patients who received CBCT for PTSD immediately demonstrated greater improvements in all PTSD symptom clusters, trauma-related beliefs, guilt cognitions.</td>
<td>CBCT or to a 3-month waitlist condition (WL). Pre-mid treatment (7 sessions CBCT, 4 weeks for WL) – post treatment</td>
<td>CBCT for PTSD improves all PTSD symptom clusters, trauma-related cognitions among individuals with PTSD; further supports value of using couple-based approach to treat PTSD. Between-group effect sizes suggested moderate-to-large effects for CBCT for PTSD over WL for majority of outcomes. Findings demonstrated importance of partners’ trauma-related beliefs.</td>
</tr>
<tr>
<td>Monson et al., 2004</td>
<td>Vietnam combat-era Veterans (n=7) Partners (n=7) No demographics</td>
<td>White River Junction, VT, VAMC</td>
<td>Level II quasi-experimental</td>
<td>CAPS, a semi-structured clinician interview, measures PTSD diagnostic status, symptom severity consistent with the DSM. PTSD Checklist PCL is a 17-item self-report measure of PTSD symptoms found in DSM-IV. Also used BDI and STAI.</td>
<td>CBCT for PTSD consists of 15 sessions in three treatment phases: psychoeducation in PTSD and its related intimate relationship problems; communication skills training; cognitive interventions.</td>
<td>Statistically significant improvements in CAPS, PCL-P ratings of Veterans' PTSD symptoms. Veterans' self-reported improvements in PTSD symptoms on PCL-S not statistically significant. Using reliable change criteria for PTSD symptoms, all seven Veterans were improved according to CAPS, five were improved according to PCL-P, four were improved according to PCL-S. One Veteran reported deterioration in his symptoms. Three Veterans no longer met criteria for PTSD diagnosis at the end of treatment. The Veterans self-reported statistically significant improvements in BDI, STAI.</td>
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TABLE 1. (Continued)  
Evidence Table

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<tr>
<td>Monson et al., 2012</td>
<td>N=80 Veterans (CBCT) (n=20)</td>
<td>VA outpatient hospital, Boston, MA; university-based research center, Toronto, Ontario, Canada</td>
<td>Level I RCT, conducted 2008-2012</td>
<td>CAPS for symptom severity. Intimate relationship satisfaction assessed with DAS. PCL provided additional measure of partner ratings of Veterans' PTSD symptoms. SCID-P, BDI, STAI</td>
<td>One partner met criteria for PTSD according to CAPS. Couples received 15-session CBCT for PTSD protocol immediately (n=20) or were placed on WL for therapy (n=20).</td>
<td>Among couples in which one partner was diagnosed with PTSD, disorder-specific couple therapy compared with WL for therapy resulted in decreased PTSD symptom severity and patient comorbid symptom severity, increased patient relationship satisfaction. PTSD symptom severity (score range 0-136) (mean change difference -23.21; 95% CI, -37.87 to -8.55). Treatment effects maintained at 3-month follow up.</td>
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<td></td>
<td>Veterans (WL) (n=20)</td>
<td>Ages 33-40 Non-White-25%-30% 35% mood disorder; 25% anxiety; 0 substance abuse</td>
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<td></td>
<td>Partners (CBCT) (n=20) Partners (WL) (n=20)</td>
<td>Ages 34-40 Non-White 20%</td>
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<td>Greater number of Whites in SAT group</td>
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<td>Sautter et al., 2015</td>
<td>Veterans (n=57)</td>
<td>Greater New Orleans area</td>
<td>Level I RCT</td>
<td>CAPS-rated PTSD; DRRI, CES-D, STAI, DAS, ECR-R</td>
<td>SAT manual-based treatment consisting of 12 60-minute sessions conducted by individual therapist with Veteran and Veteran's partner and the family education sections of behavioral family therapy. Comparative study between manualized 12-session novel couples-based PTSD treatments, to manualized 12-session couples-based educational intervention.</td>
<td>CAPS-rated PTSD (p&lt;0.0001) through 3-month follow up compared with Veterans receiving PFE: 15 of 29 (52%) Veterans receiving SAT, 2 of 28 (7%) receiving PFE no longer met DSM-IV-TR criteria for PTSD. SAT in treating OEF/OIF Veterans’ post-traumatic stress, comorbid anxiety while partners in SAT did not report comparable improvements in state anxiety or relationship satisfaction as did the Veterans simultaneously improving their relationship adjustment. Benefits found at post-treatment, maintained at follow up.</td>
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<td>Partners (n=57)</td>
<td>51% Veterans White; 33.33% African American; 7.41% Asian American; 7.41% Native American</td>
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<td>Greater number of Whites in SAT group</td>
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BDI = Beck Depression Inventory; BSI = Brief Symptom Inventory; CES-D = Center for Epidemiologic Scale for Depression; CAPS = Clinician-Administered PTSD Scale; CBCT= Cognitive Behavioral Conjoint Therapy; DRRI = Combat Experiences Scale of the Deployment Risk and Resilience Inventory; CAM = Complementary and Alternative Medicine; DSM-IV = Diagnostic and Statistical Manual; DAS-7 = Dyadic Adjustment Scale-7; ECR-R = Experiences in Close Relationship-Revised; EFT = Emotional Freedom Techniques; EP = Energy Psychology; FPSC = Family Problem Solving and Communication Scale; GSI = General Severity Index; MSPSS = Multidimensional Scale of Perceived Social Support; OEF = Operation Enduring Freedom; OIF = Operation Iraqi Freedom; PBRS-M = Personal Beliefs and Reactions Scale-Modified; PFE = PTSD Family Education; PCL = Post-traumatic Stress Disorder Checklist; PTSD = Post-traumatic Stress Disorder; RCT = Randomized Controlled Trial; REACH = Reaching Out to Educate and Assist Caring, Healthy Families; STAI = State-Trait Anxiety Inventory; SAT = Strategic Approach Therapy; SCID-P = Structured Clinical Interview for DSM-IV – Patient Version; TRGI = Trauma-Related Guilt Inventory; VAMC = Veterans Administration Medical Center; WL = Wait List
The REACH multifamily group study also showed improvements in relationship satisfaction, depression, anxiety, and social functioning in Veterans and their partners (Monson et al., 2004). However, partners of Veterans with PTSD self-reported improvement in relationship satisfaction while Veterans’ self-report of relationship satisfaction remained the same over time. Future studies about the effectiveness of FFT when the Veteran has PTSD need to assess relationship satisfaction improvements.

In three of the six studies, PTSD symptoms and family function not only appeared to improve consistently with FFT, but also were sustained over time (MacDonald et al., 2016; Monson et al., 2012; Sautter et al., 2015). As partners’ knowledge, skills, and understanding of PTSD improve, along with partner engagement in treatment, a shift appears to occur in relationship quality and family functioning. Findings from this review indicate Veterans who access services that include FFT report the greatest reduction of PTSD symptoms (Toscano & Roberts, 2014).

However, limited research in FFT may be one reason only individual forms of therapy have been verified as evidence-based treatments (eye-movement desensitization and reprocessing, exposure therapy, trauma-focused cognitive behavioral therapy) and are currently available for treatment of PTSD in Veterans (VA, 2017b). While psychosocial disturbances are experienced personally by Veterans, the impact of these disturbances permeates the entire family system. When both the Veteran and partner receive PTSD treatment, greater reduction in PTSD symptoms is experienced (Monson et al., 2012).

Implications for Practice, Education, and Research

Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (H.R. 3230-113) in 2014, allowing eligible Veterans to seek care outside Veteran healthcare facilities. This means nurses who care for Veterans in non-VA hospital settings need to understand more about Veteran family care needs. Nurses in all healthcare settings may be asked to provide coordinated efforts for Veterans’ physical and psychological needs, and engage families in the treatment plans. Nurses caring for Veterans should be knowledgeable about PTSD symptoms and be prepared to assess need for FFT treatments in inpatient and community settings. More research is needed to test the effectiveness of FFT interventions for PTSD using consistent outcome measures that fully identify the benefits of FFT for Veteran families.

NAMI provides support to families of persons with mental illnesses. As the largest grassroots mental health organization, NAMI grew out of the needs of family members who live with and are affected by members with mental illness. Programs include *Family to Family and Homefront*, a free, educational program for families, caregivers, and loved ones of Veterans (NAMI, 2013). This program is based on NAMI Family to Family, a nationally recognized family education program for families affected by mental illnesses. In 2017, NAMI *Family to Family* education was included in the U.S. Substance Abuse and Mental Health Services Administration Registry as an evidence-based program and practice.

Joining forces with the VA, the American Association of Colleges of Nursing developed the *Enhancing Veteran Care Toolkit* which provides multiple resources such as Veteran care competencies (McMillan et al., 2017). Nursing faculty are preparing nursing students to care for Veteran family care needs, with the understanding the Veterans’ physical injuries often are accompanied by mental healthcare needs.

Limitations of the Review

Limitations of this review include the small sample of identified studies, the inconsistent measures used for PTSD, and variations in the ways FFT was interpreted. Although the findings failed to provide strong evidence for the value of FFT in PTSD treatment, they suggested more inclusion of family in care delivery is needed. The small number of studies suggests more consideration be given to Veteran families and their lived experience of PTSD. Further, the findings raise questions about the need to involve families and nontraditional partners in PTSD treatment.

Conclusion

Nurses must be more aware of the links between physical and mental health. For example, Veterans diagnosed with cardiovascular disease may have co-occurring depression and anxiety (Jankowski, 2016). As nurses recognize PTSD symptoms, they also must be aware PTSD can affect physical health adversely (Schnurr, 2016). Nurses can play important roles in encouraging and supporting FFT when Veterans have PTSD symptoms. Finally, including families in treatment is shown to influence PTSD symptoms and family relationship functioning positively (Batten et al., 2009).

REFERENCES


