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## *“Closing the efficacy-effectiveness gap”*

*Editor’s note: This article continues our series on elements of a recovery model of care. Family psychoeducation is an essential element of recovery and a type of service that until recently has been very rare in the VA. As a result of the President’s New Freedom Commission Report and the VA Mental Health Strategic Plan, many facilities in the last two years have begun to offer some form of family psychoeducation.*

### **Family Psychoeducation in VISN 16**

Michelle D. Sherman, Ph.D., Oklahoma City VA Medical Center

Dating back to the research in the 1960’s on expressed emotion, the family environment has been recognized as a significant factor in the course of mental illness. Families play a major role in consumers’ lives, as 40-65% of adults with a serious mental illness (SMI) live with their families (Solomon & Draine, 1995), and 75% of people living with schizophrenia have contact with their families (Lehman et al., 1998). Estimates for the VA suggest that 60-65% of SMI veterans either live with their families or have ongoing, close contact with their families.

Many clinically effective family programs have been developed over the past twenty years, so a number of standardized family interventions are now available. Although most of the treatments target schizophrenia, family programs are also available for other mental illnesses. These interventions have produced numerous positive outcomes; a meta-analysis (Falloon, Roncone, Held, Coverdale, & Laidlaw, 2002) of 23 controlled studies concluded that the benefits of family psychoeducation (FPE) for the treatment of schizophrenia (when added to standard pharmacotherapy and case management) included reduced risk of relapse, remission of residual psychotic symptoms, enhanced social and family functioning, and financial savings (due to decreased need for hospitalization). Another meta-analysis of 25 studies found that relapse rates can be reduced by 20%, if relatives of individuals with schizophrenia are included in treatment (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001). Findings of decreased frequency of relapse have been robust across cultures (Xiong et al., 1994), and gains have been sustainable over time (Tarrier, Barrowclough, Porceddu, & Fitzpatrick, 1994). In addition, families who receive services report feeling less burdened and are more effective in helping their loved ones deal with their illnesses. Family members who participate in FPE have been found to use fewer medical services themselves and to have fewer episodes of medical illness compared to standard care control group (McFarlane, Hornby, Dixon, & McNary, 2002).

*Due to these clear positive outcomes, FPE is now accepted as an evidence-based practice* (Dixon et al, 2001). Several practice guidelines strongly recommend the use of family intervention, including the Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, the American Psychiatric Association’s best practice guidelines, and the expert consensus guidelines for schizophrenia. Further, the President’s New Freedom Commission Report and the VA Comprehensive Mental Health Strategic Plan recommend that mental health services be transformed to focus more on recovery and on consumer/family needs and interests.

*In spite of the striking research findings and accompanying guidelines, few families actually receive any services.* For example, it is estimated that nationally less than 10% of families of outpatients with schizophrenia receive support services (Lehman et al., 2001) and the use of FPE “in routine clinical practice is alarmingly limited” (p. 908) (Dixon et al., 2001). An informal survey conducted in 2003 in the VA system revealed that *evidence-based models of family psychoeducational programs were not routinely being provided in any VAMC across the country* (McCutcheon, 2003).

#### **Status of Family Psychoeducation in VISN 16**

Three medical centers in our VISN have been fortunate to receive funding from VA Central Office to hire staff to implement FPE. Oklahoma City VA Medical Center received funding in the first round, and we are providing the REACH Project (**R**eaching out to **E**ducate and **A**ssist **C**aring, **H**ealthy Families). We are modifying Dr. William McFarlane’s Multifamily Group Model to meet the needs of the VA system. We are providing care to three groups of families: veterans living with PTSD, veterans living with an affective disorder, and veterans living with a schizophrenia-spectrum disorder. We are also incorporating elements of the existing Support And Family Education (SAFE Program). The REACH Project is off to a great start, having engaged many more veterans and their families in care than we had projected.

The Southeast Louisiana Veterans Health Care System (formerly the New Orleans VAMC) received funding in this most recent round and, under the leadership of Frederic Sautter, Ph.D., will provide Behavioral Family Therapy (Mueser & Glynn, 1995) to veterans and their family members. They will be providing care to two groups of families: veterans living with PTSD, and veterans with serious mental illness. The emphasis of the PTSD aspect of the program will be to engage and treat veterans of Operation Iraqi Freedom and Operation Enduring Freedom. A unique aspect of the New Orleans program is that veterans will initially receive 10 sessions of individual behavioral family therapy and will then be offered a choice of individual or group-based behavioral family therapy (as well as other complementary family- and couple-based treatments). Dr. Sautter is currently preparing to advertise for the new clinical positions.

Finally, the Michael E. DeBakey VA Medical Center in Houston also received funding recently, and under the direction of Quang (Charlie) Nguyen, Ph.D., plans to implement McFarlane’s Multifamily Group Program. Currently, they are interviewing applicants for their three positions and are exploring training options.

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## Meet the MIRECC Researchers: Dr. Scott F. Coffey

*Editor's note: This series of short interviews with South Central MIRECC researchers is intended to introduce readers to these investigators and their research. We hope that this series will communicate the wide range of mental health research being conducted in VISN 16 and also cue other investigators about possible links to their own work.*

### Interview with **Scott F. Coffey, Ph.D**

Associate Professor, Director, Addiction Research and Treatment Laboratory (ARTLab),  
Department of Psychiatry and Human Behavior, The University of Mississippi Medical Center  
and G. V. "Sonny" Montgomery VA Medical Center, Jackson, MS

**Editor:** *What is your area of research?*

**Dr. Coffey:** Broadly speaking, substance abuse, posttraumatic stress disorder (PTSD), and the relation between substance abuse and PTSD are my main areas of research interest. More specifically, I enjoy studying basic psychological processes that impact these disorders and how these basic psychological processes impact treatment outcome. For the past few years, my primary line of research has been examining trauma-related negative emotion in people with co-occurring PTSD and a substance use disorder and how the experience of this trauma-related negative emotion may impact substance abuse. In prior research, we have shown that when substance dependent (i.e., alcohol or crack cocaine dependent) patients with PTSD are presented with audiotaped descriptions of their worst traumatic event, craving for their preferred substance increases significantly. In a follow up study, we used the same intrusive memory inducing paradigm that we used in the first study but, following that laboratory session, participants either completed 6 sessions of exposure therapy, a PTSD treatment effective in reducing trauma-related negative emotion, or 6 sessions of relaxation training. What we found in this study was that in the exposure condition, alcohol craving elicited by the trauma narrative decreased but in the relaxation condition there was no change in alcohol craving between the two laboratory sessions. PTSD symptoms also decreased significantly and study retention was the same in the two conditions.

**Editor:** *What active studies do you have going?*

**Dr. Coffey:** We have a few studies that we are currently conducting, a few that we recently finished, and a few that we are just starting. One ongoing study, funded by the National Institute of Mental Health (NIMH), looks at impulsivity and emotion dysregulation in participants with borderline personality disorder (BPD), BPD and a substance use disorder, and a group of matched healthy controls. This is a laboratory-based study using behavioral tests to assess impulsivity and a psychophysiological paradigm to assess emotion dysregulation. The second ongoing study is directed by Dr. Julie Schumacher and is funded

by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). In this study, we are developing a brief intervention for alcohol dependent men who engage in intimate partner violence. We are hoping the intervention will increase motivation for these men to seek additional treatment to reduce their violence.

A study that Dr. Gayle Beck and I recently completed was a treatment development study for PTSD. In this NIMH-funded study, we developed a 14-week group-based cognitive behavioral therapy for PTSD. This small trial is very promising with approximately 88% of patients no longer meeting criteria for PTSD following the group treatment compared with 31% not meeting criteria following a minimal contact condition.

We are just starting three studies in our laboratory. The first study, funded by NIAAA, is directed by Dr. Schumacher and will look at impulsivity and executive cognitive functioning in alcohol dependent men who engage in, and who do not engage in, intimate partner violence. The second study is directed by my postdoctoral research fellow, Dr. Joseph Baschnagel. This study was recently funded by a MIRECC Pilot Research Award. Dr. Baschnagel will attempt to demonstrate in a laboratory-based experimental paradigm that veterans with PTSD who smoke may have particular difficulty quitting smoking because their symptoms of PTSD may increase their desire for nicotine. The last study that we are starting is funded by NIMH and is a collaboration with researchers at the University of Michigan and the National Center for PTSD. This epidemiological study looks at the mental health impact of Hurricane Katrina on approximately 1,000 Mississippi residents who were living in southern Mississippi in August 2005. This study is directed by Dr. Sandro Galea at the University of Michigan.

**Editor:** *What are the implications or potential benefits of your research?*

**Dr. Coffey:** I think my research in the area of PTSD/substance abuse comorbidity has the most potential to lead to direct improvements in treatment strategies within the next few years. PTSD and substance abuse often co-occur but, until recently, there was a reluctance to treat PTSD when a patient was also a substance abuser. There has been a fear that treating PTSD will lead the substance abusing patient to relapse. The problem is that relapse rates among substance abusers with PTSD are already high and the high relapse rate may be driven by the symptoms of PTSD, such as trauma-related negative emotion. Much more research needs to be conducted, but my research along with research from other groups (e.g., Ouimette, Moos, & Finney, 2003) suggests that reducing symptoms of PTSD may improve substance abuse treatment outcomes.

**Editor:** *How did you get started in this area of research?*

**Dr. Coffey:** I had an interest in addictions research as an undergraduate at Arizona State University and then followed up on that interest in graduate school at the University of Mississippi. I worked with Dr. Tom Lombardo, who studies smoking, and he helped to focus my interest on the role of negative emotion in the maintenance of addictions and taught me about research design and methodology.

**Editor:** *What person or experience had the most influence on your research career?*

**Dr. Coffey:** I think both one person and one experience influenced me greatly. The person is Dr. Donald Homa, a psychology professor at ASU. I took two classes from Dr. Homa, Learning and Memory and Experimental Psychology. Typically, these courses are not the most popular courses on campus, but Dr. Homa had a way of making the courses very interesting and got me excited about laboratory-based research with humans.

The experience that most influenced me was the training I received at the Medical University of South Carolina during my internship and fellowship. My internship was housed at the National Crime Victims Research and Treatment Center and my fellowship was housed at the Center for Drug and Alcohol Programs, a designated research center for both NIAAA and the National Institute on Drug Abuse (NIDA). Through this experience, I was able to work with Dr. Bonnie Dansky and complete a NIDA research fellowship with Dr. Kathleen Brady. Training with these very accomplished researchers opened the door to issues of comorbidity – specifically, PTSD and substance abuse comorbidity.

**Editor:** *What advice would you give to junior investigators and to people who are new to research?*

**Dr. Coffey:** Finding an area of research that you are passionate and excited about is very important. Certain aspects of research can be somewhat mundane, for example, treatment adherence checks in treatment outcome research, or staining in basic research. These aspects of research are more easily tolerated if an investigator is passionate about his or her research. For researchers with a little experience under their belt, good grantsmanship is essential. Grants expand the type and scope of projects that a researcher can initiate and, as research questions become more complex, grants are becoming increasingly important in answering the important questions.

**Editor:** *How can people get in touch with you if they have questions about your work?*

**Dr. Coffey:** I can be reached most easily by email at [scoffey@psychiatry.umsm.edu](mailto:scoffey@psychiatry.umsm.edu).



## No Web-based Presentations until January

Due to the holidays, the **MIRECC *Bringing Science to Practice*** web-based conference series on the third Thursday of the month is suspended for November and December. The series will resume again in January 2007. Watch this newsletter for further announcements. For additional information about this series, contact [Randy.burke@med.va.gov](mailto:Randy.burke@med.va.gov)

## Stedman's Abbreviations Now Available

Dixie A. Jones, MLS, AHIP, Overton Brooks VA Medical Center Library

The [Virtual Library](#) has added a new resource: *Stedman's Abbreviations*. Uncertain of the correct abbreviation to use for a word in a patient record? See an abbreviation and don't know what it means? Consult Stedman's Abbreviations! You can search by abbreviation, word or phrase, or simply scroll through the alphabetical list. An additional feature of Stedman's is that non-approved abbreviations contain notes in red type explaining why they should not be used. This resource is available 24/7 at your desktop.

For a half hour of continuing education credit, see the VISN 16 Librarians' tip on using Stedman's Abbreviations—also at the Virtual Library.

## MIRECC Research Rounds

The South Central MIRECC **Research Rounds** features Jeff Pyne, MD, on "Virtual Reality in the Treatment of PTSD," Monday, December 11 at 2:00 PM CT. Dr. Pyne will discuss a recently funded study to examine the use of virtual reality exposure therapy in the treatment of combat-related PTSD. Dr. Pyne is a MIRECC investigator with the Center Arkansas Veterans Health Care System, Little Rock, and  
XXXXXXXXXXXXXXXXXXXX[more here]

The purpose of the Research Rounds is to inform MIRECC investigators about each others' research interests and expertise and solicit feedback about work in progress. This series employs a commercial web-based conferencing technology called Web-Ex. Please contact Dr. Thomas Teasdale ([Thomas-teasdale@ouhsc.edu](mailto:Thomas-teasdale@ouhsc.edu)) for information about how to access the system.

## Online Resources for Psychiatric Rehabilitation

Compiled by Kathleen Dohoney, PsyD, VA North Texas Health Care System, Dallas, and  
Lisa Martone, APN, Central Arkansas Veterans Health Care System, Little Rock

[more here]



### December Conference Calls

1-800-767-1750

- 4—Education Core, 2:00 PM CT, access code 16821#
- 8—PSR Group Call, 1:30 PM CT, access code 85388#
- 11—Research Rounds, 2:00 PM CT, contact [Thomas-teasdale@ouhsc.edu](mailto:Thomas-teasdale@ouhsc.edu)
- 15—Directors Call, 3:30 PM CT, access code 19356#
- 20—Program Assistants, 2:00 PM CT, access code 43593#
- 26—Directors Call, 3:30 PM CT, access code 19356#
- 28—National MIRECC Recovery Interest Group – *canceled*

The next issue of the *South Central MIRECC Communiqué* will be published January 2, 2007. Deadline for submission of items to the January newsletter is December 21. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Michael R. Kauth, Ph.D., at [Michael.Kauth@med.va.gov](mailto:Michael.Kauth@med.va.gov).

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SC MIRECC intranet site: [vaww.visn16.med.va.gov/mirecc/mirecc.htm](http://vaww.visn16.med.va.gov/mirecc/mirecc.htm)

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