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New Zealand Vietnam Veterans' Family Programme, Nga Whanau a Tu (Families of War): Development and Outcome[1]

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This article reviews recent research concerned with the association between combat-related posttraumatic stress disorder (PTSD) and interpersonal functioning, before describing the development of a pilot program established to provide mental health services for Vietnam veteran family members. The results of a brief program evaluation are also presented. Sixty clients provided posttreatment and six-month follow-up data on a variety of outcome measures which were compared with independent ratings returned by 33 therapists. On average, clients reported that counselling had been beneficial and indicated satisfaction with services received. However, at posttest, therapists indicated that approximately 50% of clients were in need of continued treatment. There was a decrease in satisfaction with services over the posttest-follow-up period, but no change on most measures of psychotherapy outcome.

INTRODUCTION

The extensive literature on the readjustment of combat veterans clearly documents posttraumatic stress disorder (PTSD) as a major outcome of exposure to combat, and demonstrates that PTSD in veterans is associated with other substantial negative effects. In addition to psychiatric and physical health symptoms, PTSD occurs in conjunction with a range of social adjustment and interpersonal problems (Kulka, Schlenger, Fairbank, Hough, Jordon, Marmar and Weiss, 1990). These include marital and family dysfunction, interpersonal relationship and sociability problems, violent behaviour, and employment difficulties (Carroll, Rueger, Foy and Donahoe, 1985; Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough and Weiss, 1992; Roberts, Penk, Gearing, Robinowitz, Dolan and Patterson, 1982; Silver and Iacono, 1986; Solomon, Mikulincer, Freid and Wosner, 1987).

In addition to poorer relationship adjustment, Carroll et al. (1985) found that PTSD veterans reported significantly more problems than other groups with self-disclosure, expressiveness and physical aggression toward their partners. Similarly, Roberts et al. (1982) found that PTSD veterans scored significantly higher than non-PTSD veterans on problems dealing with intimacy and sociability. Families of PTSD veterans have reported elevated levels of violence, decreased levels of marital and family adjustment, and poorer parenting skills (Jordan et al., 1992). Amongst Israeli combat veterans, higher rates of PTSD were associated with low expressiveness, low cohesiveness, and high conflict in the casualties' families (Solomon et al., 1987). In a study of New Zealand Vietnam veterans, those with PTSD were twice as likely to be divorced or separated, and they reported significantly greater interpersonal problems, worse family functioning, and lower dyadic adjustment than did veterans without PTSD (Chamberlain, Vincent and Long, 1994).

The partners of veterans can also experience immense stress and may be at risk of psychiatric disturbance themselves (Coughlan and Parkin, 1987; Figley, 1993; Maloney, 1988; Solomon, Waysman, Avitzur and Enoch, 1991). In troubled families of Vietnam veterans, the partner is frequently the primary financial provider, and these spouses may feel overwhelmed by the pressures of dealing with family responsibilities and the veteran's dysfunctional behaviour; they may also feel trapped, defeated, lonely, and isolated (Coughlan and Parkin, 1987; Matsakis, 1988; Verbosky and Ryan, 1988). Amongst partners of Vietnam veterans with PTSD, Beckham, Lytle and Feldman (1996) found that patient symptom severity was positively associated with caregiver

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burden, which was in turn associated with caregiver psychological distress, dysphoria, and anxiety.

That the effects of PTSD continue to be experienced by Vietnam veterans and their families is consistent with theories suggesting that when interpersonal consequences of acute traumatisation are not treated, there is risk of re-traumatisation and ongoing maladaptive lifestyle patterns. Empirical findings suggest that 'problems in family system functioning may persist or manifest after incubation well past that of acute readjustment' (Ford, Shaw, Sennehauser, Greaves, Thacker, Chandler, Schwarz, and McClain, 1993: 94). Researchers are increasingly emphasising the need to include family members in the ongoing treatment of veteran PTSD casualties and arguing that the inclusion of family members as an integral part of therapy is beneficial for the veteran and for the family members themselves (Brende and Goldsmith, 1991; Carroll et al., 1985; Jordan et al., 1992; Silver and Iacono, 1986).

The policy of the United States Veterans Administration (VA) does not permit the treatment of spouses and other family members, however, unless it can be justified as a means of treating the veteran (Figley, 1993). This policy appears to be reflected in other areas of service provision in VA treatment programs. In a national survey of services for families of alcoholics in VA treatment programs, it was found that few of the programs offered services directed at the individual needs of spouses or children of alcoholics (Salines, O'Farrell, Jones and Cutter, 1991). These authors argued for greater use of family services and advocated that the VA develop policy guidelines for the type and intensity of marital and family services in their programs.

Many articles provide models, guidelines and descriptions of the issues involved in therapy for veteran families (e.g. Johnson, Feldman, Southwick, and Charney, 1994; Scaturo and Hardoby, 1988; Shehan, 1987; Solomon, Bleich, Shoham, Nardi and Kotler, 1992), but few provide data regarding outcomes. Allen and Bloom (1994) reviewed psychotherapeutic approaches to PTSD and noted that, given that group and family therapy techniques are commonly used, surprisingly few studies have systematically evaluated treatment effectiveness.

Despite evidence suggesting that the effects of PTSD on families is substantial, and despite more frequent appeals by researchers to include family members in the ongoing treatment of veteran PTSD casualties, there have been no services designed to address the needs of veteran family members in New Zealand. During the years 1964 to 1972 New Zealand committed over 3,000 Defence Force personnel to serve in the Vietnam War. While physical and mental health needs of veterans could be met through national health services and provision of the War Disablement Pension, it is only in recent years that the needs of veterans' families have been recognised. Research findings indicating problems in the families of New Zealand Vietnam veterans (Chamberlain, Vincent and Long, 1994; Vincent, Chamberlain, and Long, 1994) provided a final impetus, and the New Zealand Vietnam Veterans' Family Programme: Nga Whanau a Tu was established to address these problems.

THE PROGRAM

Development

In February 1993, twenty-one years after the last Vietnam veteran returned, a grant was approved to develop and implement a six-month pilot program to provide counselling for veterans' families. The underlying philosophy of the program was to provide an effective, efficient service which would meet the clients' needs with minimum administrative procedures and maximum flexibility, while maintaining a high level of accountability to both the client group and the funding body.

The project was administered by a co-ordinator employed in the Department of Psychology, Massey University. The management was overseen by an Advisory Committee which comprised representatives from the Ministry of Health and Income Support Services, as well as veteran family (whanau) representatives. An estimate suggested that approximately 30% of the New Zealanders who served in the Vietnam War were Maori (Vincent, Chamberlain and Long, 1994). To ensure the program was culturally sensitive and accessible to both Maori and Pakeha (European) families, the Advisory-Management Committee included a Maori whanau (family) representative and consultations were held with the Department of Maori Studies, Massey University. As a result, an appropriate Maori name for the program was selected: 'Nga Whanau a Tu' (Families of War). Consultative meetings were also held with veterans and family members in three major cities.

Client eligibility

The definition of a 'client' was guided by three central tenets. First, claims that an individual had served in the Vietnam War were accepted on trust: formal verification was not undertaken. Second, clients self-identified as family members. Third, to ensure that the primary focus of the program remained the family, a veteran received counselling only if attending with a consenting family member. A client was considered to be anyone who identified as a member of a Vietnam War veteran's family, such as current, widowed, divorced or separated partners, children, parents, or siblings. More than one member of a family could receive counselling either jointly or separately.

Service provider eligibility

Developing criteria for service provider eligibility was a difficult task that was guided by the belief that the program should: maintain as much flexibility as possible in establishing service provider criteria; accept that the most experienced and often preferred service providers might not be those with the most formal or extensive qualifications; work towards ensuring cultural preferences. Service providers were required to state their

professional organisation, qualifications, experience, training and the code of ethics to which they adhered.

Publicity

A comprehensive promotional campaign was undertaken which included poster and pamphlet advertising, radio interviews, interviews or articles in newspapers, and a Vietnam Veterans newsletter. Promotional material was also distributed to general practitioners, all Iwi (tribal) Authorities, all mental health services and Citizens' Advice Bureau agencies throughout New Zealand.

Registration

A national toll-free telephone service and free-post mail registration were provided for potential clients to register for counselling. Registration was completed by the Program Coordinator, usually by telephone, and included the recording of descriptive and demographic information. Where the client did not have a preferred service provider, the Coordinator attempted to match client needs with appropriate providers. To maintain client confidentiality and control of the procedure, potential providers were not given client contact details. Instead, once a provider had accepted a referral, the client was asked to contact that provider directly to arrange an appointment. This allowed clients the opportunity to change counsellors if they chose. If the client did not make contact with the suggested provider, the Programme Coordinator made follow-up contact with the client to ensure there were not avoidable barriers to service provision. The program provided six one-hour counselling sessions to clients and had a registration period lasting approximately three months. Clients living in isolated locations were provided with financial assistance to meet travel costs.

Client characteristics

At the conclusion of the registration period 112 individuals had registered for counselling and been referred to 57 different counsellors across the country. The majority of those seeking services were wives (37%), ex-wives (17%) and widows (4%) of Vietnam veterans. Veterans themselves accounted for approximately 21% of those seeking services, and veterans' children accounted for 17%. Sixty-seven percent of the clients were female and 33% male. Sixty-one percent were married while 21% were separated or divorced, 13% never married and 5% widowed. The majority were of European descent (79%) with 15% Maori and the remaining 6% indicating a range of ethnic affiliations. Forty-one percent of those seeking help were not currently employed, with 22% in part-time employment and 37% in full-time employment. The age of clients ranged from 11 to 77 years ($M = 41.58$; $SD = 12.14$).

Presenting problems

Where possible, the Coordinator categorised the type of counselling or therapy being requested. Data on therapy preference was available for 50% of the clients who registered. Of these, 57% requested individual therapy, 23% couples therapy, 19% family therapy; only 1% requested child therapy. This data was independently confirmed by therapists who returned questionnaires on 90 of the clients and indicated that most of the therapy provided was individual (55%) followed by couples therapy (27%) and family therapy (16%).

Where contact was made by telephone, the Coordinator also made efforts to categorise the problems for which help was being sought. As there was missing data for mail registrations, data was only available for 75 clients. At the first level of analysis six broad problem categories (Yoken, 1988) were checked as present or not present: emotional, relationship, self-concept, achievement, physical complaint and trauma. Within five of the broad categories (trauma excluded) there were between three and eleven subcategories of problems which could be designated.

Most frequently, clients sought help with emotional problems (71%); relationship difficulties (56%); and physical complaints (13%). Of the clients who reported having emotional problems, the majority were experiencing multiple emotional reactions (37%). The largest single categories of emotional problems were 'anger' (10%) and diffuse 'distress' (10%). The most frequent relationship problems were: marital or romantic problems (38%); multiple relationship problems (35%); and non-marital family problems (27%). There was insufficient data on other categories to provide more detailed descriptions.

PROGRAM EVALUATION

Procedure

The design of the program evaluation was constrained by a number of factors. The most important of these was the principle emphasised by the Advisory-Management Committee that access to services for clients should take precedence over any evaluation. Consequently, it was decided that the evaluation could not include a pretreatment questionnaire or a request for client consent for therapists to divulge identifying information, as either might discourage utilisation of the program. Similarly, therapists were asked not to identify their clients when completing evaluation questionnaires. While this procedure protected client confidentiality, it meant that pre-posttest ratings could not be used and within-subject comparisons of client and therapist ratings were not possible.

Given these constraints, the following procedure was followed. A 'Posttest' questionnaire was sent to all clients three months after they had registered with the program. In this questionnaire they were asked to indicate if they were willing to have a similar questionnaire sent to them in another six months. The 'Follow-up' questionnaire was subsequently sent to all those who had indicated a willingness to participate further. Service providers were sent an evaluation questionnaire at the conclusion of each client's treatment, or after the allowable six sessions, whichever occurred first.

Measures

Psychological Distress

Current psychological distress was measured using the 21 item version of the Hopkins Symptom Checklist (HSCL-21) (Green, Walkey, McCormick and Taylor, 1988) which can be summed to obtain a Total Distress Score. The HSCL-21 has good psychometric properties (Green et al., 1988) and has been found to be a valid measure of psychotherapy change (Deane, Spicer and Leathem, 1992).

Client satisfaction

The eight item Client Satisfaction Questionnaire (CSQ-8) has been widely utilised and recommended as a measure of satisfaction with mental health service (Lebow, 1982; Nguyen, Attkisson and Stegner, 1983).

Target complaints

Using the target complaints measures (Battle, Imber, Hoehn-Saric, Stone, Nash and Frank, 1966) respondents recorded their two main complaints and then rated these according to the degree each disturbed them. Following Rosen and Zytowski (1977), these complaints were transferred verbatim onto the follow-up questionnaires. At this stage, clients were also asked to rate the extent to which each problem had changed, and to indicate how long each complaint had been bothering them prior to their seeking therapy.

Guided Inquiry

At follow-up, clients completed the Guided Inquiry (Heppner, Rosenberg, and Hedgespeth, 1992) which includes nine open-ended questions assessing client perceptions of various aspects of the counselling experience. Responses were coded using the classification system developed by Heppner et al. (1992).

Client or therapist ratings

Consistent with the recommendations of Beutler and Crago (1983), clients and therapists rated client status as they remembered it at the time they entered treatment, and also rated their current status ('now') at the end of treatment. Clients and therapists also rated client need for further therapy, and clients rated the overall 'helpfulness' of therapy.

Therapist ratings

Using the Global Assessment of Functioning Scale (American Psychiatric Association, 1987) therapists indicated client functioning along a continuum from 'mental health to illness'. Based on therapists' ratings, clients were also categorised as 'dropouts' (clients who did not attend their most recent scheduled appointment, and were considered in need of further treatment at their last visit), 'continuers' (same as dropouts, except that they attended their last appointment), or 'completers' (not considered in need of further treatment at their last visit) (Pekarik, 1985).

RESULTS

Sample description

Of the 112 clients referred to counsellors, 60 (54%) returned the posttest questionnaire, and 52 (87%) of these indicated a willingness to complete the six month follow-up questionnaire. Forty (36%) respondents returned the follow-up questionnaire. Respondents were compared to non-respondents on a range of demographic variables, using Chi-square or t-tests. No significant differences were found on any of the demographic variables: gender; marital status; ethnic identification; employment status; relationship to veteran; or age. This suggests that respondents were representative of all clients registered with the program.

The majority of respondents were current or past wives (55%), or children (17%) of Vietnam veterans. Veterans themselves accounted for approximately 22% of those seeking services. Sixty-five percent of clients were female and 35% male. The majority were of European descent (78%) with 15% Maori. Respondent age ranged between eleven and 77 years (M = 41.51; SD = 13.12 years). Over half (59%) of the respondents were engaged in part-time or full-time employment. Most respondents (94%) indicated that their target complaints had been bothering them for some considerable time prior to participation in the program, with the average length of time being approximately 14 years.

Therapy

At the conclusion of treatment, 33 (58%) therapists returned questionnaires relating to 90 (80%) clients. Over half (57%) of the therapists indicated that they had prior experience in either assessing or treating Vietnam veterans and/or their family members. Therapist responses confirmed that the majority of clients seen were veterans' wives or ex-wives (54%) and children (20%). Most of the therapy provided was individual (55%), couples therapy (27%), or family therapy (16%). Therapists indicated that 57% of clients had received some form of prior counselling.

Over one-quarter of therapists (26%) reported that treatment involved a 'combination' of approaches. Other approaches used included: cognitive-behavioural (11%); systemic family therapy (9%); unspecified family therapy (6%); 'Rogerian (supportive)' (7%); relationship-couples counselling (9%); 'brief' therapy (8%); and grief therapy (6%).

Clients attended between one and 12 therapy sessions (M = 5.18; SD = 2.83) and were, on average, in therapy for a period of nine weeks. The few clients who had more than six sessions had either been in therapy prior to the commencement of the program, chose to continue beyond the six sessions at their own expense, or, in exceptional circumstances, received additional funded sessions. While most sessions (67%) lasted for one hour, some (15%) were between 90 and 120 minutes duration. Of the 32 clients who responded to

the follow-up questionnaire, eight indicated they were still seeing their therapist at that time.

Dropout, reasons for therapy ending and need for further therapy

Using the definition advocated by Pekarik (1985), clients were categorised as 'dropouts' (12%); 'continuers' (41%); or 'completers' (47%). Therapists independently classified eleven cases as 'dropouts', however only nine of these cases matched the client categorisations. This suggests that the dropout rate over this short duration of therapy may have been as high as 15%.

The inability to match client and therapist ratings did not allow for a within-subject comparison of the reasons why clients dropped out of therapy. However, group comparisons indicate that the most frequently client-cited reasons for therapy ending was that allowable sessions had been completed (46%) or that problems had been solved or improved (15%). Conversely, therapists thought most clients (37%) ended therapy because the problem had been solved or improved, with the second most frequent reason being the completion of allowable sessions (17%).

In response to a dichotomous item, therapists indicated that 53% of clients were in need of further therapy at their last visit. Therapists were also asked to rate the extent to which further therapy was needed from 'no need' (1) to 'extremely high need' (7). The mean need rating for all clients was 3.84 ($SD = 1.84$, $n = 87$). The group of clients categorised on the dichotomous item as needing further therapy had significantly higher mean need levels than did those categorised as not needing further therapy ($t(84) = 9.19$, $p < .001$). This suggests internal consistency amongst these items. Using the same scale as therapists, the mean rating of 'need for further therapy' made by clients at posttest was 4.18 ($SD = 2.07$). Client ratings of perceived need did not alter significantly from posttest to follow-up.

Posttest outcome ratings

At the conclusion of the counselling sessions, therapists' ratings of clients on the Global Assessment of Functioning Scale (American Psychiatric Association, 1987) ranged from 35 to 90 and averaged 70.68 ($SD = 11.67$). The percentage of clients falling into each of the symptom ranges were: 'minimal' (20%); 'transient' (36%); 'mild' (24%); 'moderate' (14%); 'serious+' (6%). In general, the ratings suggest that most clients (80%) were experiencing minimal to mild symptoms but functioning reasonably well, while 20% continued to experience at least moderate problems which led to significant impairment in 'social, occupational or school functioning'.

At posttest clients indicated how well they were functioning when they *began therapy,* and how much two target complaints were bothering them when they *first started therapy.* They also indicated how they were *currently* functioning and how much each target complaint was *currently* bothering them. The results from a series of t tests used to compare each of the 'beginning therapy' and 'current' estimates of functioning, generally and for each target complaint, are presented in Table 1. The results suggest that, on average, clients felt that they had made significant gains generally and in terms of the specific target problems.

Therapists also rated client functioning as they remembered it at the time treatment started and 'now', at the end of treatment. The difference between these estimates of functioning were significant ($t(79) = -13.67$, $p < .001$), indicating that therapists also believed that clients had made significant gains in functioning after therapy.

Similar comparisons were made for estimates of functioning provided by clients at follow-up. The results of these analyses are presented in Table 2. Once again there were significant differences between the retrospective ratings for functioning when treatment started and current status (at follow-up). This was true for functioning in general, and for each of the target complaints identified by clients.

Maintenance of treatment gains

Comparisons were made between the posttest and follow-up client outcome measures of: current functioning; current target complaint functioning; HSCL-21; CSQ-8; helpfulness of therapy; and need for further therapy. Results of pairwise t test analyses are summarised in Table 3.

Significant differences were found between the means of only two measures. Ratings of current functioning and satisfaction with services both reduced significantly from posttest to follow-up. Thus, while clients' retrospective ratings of progress during therapy were generally positive, there was a slight tendency toward decline in therapeutic gains from posttest to follow-up.

To further clarify the maintenance of therapy gains, a method similar to that used when evaluating 'negative outcomes' was utilised (Mohr, Beutler, Engle, Shoham-Salomon, Bergan, Kaszniak and Yost, 1990). Following the procedure of Mohr et al., (1990) client outcomes were classified using a normative standard error estimate (SEest) on the Hopkins Symptom Checklist-21. HSCL-21 standard error estimates ranging from .44 to .57 have been reported for a random community sample, and samples of nurses, students and farmers (Deane, 1995). Using the more stringent criteria of .57, clients were classified into 'no change' (6%), 'deteriorated' (38%), and 'improved' (56%) groups. These results suggest that while there appeared to be a loss of therapeutic gains on the single global measure of functioning, when the HSCL-21 was used, 62% of respondents showed either improvement or no change over the six month follow-up period.

Guided Inquiry

When clients were asked to recount the most important thing that happened in counselling, the most frequent

Table 1: Comparison of mean scores of client estimates of 'beginning therapy' functioning and 'current' functioning, at posttest.

	Beginning therapy			Current		
	M	SD	M	SD	N	t
General functioning	3.09	1.10	4.81	1.18	58	–10.04**
'Bothered' by target complaint 1	7.04	1.87	4.91	2.11	53	6.28**
'Bothered' by target complaint 2	7.55	1.54	5.11	2.20	47	7.57**

*p <0.001

Table 2: Comparison of mean scores of client estimates of 'beginning therapy' functioning and 'current' functioning, at follow-up.

	Beginning therapy			Current		
	M	SD	M	SD	N	t
General functioning	2.90	1.18	4.37	1.51	38	–5.98*
'Bothered' by target complaint 1	7.05	1.90	5.45	2.24	38	3.80*
'Bothered' by target complaint 2	7.33	1.61	5.55	2.33	33	4.39*

*p <0.001

Table 3: Comparison of mean scores of client outcome measure at posttest and follow-up

	Posttest			Follow-up		
Measures	M	SD	M	SD	N	t
Current functioning	4.87	1.24	4.39	1.50	39	2.47*
Target complaint 1, now	5.17	2.08	5.39	2.28	36	–0.77
Target complaint 2, now	5.36	2.33	5.58	2.35	31	–0.56
HSCL-21	48.77	13.88	47.18	13.20	34	1.06
CSQ-8	24.58	5.95	23.33	5.98	36	2.06*
Helpfulness of therapy	5.31	1.45	5.00	1.85	39	1.19
Need for further therapy	4.60	1.83	4.41	1.99	37	0.63

*p <.05

responses related to: the opportunity to talk (25%); emotional support (18%); and no impact or a negative impact (18%). When asked what changes they made, respondents fairly evenly endorsed three response categories: behavioral changes in coping more effectively (35%); general statements about coping or maintenance (26%); and no impact or a negative impact (29%). In response to the question about what in counselling helped achieve desired changes, the opportunity to talk (28%) was again an important feature. This was followed by statements related to emotional support (17%) and 'not much or nothing' (22%). Insufficient time (34%) was the most frequent response to a question about obstacles to change. This may reflect idiosyncratic responses related to the time-limited nature of the program. The next most frequent statements indicated 'nothing' or no barriers to change (22%) and difficulty in being open (11%).

Three questions were related to how clients' perceptions of counsellors affected their perceptions of success in counselling. Over half (56%) of the clients reported that their liking for, or compatibility with, the counsellor had positive effects. Similarly, many (58%) felt that their trust in the counsellor affected counselling positively and over one third (37%) felt that the skill of the counsellor also affected therapy in a positive way, or mentioned specific qualities in relation to the skill of their counsellors (37%).

Most clients (72%) indicated that they thought about their counsellor or counselling between sessions, with most thinking about: possible future topics (26%); past counselling discussions (22%); or how to apply sugges-

tions or problem solving strategies (19%). Finally, consistent with the findings of Heppner et al. (1992), most respondents (70%) indicated that they had derived unexpected benefits from counselling. Of these, new or different cognitive information about coping (42%) and affective changes (38%) featured prominently.

DISCUSSION

While it is not surprising to find that wives and ex-wives of Vietnam Veterans were those most likely to seek help through the program, it is possible that they may have been seeking services on behalf of other family members. As with other outpatient treatment programs, more females than males sought therapy. Again, this is not surprising as almost all New Zealand Vietnam veterans are male. Although the ethnic composition of New Zealand Vietnam forces is not recorded, it is estimated that around 30% may have been Maori (Vincent et al., 1994). Despite efforts to include Maori in the development of the program, and efforts to encourage Maori to make use of services, they accounted for only 15% of clients. This suggests a need for greater outreach and for even greater cultural sensitivity in future.

Of those who gave some indication of their preferred mode of therapy, most were seeking individual therapy; however a significant proportion wanted couples therapy or family therapy. This finding could be seen as lending support to the calls for more family oriented therapy by researchers and practitioners involved in the care of veterans (Brende and Goldsmith, 1991; Carroll et al., 1985; Jordan et al., 1992; Silver and Iacono, 1986). However, we can only speculate about why there was not a greater client preference for family therapy and why more family therapy was not encouraged by therapists. Firstly, it may have been that there were difficulties in clients' and therapists' making distinctions between individual and family therapy. For example, a broad inclusive definition of marital or family therapy may include family therapies where there is only one 'patient' in the room. This may be particularly the case in behavioural family therapy (BFT) approaches where, as Todd (1988) notes in his comparison of behavioural and systemic therapy:

> ... in BFT the routine involvement of the spouse or family is often viewed as unnecessary and inefficient. The family may be brought in only when individually oriented procedures fail, or when behavioral observation suggests that the family members are helping to maintain the symptomatic behavior (p. 454).

In the context of the present study, it is possible that the therapists may have have been addressing family issues, but working with individual patients toward their goal. Future studies should attempt a clearer definition, or obtain more detailed therapist descriptions of what is conceptualised as family therapy.

It may also have been the case that given the long period of time since the veterans actually served in Vietnam, there might have been considerable family dislocation. Twenty-one percent of the sample were ex-wives or widows, and so it was unlikely that they were able to engage in therapy with their husbands. Similarly, a considerable proportion of the children of Veterans who sought help would no longer have been living in the family home. Given this, it may not have been physically possible to bring families together after such a long period of time. Similarly, it may have been too anxiety provoking for the individuals seeking help to engage in therapy with other family members whom they may not have seen for long periods of time. It would be helpful for future programs to clarify these issues.

If family therapy was underutilised as an option, then what implications does this have for future family therapy programs such as this? Forty-three percent of therapists in the study did not have prior experience in assessing or treating Vietnam Veterans or their families. In addition, the preferences and experience of the therapists with regard to family therapy approaches was not clear. The available data suggested considerable variability in therapeutic approaches. Inexperience with, or low preference for, family therapy may well have contributed to the low frequency with which family therapy was utilised. It would be self-evident to most family therapists that the families of Vietnam Veterans would be affected by the veteran's experience or psychopathology (e.g. PTSD). However, to those with less understanding of family dynamics, treatment issues related to the family of procreation or with the family of origin (e.g. Scaturo and Hardoby, 1988), the need to include family members might be far less obvious.

A minimal response to addressing such gaps might involve sensitising potential therapists to the issues specific to the program recipients (clients). This could be accomplished by either providing educational material to potential therapists or ensuring a minimum level of experience in therapy approaches considered optimal to the target client group. Given the wide physical distribution of clients in the present study, the need for accepting a range of therapists was compelling. Similarly, it might be advisable to provide additional information to clients regarding the various treatment options (where they are available). Simple explanations of the relative benefits and appropriateness of individual, couple, family or group therapies for different problems could be provided.

The descriptions of client problems recorded at registration were based on details provided by clients over the telephone. The provision of such details was not a pre-requisite for gaining access to the program, and some clients may have been reluctant to discuss problems under these circumstances. Despite this limitation, the problem descriptions confirm previous research (Jordan et al., 1992; Solomon et al., 1987; Chamberlain, Vincent and Long, 1994) and show that, overall, clients were experiencing multiple problems particularly in their marital and family relationships, and in handling their emotions.

Results from the program evaluation indicate that the treatment dropout rate may have been as high as 15% which is relatively low compared to the more usual rates

of around 40% reported for mental health services (e.g. Wierzbicki and Pekarik, 1993). A link between the low rate and the relative brevity of the program is supported by the reasons given by clients for termination of treatment. In addition to those who maintained that the end of funded sessions was the main reason for ending therapy, some indicated cost was a factor. Given that this was a free service, 'cost' concerns most likely referred to a wish to continue beyond the free sessions. Together, 'all allowable sessions completed' and 'cost too high' account for over half (56%) of clients' reasons for terminating therapy. The finding that cost was cited as a reason for termination is also somewhat puzzling in the light of the fact that state funded mental health services are available as part of the national health scheme. However, there are frequently substantial waiting times in Family Mental Health services. Difficulties with access may also include transportation problems for those in more remote areas. In the light of these factors, there may be utility in targeting specific 'at risk' groups in such programs. Although client and therapist reasons for ending therapy were not directly comparable, the results suggest that they do view the reasons for termination differently. However, there appeared to be a higher level of agreement between clients and therapists with regard to the need for further therapy.

At posttest and follow-up, clients gave estimates of change over the course of therapy. For all analyses, including therapist ratings, the results suggested that clients had made improvements as a result of therapy. These ratings should be viewed with caution since they relied on retrospective estimates of functioning at the beginning of treatment and utilised single item indicators. However, there seems to be concurrent evidence for improvement, with a proportion of both clients and therapists indicating problem improvement as a reason for therapy ending. These results support the fairly widely accepted view that psychotherapy, and in particular, broadly defined family and marital therapies, do produce benefits greater than for control groups (Shadish et al., 1993).

Results from the clients' global rating of current functioning suggest that there was deterioration from posttest to follow-up. Similarly, there was a reduction in satisfaction with services over this period. Using the more psychometrically sound HCSL-21 measure of general psychological distress, a different picture emerged which suggested that while some clients had deteriorated, a larger proportion had shown improvement, or no change. Consistent with previous findings (Nicholson and Berman, 1983; Shadish et al., 1993), the current results suggest minimal within-group deterioration over the posttest to follow-up period.

Descriptive analyses of the Guided Inquiry responses indicated that most clients felt one of the most important things that happened in therapy was the opportunity to talk and receive emotional support. However, consistent with outcome data, a number indicated that therapy had no impact or a negative impact on them. Most clients also indicated they had experienced unexpected benefits from counselling and this was mostly related to different cognitive information about coping and affective changes. As reflected in the reasons they gave for therapy ending, they saw the greatest obstacle to change as 'insufficient time'. Most felt that their trust in the counsellor and the skill of the counsellor affected therapy positively.

The current study was limited by a number of methodological problems. It was not a controlled study, and the inability to match client and therapist data on a case basis meant that only group comparisons were possible. The measures used in the study were limited to the extent that they reflected the individual functioning of family members of Vietnam Veterans, but provided no information about the functioning of the family unit. While the measures used appeared to suggest individual improvements as a result of therapy, we cannot necessarily assume these led to improvements in family functioning overall (although systems theory would predict that sustained change in individuals would elicit an improved level of functioning in other parts of the system). The small sample size further restricted the level of statistical analyses which could reliably be undertaken. For example, it had been hoped that we would be able to assess process related variables which might provide some clues as to what determined whether an individual improved or deteriorated over the follow-up period. Unfortunately, the sample size prevented any meaningful analysis and this question awaits further investigation.

While the response rate to the client posttest questionnaire (54%) was adequate, there was a poorer response at the follow-up phase of the study (36%). The response of over half (58%) of the therapists was most satisfactory, as their questionnaires related to a large percentage (80%) of all clients. When commenting on the external validity of studies included in their review, Shadish et al. (1993) indicated that most of the clients concerned had been experimenter-solicited or that treatment was based in a university setting. In contrast the present study had good external and ecological validity, since it used a wide range of therapists of different orientations, working with a group identified as being in genuine need of help.

Despite the limitations, and the largely descriptive nature of the findings, this study represents a useful contribution to the debate over the need for therapy for families of veterans, and the need for research which evaluates the effectiveness of such treatment. The established long term consequences of combat duty on families will probably continue to require 'second generation programs' which tend to focus 'on involvement with family and community rather than fellow veterans, and on relationships outside of the Vietnam/trauma circle' (Johnson, Feldman, Southwick and Charney, 1994: 227). The New Zealand Vietnam Veterans' Family Program was somewhat unusual in its focus on families and its restrictions on providing services to veterans unless accompanied by a consenting family member. While this policy may at first appear overly restrictive, it was made

in the context of a perceived need from family members which had been neglected over the years. In addition, it is consistent with systemic family therapy approaches which tend '... to assume that the family is almost universally involved in the symptomatology of a family member, and therefore advocates the routine inclusion of the whole family in therapy' (Todd, 1988: 453). If this is the underlying philosophy or premise of such a program, then consistency in its implementation may require clearer statements regarding the goals of family inclusion. As noted earlier, the present program had the broad aim of providing counselling services to families of Vietnam Veterans with few guidelines regarding specific counselling goals or emphasis. Clearer program goals could have been stated by, for example, emphasising the treatment of presenting problems or growth of the individual in the family.

SUMMARY

The present study replicates several existing findings and suggests a number of future considerations. There was a demand for services for family members of Vietnam veterans and a number of the problems centred around relationship difficulties. There is the need to clarify why Maori did not utilise the services to an extent propotional to their representation among veterans, and this may suggest the need for more culturally appropriate services or more aggressive outreach in future programs. The limited data suggest that even the brief therapy was associated with measurable improvements, with minimal deterioration over the six-month follow-up period. Caution is needed in interpreting these results, since longer follow-up periods may reveal greater loss of therapy benefits. Both therapists and clients agreed that continued treatment in a number of cases was needed and future programs might provide increased flexibility and clearer criteria for extended treatment.

There is a clear need to more carefully assess overall family functioning in future studies. In addition, indications for the use of individual or family therapy modes and their relative efficacy for specific goals should be investigated. Clearer specification of program goals or emphases may facilitate this process. Increasing participating therapists' awareness of the individual and systemic problems which arise in Vietnam or other veterans' families will also help focus treatment issues (see Scaturo and Hardoby, 1988). There is increasing awareness of the need to support families, not just after conflicts are over, but while their family member is actively engaged in the conflict (e.g. Shamai, 1994). Ongoing research assessing the effectiveness of these various interventions will hopefully lead to better treatments, less family breakdown, and reassure those funding the programs that this is money well spent. The descriptive evaluation of the Nga Whanau a Tu pilot program provides initial cause for optimism and a platform from which improved evaluation and services might be provided in the future.

Notes

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