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# Trauma in Patients with Serious Mental Illness: The Acceptability and Impact of a Brief Psychoeducational Intervention for Trauma in the General Acute Inpatient Psychiatric Setting

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Philadelphia College of Osteopathic Medicine

Department of Psychology

TRAUMA IN PATIENTS WITH SERIOUS MENTAL ILLNESS: THE  
ACCEPTABILITY AND IMPACT OF A BRIEF PSYCHOEDUCATIONAL  
INTERVENTION FOR TRAUMA IN THE GENERAL ACUTE INPATIENT  
PSYCHIATRIC SETTING

Kevin E. A. Giangrasso

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of

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DEPARTMENT OF PSYCHOLOGY**

**Dissertation Approval**

This is to certify that the thesis presented to us by Kevin E. Giangrasso  
on the 11<sup>th</sup> day of August, 2014, in partial fulfillment of the  
requirements for the degree of Doctor of Psychology, has been examined and is  
acceptable in both scholarship and literary quality.

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### Abstract

Prevalence rates of posttraumatic stress disorder (PTSD) for individuals with serious mental illnesses (SMIs) are high, with an estimated 49% to 100% being exposed to potentially traumatic events. The consequences of these disorders are serious and lasting, with PTSD being the costliest of mental health disorders. At the same time, established evidence-based treatments for PTSD are often not feasible in treatment settings utilized by individuals with SMIs, namely the general acute inpatient psychiatric hospital. Psychoeducational approaches have been incorporated as a component of evidence-based interventions for trauma and have been feasibly implemented in the general acute inpatient psychiatric hospital. The objective of this study was to examine the acceptability and impact of a two-session psychoeducational intervention for trauma for individuals in a general acute inpatient psychiatric facility. Participants (N = 70) on a general acute inpatient psychiatric unit were assigned to one of two conditions: a) two-session psychoeducational intervention or b) general group treatment as usual. Measurements of participant PTSD symptoms and knowledge of PTSD were collected before and after treatment. Participants were also assessed subsequent to the intervention to examine treatment acceptability, as well as readiness to engage in future trauma-focused treatment. Results indicated that participants in the two-session psychoeducational group rated the group as significantly more acceptable than participants rated the acceptability of the general treatment group. Involvement in the two-session psychoeducational group did not result in an increase in PTSD symptomatology. No significant differences in knowledge of PTSD or readiness for future trauma-focused treatment were found. Nonetheless, these findings have implications for the treatment and

dissemination of evidence-based treatment of PTSD for patients with SMI in the general acute inpatient psychiatric hospital.

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## Chapter 1: Introduction

### Statement of the Problem

Lifetime rates of exposure to potentially traumatic events (e.g., gun violence or sexual assault) among nationally representative samples of the general population have been estimated at 18% (Mills et al., 2011), with lifetime estimates of posttraumatic stress disorder (PTSD)<sup>1</sup> as a result of traumatic events ranging from 7% to 12% (Kessler et al., 2005). The rates of prevalence of PTSD and exposure to trauma in more complex patient populations, such as those with serious mental illnesses (SMI), are even higher (Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011). Available evidence suggests that individuals with SMI have a prevalence of PTSD estimated between 29% and 43% (Mueser, Rosenberg, Goodman, & Trumbetta, 2002).

PTSD is associated with extremely high rates of service utilization and is considered one of the costliest mental disorders (Frueh et al., 2004). Additionally, PTSD is believed to persist over time if no intervention is sought (Resick, Monson, & Gutner, 2007). For these reasons, PTSD is an especially appropriate target for treatment. Further, traumatic events experienced by those with the most serious mental health problems (i.e., SMI) are often prolonged, repeated, and extended over years of individuals' lives (Jennings, 2004), making periodic hospitalizations more likely (Sharfstein, 2009). Patients with SMI and comorbid PTSD, however, have often been excluded from PTSD clinical trials; consequently, data are lacking regarding treatment outcomes with this population (Cusak, Grubaugh, Knapp, & Frueh, 2006; Grubaugh et al., 2011). As

<sup>1</sup> While *DSM-5* (American Psychiatric Association, 2013) is currently available at the writing of this dissertation, it had not been published during study conceptualization and data collection. As such, *DSM-IV-TR* criteria for PTSD are used here.

such, less is known about the treatment of PTSD in patients with comorbid SMI. Of those studies that have examined the treatment of PTSD, evidence supports the effectiveness of a variety of treatment approaches, most notably cognitive-behavioral treatments for PTSD, of which cognitive processing therapy (CPT; Resick & Schnicke, 1992) and prolonged exposure (PE; Foa, Rothbaum, Riggs, & Murcock, 1991) have garnered the most support (Foa et al., 1999; Foa et al., 2005; Monson et al., 2006; Mueser et al., 2008; Ponniah & Hollon, 2009; Resick, Monson, & Rizvi, 2008; Tuerk et al., 2011). These studies provide support for the delivery of these cognitive-behavioral treatments in a variety of formats, including group formats, to patients in both outpatient and long-term inpatient settings. These treatments, however, are not always feasible in available treatment settings, such as the general acute psychiatric inpatient setting.

Psychoeducation has been incorporated as a component of these evidence-based interventions for trauma and, less frequently, has been examined as a stand-alone intervention (Xia, Merinder, & Belgamwar, 2011). Psychoeducation as a component of developed interventions is thought to enable patients to cope more effectively with their illness and engage in treatment, as well as to contribute to a reduction of relapse and readmission rates, an improvement in compliance with medication, and an increase in social functioning and personal well-being (Xia et al., 2011). Thus, psychoeducation is believed to be a valuable component of intervention for patients, as it contributes to the reduction of symptoms and improvement in quality of life.

Various studies have examined the efficacy of psychoeducation for SMI (Colom et al., 2003; Falloon, 2003; Magliano et al., 2006; Miklowitz et al., 2000; Xia et al.,

2011). Fewer, however, have examined the impact of psychoeducation for PTSD (Ehlers et al., 2003; Lubin, Loris, Burt, & Johnson, 1998; Oflaz, Hatipoglu, & Aydin, 2008), with an even smaller number examining the impact of psychoeducation for patients with PTSD and SMI (Pratt et al., 2005). Results from one study that examined psychoeducation for patients with PTSD and SMI in an inpatient psychiatric treatment facility showed post treatment gains in knowledge about trauma and PTSD, as well as high levels of treatment satisfaction; however, it was conducted without a control condition and did not systematically evaluate changes in posttraumatic symptomatology (Pratt et al., 2005).

Empirically supported treatments for PTSD often require a length of treatment that is not feasible within the acute inpatient treatment environment. Further, they may produce an initial exacerbation of re-experiencing symptoms (Nishith, Resick, & Griffin, 2002). This initial worsening of symptoms would not be indicated in the acute inpatient setting, a treatment environment primarily aimed at crisis stabilization.

Therefore, alternative treatments for patients with SMI and PTSD in inpatient psychiatric settings must be developed and investigated. Inpatient psychiatric care, including acute-care settings, has been deemed appropriate for a significant segment of the patient population in practice (U.S. Department of Health and Human Services, 1999), but because of the nature of this treatment setting, the high prevalence of patients with PTSD and comorbid SMI, and the lack of appropriate treatments available, the pursuit of alternative treatments for psychological trauma in the inpatient psychiatric setting is a valuable area of study.

Psychoeducational interventions provided in the inpatient facility may promote

the goal of the acute-care setting by facilitating symptom stabilization and increasing the likelihood of continued treatment. Symptom stabilization may be facilitated in part by increasing knowledge of PTSD symptoms and indicated treatments without exacerbating posttraumatic symptoms while in the inpatient facility (Pratt et al., 2005). Further, psychosocial interventions may help to reduce rehospitalizations for patients with SMI as they facilitate engagement in effective outpatient care (Bach & Hayes, 2002). By facilitating the process of crisis stabilization, a psychoeducational approach to trauma in the psychiatric inpatient setting fits within already established goals for psychiatric inpatient stay (Bowers et al., 2005).

In addition, Recovery Transformation (Achara-Abrahams, Evans, & Kenerson, 2011), a movement in mental-health treatment that has become the guiding paradigm in mental-healthcare provision, has emphasized the importance of addressing trauma because of its impact on numerous indicators of overall well-being among mental-health consumers. Trauma-informed care has thus become a cornerstone of recovery-oriented care, and a psychoeducational approach to the treatment of trauma coincides with this emphasis. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2005) offers the following working definition of recovery: “A process of change through which individuals work to improve their own health and wellbeing, live a self-directed life, and strive to achieve their full potential” (p. 5). A recovery-informed approach to treatment implies that the individual being treated has control over directing his or her own treatment and that the individual is supported by peers and allies during the recovery process. In particular, self-management of psychiatric illnesses is an integral aspect of consumer-directed mental-health treatment (Cook, 2005). By offering information about

the consequences of trauma with an emphasis on those aspects that support resilience and adaptation, a short-term psychoeducational group treatment for trauma has the potential to support a person-centered approach to overall treatment and is in keeping with the central components of a recovery approach.

In order to examine the acceptability and impact of a two-session psychoeducational intervention for trauma for individuals in a general acute inpatient psychiatric facility, the following study was proposed and conducted.

### **Purpose of Study**

The goal of this study was to investigate the acceptability and impact of a two-session psychoeducational group intervention for trauma in an acute inpatient psychiatric setting. The aims of the study included (a) to assess the impact of the group intervention on patient knowledge of PTSD and its clinical correlates, (b) to understand the acceptability of this intervention from the patient perspective, and (c) to further explicate the relationship among presence of PTSD symptoms, acceptability of this treatment, and readiness to engage in trauma-related clinical treatment.

## Chapter 2: Literature Review

The following review will provide the reader with a background of the research literature that formed the framework for an investigation into the acceptability and impact of a psychoeducational approach for trauma in patients with serious mental illnesses (SMI). The review will give a background of key terms, concepts, and current literature, followed by the description of a study that evaluated the acceptability and impact of the developed two-session psychoeducational intervention for trauma in the general acute inpatient psychiatric setting.

### Psychological Trauma, PTSD, and SMI

Trauma is defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> ed., Text Revision (*DSM IV-TR*, 2000) within the disorder of Posttraumatic Stress Disorder (PTSD; see Footnote 1). This definition defines psychological trauma, within Criterion A1, as follows:

The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (APA, 2000, p. 467)

The diagnostic criteria of this disorder, however, establish a narrower definition for psychological trauma than is useful when considering a psychoeducational intervention. Extreme emotional abuse, major losses or separations, degradation or humiliation, and

coerced (though not physically forced) sexual experiences are missing from the currently accepted definition (Briere, 2006), and conditions that do not meet the full criteria for PTSD have been shown to have a deleterious impact on functioning (Erickson, Hedges, Call, & Bair, 2013).

Much of the investigation into the treatment of psychological trauma has focused on the treatment of PTSD as delineated in the *DSM-IV-TR*. Additional criteria for the diagnosis of PTSD include a response of intense fear, helplessness, or horror to the event (Criterion A2), persistent re-experiencing of the event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D; APA, 2000). Symptoms must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F). Specifiers for the disorder include acute, chronic, or with delayed onset. PTSD shares some characteristics with the other anxiety disorders, but it is clearly understood as a separate diagnosis with different features (APA, 2000).

Using a wider definition of trauma by considering an event as traumatic “if it overwhelms the individual’s internal resources” (Briere, 2006, p. 5) may more closely capture the true scope of the problem of psychological trauma (Briere, 2006). This review will include both the *DSM-IV-TR*-informed conceptualization of psychological trauma and Briere’s (2006) wider definition of trauma. PTSD and PTSD-related research will nonetheless be described, as the majority of research on trauma is limited to this disorder.

The study described later addresses the treatment of trauma within individuals with SMI. Public Law 102-321, The ADAMHA Reorganization Act (1992), established

in Congress the Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of SMI. A person is considered to have a Serious Mental Illness when that person has as least one *DSM* disorder other than a substance use disorder for a period of at least 12 months, with this disorder causing serious impairment in daily life (Kessler et al., 1996). Serious impairment is defined by severity of mental illness, having planned or attempted suicide, substantial vocational interference, and/or serious interpersonal impairment (Kessler et al., 1996).

## **Epidemiology**

### **Prevalence.**

Lifetime prevalence estimates of PTSD range from 7% to 12% within the general adult population (*DSM*, 2000; Kessler et al., 2005), while prevalence of exposure to potentially traumatic events has been estimated at 18% (Mills et al., 2011). Individuals who live with SMI experience traumatic events at greater rates than individuals within the general population. Accordingly, PTSD prevalence in samples of individuals with SMIs has been estimated at between 29% and 43% (Mueser et al., 2002), indicating a much higher likelihood of PTSD diagnosis over the course of a lifetime as compared with the general population. Rates of traumatic exposure among individuals with SMIs have been documented at prevalence rates between 49% and 100% (Grubaugh et al., 2011). The environments in which many individuals with SMIs seek treatment, such as inpatient settings, may contribute to increased prevalence of trauma exposure as a result of the procedures employed (i.e., use of restraints) in these settings (Huckshorn, 2004).

**Course.**

Among the general population, PTSD is associated with extremely high rates of service utilization and is considered one of the costliest of mental disorders (Frueh et al., 2005). Additionally, PTSD symptomatology has been shown to persist over time without intervention (Mueser et al., 2002; Resick et al., 2007). In addition, The President's New Freedom Commission on Mental Health (2003) has called for more research in the area of the treatment of trauma and has identified this area as important for future investigation. For these reasons, PTSD is an especially appropriate target for treatment.

Further, the traumatic events experienced by those with SMI are often prolonged and repeated and may extend over years of a person's life (Jennings, 2004), making periodic hospitalizations more prevalent among this population (Sharfstein, 2009). Indeed, individuals with SMIs and a history of child abuse often present with more severe symptomatology and can be more than twice as likely to commit suicide as compared to individuals with SMIs without a history of abuse as a child (Alvarez et al., 2011). Men and women with SMIs are also at a higher risk of being victims of violence as compared to the general population (Khalifeh & Dean, 2010). Owing to the higher rates of exposure to trauma and PTSD in individuals with SMIs and the increased vulnerability of these individuals, individuals with SMIs may also be more likely to develop PTSD after exposure to traumatic victimization (Goodman et al., 2001). Patients with SMI and comorbid PTSD, however, have often been excluded from PTSD clinical trials, resulting in a lack of data regarding treatment outcomes with this population (Cusak, Grubaugh, Knapp, & Fueh, 2006; Grubaugh et al., 2011). As such, less is known about the treatment of PTSD in patients with comorbid SMI. Additionally, PTSD is often underdiagnosed. In

the inpatient psychiatric setting, for example, as few as 5% of patients with PTSD have this diagnosis documented in their treatment chart (Mueser et al., 2002). Note that the studies cited each used different assessment methods for identifying PTSD; these varying methods may result in differences in obtained PTSD diagnoses. This low percentage of documented PTSD, however, does suggest a lack of awareness of the disorder in these facilities when compared with estimates of general PTSD prevalence in samples of individuals with SMIs.

One promising theoretical model for understanding the nature of the interaction between PTSD and SMI has been proposed, in which PTSD is theorized to influence other psychiatric disorders both directly and indirectly (Mueser et al., 2002). In this model, PTSD directly impacts the individual's experience of SMI via PTSD symptoms, such as avoidance, hyperarousal, and reexperiencing of the trauma. Indirect impacts include common correlates of PTSD, such as retraumatization, substance abuse, and interpersonal difficulties. These specific symptoms and clinical correlates of PTSD are expected to exacerbate the co-occurring psychiatric disorder and increase the likelihood of poor outcomes and use of higher cost psychiatric services among individuals with SMI (Mueser et al., 2002). In addition, individuals with SMIs and PTSD often are at higher risk for suicide and experience more severe symptomatology as compared to individuals without SMIs who have PTSD (Alvarez et al., 2011; Khalifeh & Dean, 2010). Thus, PTSD is an especially important area of investigation among individuals with SMIs, as the experience of PTSD may further complicate individual experiences of people with both an SMI and PTSD. The President's New Freedom Commission on Mental Health (2003) has recognized this research need with its call for more investigation into effective

treatments for trauma.

Understanding the theoretical underpinnings of the contributions of SMI and PTSD to problematic symptomatology in individuals with a co-occurring SMI and PTSD is important for the development of evidence-based approaches for PTSD in individuals with SMIs for a number of reasons. First, given that patients with SMIs have been excluded from clinical trials for the treatment of PTSD, gaps exist in current research literature in the area of treatment for these individuals. Second, those with SMIs may be at heightened risk for the development of PTSD as compared to the general population, and theory may help explicate why. Third, PTSD is often under diagnosed in treatment settings in which individuals with SMI seek treatment, and a resulting lack of clinical emphasis on PTSD may be a contributor to patient symptomatology in utilized treatment settings. Taking both theoretical underpinnings of the interactions of SMI and PTSD and established research literature in the treatment of PTSD into account can help to best inform a treatment approach for trauma in the general acute inpatient psychiatric setting.

### **Evidence-Based Treatments for PTSD**

Many psychological interventions exist for the treatment of PTSD in adults. These treatments have varying degrees of support for their efficacy. The psychological interventions that have been shown to be the most efficacious in the treatment outcome literature are reviewed here. Those components that are believed to be or have been shown to reduce PTSD symptom severity, and, thus, are considered essential ingredients, are also discussed. Additional components that are believed to support or enhance these essential interventions are also reviewed.

Cognitive-behavioral therapy (CBT) for PTSD has the most empirical support in

the reduction of PTSD symptoms in the treatment outcome literature. Both cognitive processing therapy (CPT; Resick & Schnick, 1992) and prolonged exposure (PE; Foa et al., 1991) are types of CBT approaches for PTSD that have demonstrated to account for a significant reduction in PTSD symptoms. Emotional processing of a traumatic memory via therapeutic exposure to that memory, as well as supporting changes in the meaning that the individual associates with the traumatic event is the mechanism of action theorized to underlie the efficacy of CBT treatments (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000). While both CBT interventions have shown to reduce symptoms of PTSD, they achieve this goal in different ways.

CPT has been shown to be effective in improving PTSD in rape victims, in military-related PTSD, and on an outpatient basis in individual and group formats (Resick & Schnicke, 1992; Monson et al., 2006; Resick et al., 2008; Mueser et al., 2008). CPT is conducted in approximately 12 weekly 1.5-hour sessions and includes psychoeducation, exposure, and cognitive interventions in its treatment of patients experiencing PTSD (Resick & Schnicke, 1992). CPT begins by utilizing psychoeducation, which includes educating the client on theory about the development of PTSD, instructing the patient on identification of thoughts and feelings, and providing education about the course of CPT. Later sessions focus on exposure to a traumatic memory and challenging maladaptive beliefs related to the traumatic experience that may influence the maintenance of PTSD symptoms.

PE has demonstrated the most consistent evidence supporting its use with patients diagnosed with PTSD (Ponniah & Hollon, 2009; Foa et al., 1999; Foa et al., 2005; Tuerk, 2010). PE is conducted in weekly 1.5 hour sessions and incorporates psychoeducation,

exposure, and processing components over the course of eight to 15 sessions. PE begins with and relies on the patient's understanding of the *treatment rationale* (Foa et al., 1991; Foa et al., 1999). The patient is first educated about the rationale for how PE can reduce the patient's PTSD symptoms and PTSD-related distress and is provided psychoeducational information about common PTSD symptoms and skills for coping with anxiety in general. Following delivery of the treatment rationale, the sessions proceed with both *imaginal* exposures, as part of which the patient activates anxiety associated with the traumatic memory, and *in vivo* exposures, during which the individual confronts in person reminders of the trauma in between sessions.

While other treatments exist for PTSD, they have garnered less support as compared to PE and CPT in the outcome literature. These treatments include stress inoculation therapy (SIT; Meichenbaum, 1994) and eye movement and desensitization reprocessing (EMDR; Shapiro, 1995). Both incorporate components that directly address posttraumatic symptoms as well as components that support or enhance those interventions. While brief psychodynamic therapy (Horowitz et al., 1997) is also used to treat PTSD, support for its efficacy is lacking in the literature, and therefore, it is not included in this review. SIT and EMDR are briefly reviewed here.

Although SIT has been shown to reduce PTSD symptoms immediately post treatment, PE appears to elicit a longer maintenance of PTSD symptom reduction when compared to SIT (Foa et al., 1991). SIT consists of three phases: conceptualization, skill acquisition and rehearsal, and application and follow-through (Meichenbaum & Deffenbacher, 1988). The first phase, conceptualization, primarily consists of patient education. This phase involves collaboration between the therapist and patient, in which a

common *explanatory scheme* for understanding the nature of anxiety is developed.

Ongoing treatment in the final two stages emphasizes relaxation-based coping skills to lower arousal and cognitive coping skills to alter anxiogenic thoughts and images.

EMDR has been shown to be effective for PTSD (Ponniah & Hollon, 2009; Seidler & Wagner, 2006). This treatment aims to help the client to desensitize to traumatic stimuli through movement in the eyes while recalling a traumatic memory (Shapiro, 1995). EMDR consists of exposure, eye movements, hand taps, and sounds that are designed to help the client with symptoms of trauma. In EMDR, eliciting the traumatic memory is an explicit part of the approach.

The interventions reviewed here have been demonstrated to be effective in the treatment of PTSD; however, individuals with SMI are often not included in empirical studies (Mueser et al., 2002), and these approaches are not always feasible to implement in available treatment settings, such as the general inpatient psychiatric facility, in which a primary goal is patient stabilization (Bowers et al., 2005). Conducting an exposure-based intervention in the inpatient setting is not thought to complement the overall goals of the general psychiatric inpatient setting, as the use of such treatment may result in an initial re-exacerbation of PTSD symptoms (Nishith et al., 2002; Tarrier et al., 1999) and thus may disrupt the patient's stability. In addition, the amount of time required for any of the reviewed treatments is longer than the average stay of 1 week in a general acute inpatient psychiatric setting (Hutchins, Frank, & Glied, 2011).

All approaches for PTSD described include education as an initial treatment component and rely on the patient's understanding of a basic rationale for each intervention. Offering the patient initial information about typical reactions to trauma, as

well as information about available and effective approaches for trauma, may help to encourage patients suffering from PTSD to seek mental-health treatment following their discharge from the inpatient psychiatric facility. In addition, educational approaches can be empowering, as these approaches allow patients to develop as more informed consumers of the treatment. As such, the provision of psychoeducation related to common PTSD symptoms and available effective interventions has the potential to assist further in the attainment of the goal of stabilization and address the short-term needs of the patient during the psychiatric inpatient stay.

### **Psychoeducation**

Psychoeducation has been described as a model of treatment that is grounded in teaching knowledge, personal and interpersonal attitudes, and skills to empower the individual to solve present and future psychological problems and enhance life satisfaction (Guernsey, Stollak, & Guernsey, 1971). The goal of psychoeducation is often distinct from that of an intervention in which the reduction of symptoms is a theorized outcome of treatment. Rather, the outcome of treatment may be focused on the integration of knowledge, skills, and attitudes into the individual's repertoire such that the person may apply knowledge, attitudes, and skills in order to address present and future concerns and enhance life satisfaction. Authier (1977) shared the following view of an advantage of a psychoeducational intervention:

The content is limited only by the imaginations of the persons seeking help and by the ability of the psychological practitioner to be innovative and creative enough to design a systematic program for teaching his/her clients what they want to learn. (p. 17)

This statement further elucidates the point that psychoeducation can be flexibly implemented. Rather than a problem-specific intervention through which the treatment provider offers a specified set of procedures, psychoeducation can be tailored in such a way as to provide the client with the information, skills, and/or attitudes they may use to address the difficulties they experience.

Hornby (1990) later explicated a developmental model of psychoeducation in which treatment providers are seen as having the goal of helping clients to “develop skills rather than solve problems” (p. 191). This model includes three stages: exploration, intervention, and empowering. Exploration involves relationship building and clarifying concerns, while the intervention stage includes developing new behaviors and perspectives. The empowering phase involves consolidating changes and supporting future action. Within this model of psychoeducation, interventions are conducted with the goal of helping the client to gain a better ability to effectively manage daily life. The techniques used to achieve this goal may be chosen from a variety of theoretical approaches; by this definition, psychoeducation can be considered eclectic in its approach to treatment.

An increased knowledge about the symptoms, etiology, and course of their disorder, as well as the nature of the treatment, is thought to enable patients to cope more effectively with their illness and to engage in treatment and thus reduce severity of symptoms (Xia et al., 2011). Thus, psychoeducation has been incorporated as a component of evidence-based interventions and, less frequently, has been examined independently (Xia et al., 2011). The inclusion of psychoeducation in interventions may also contribute to a reduction of relapse and readmission rates, an improvement in

adherence to medication, and an increase in social functioning and personal well-being (Xia et al., 2011). Thus, psychoeducation is believed to be a valuable component of interventions for patients as it contributes to the reduction of symptoms and improvement in quality of life.

Psychoeducation directed at reducing symptoms of PTSD can be defined as the process of providing information about the nature of stress, symptoms of PTSD, skills to cope with symptoms, and available treatments for symptoms (Wessely et al., 2008). Psychoeducation about PTSD has been recommended as a treatment or component of treatment for persistent PTSD (Foa et al., 1999). Psychoeducation about the persistent impact of trauma can help survivors better understand their own stress response and increase their knowledge of coping strategies, while concurrently providing a sense of control over these responses (Phoenix, 2007). Further, the provision of resiliency-focused knowledge about PTSD may lead to a greater sense of competence, which can positively impact both acceptability of treatment and the experience of PTSD symptoms (Bryant et al., 2008). Psychoeducation for SMIs, defined as education about symptoms of the psychiatric disorder, expectations/prognosis, and benefits of treatment, has the goal of preventing further hospitalization or of managing the individual's illness in order to maximize overall health (Xia et al., 2011).

### **Psychoeducation for SMI.**

Various studies have evaluated the efficacy of psychoeducation for SMI (Colom et al., 2003; Falloon, 2003; Magliano, Fiorillo, Malangone, De Rosa, & Maj, 2006; Perry, Tarrier, Morriss, McCarthy, & Limb, 1999; Xia, 2011). Fewer, however, have examined the impact of psychoeducation for PTSD (Ehlers et al., 2003), with an even small number

examining the impact of psychoeducation for patients with PTSD and SMI (Pratt et al., 2005). Studies examining psychoeducation for SMI and psychoeducation for PTSD, as well as one available study examining psychoeducation for patients with PTSD and SMI, are discussed briefly in the following pages.

Colom et al. (2003), in a single-blind, randomized, prospective clinical trial, examined the efficacy of a group psychoeducational intervention added to standard psychiatric care in patients with remitted Bipolar 1 as diagnosed via *DSM-IV-TR* (2000). The psychoeducational intervention examined in this trial involved 20 in-person sessions of 90 minutes each and a sample of 50 individuals whose symptoms had remitted and who were not engaged in any other psychotherapy. It focused on illness awareness, treatment compliance, early detection of prodromal symptoms and relapse, and lifestyle regularity during discussions among eight to 12 patients and two psychologists. During the intervention, 30 to 40 minutes of information presentation were followed during each group session by a related group activity involving discussion of the day's topic. Significant differences between the standard-care-only group and the standard-care-plus-psychoeducation group were found in terms of episodes of Bipolar 1 relapse as measured once every 2 weeks during the study period (including 2-year follow-up) by recurrence of either mania or depression. Mania and depression were measured by interview assessment of whether the individual met *DSM-IV-TR* (2000) criteria as well as by score on the Young Mania Rating Scale (YMRS) or the Hamilton Depression Rating Scale (HDRS). The findings of this study support psychoeducation as a method of helping patients to detect prodromal symptoms and as a support for early intervention among patients with SMIs in a long-term (20-week) approach.

In another study of psychoeducation delivered individually to patients with SMIs, Perry et al. (1999) examined the efficacy of teaching the identification of prodromal symptoms of bipolar disorder and how to seek treatment in the event of the occurrence of such symptoms. This research used a single-blind, randomized controlled trial with 69 participants diagnosed with bipolar disorder who had experienced a relapse in the previous 12 months. Psychoeducation-based treatment in this study involved training the patient to identify early signs of mania or depression and rehearsing a developed action plan once these symptoms were identified. During this treatment, participants were asked to self-monitor by using diaries in order to help them to distinguish between normal mood fluctuations and prodromal symptoms of mania and depression. Between seven and 12 sessions of 1 hour each were conducted over the course of 18 months; one participant and one research psychologist met individually to conduct each treatment session. Time between manic episodes was significantly increased by the introduction of psychoeducation with these participants, and the overall number of mania relapses was reduced, although depressive symptoms were not significantly affected by the psychoeducational intervention. Psychoeducation with the goal of helping individuals to identify prodromal symptoms of bipolar 1 disorder has been shown to add additional treatment benefit when added to standard psychiatric care and thus may be considered a useful adjunct to standard psychiatric treatment among these individuals.

Psychoeducation has also been shown to add substantial benefits to the standard care of individuals diagnosed with psychotic disorders. In particular, family-based psychoeducation has been shown to add significantly to standard care in individuals with schizophrenia (Falloon, 2003). Magliano et al. (2006) demonstrated that providing a

psychoeducational intervention for families may also be effective in the improvement of functional outcomes in the areas of social relationships, job attainment, and management of social conflicts for individuals with schizophrenia. Falloon (1985) developed a psychoeducational intervention that consisted of assessment of individual and family needs, information about clinical aspects of schizophrenia, treatment, early signs of relapse, communication skills training, and problem-solving skills training. This intervention was used in a multisite effectiveness trial in public-health centers in Italy. Among 71 families, 42 completed the intervention, and 29 served as controls. Families attended at least three 1-hour sessions a month over a period of 6 months, with the final number of sessions varying somewhat by family involved. Significant improvements in levels of disability, social withdrawal, interest in employment, and management of irritability within interpersonal interactions were found in the study participants in the intervention group when compared to controls.

Outcomes have been mixed in studies examining the impact of psychoeducation as a stand-alone treatment for trauma. Oflaz, Hatipoglu, and Aydin (2008) demonstrated that the inclusion of a psychoeducational component following experience of trauma led to increased adherence to medication treatment. This study examined 68 adults diagnosed with PTSD in a military-based outpatient clinic in Turkey. These study participants had no diagnosis of a psychotic disorder, had not recently received psychological treatment or psychiatric medication, and did not have brain injury. Six individual psychoeducational sessions were conducted using a problem-solving-based approach, keeping in line with Hornby's three-stage model. They demonstrated that a psychoeducational intervention was associated with a decrease in avoidance, PTSD, and depression-related symptoms

(Olfaz et al., 2006). Specifically, significant differences were found between psychoeducation with medication and medication-only groups, with the former resulting in fewer PTSD symptoms, reductions in depressive symptoms, and improvements in problem-solving ability. Although a promising initial view of the potential impact of psychoeducation on PTSD symptomatology, this study excluded the individuals with multiple experiences of trauma, as well as those with an additional psychiatric diagnosis (except depression). Thus, the findings of the study may not be generalizable to populations seen in inpatient settings with a different disorder profile.

In a sample of multiply traumatized women, approximately 50% of whom had been hospitalized or had attempted suicide (one major indicator of an SMI), Lubin, Loris, Burt, and Johnson (1998) demonstrated that a 16-session, group-delivered psychoeducational intervention for PTSD resulted in a reduction of PTSD symptoms and that this reduction in symptoms was maintained at 6-month follow up. While demonstrating some success, the treatment was lengthy and thus unsuitable for certain treatment settings. As such, an investigation of a shorter-term group psychoeducational treatment for trauma with individuals with PTSD would be of use. Additionally, while this study included a high number of patients who could be considered to have SMIs, the intervention itself was not explicitly directed toward patients with both SMI and PTSD.

One study has assessed the feasibility of delivering psychoeducation for PTSD to individuals with SMIs in an inpatient facility (Pratt et al., 2005). This study was not developed as a therapeutic treatment for the symptoms of PTSD, but rather in order to evaluate gains in knowledge and patient satisfaction after educating patients about the nature of the disorder and possible treatment options. This study, which included 70

individuals in a state psychiatric hospital and involved three videotaped sessions of a therapist and client that were viewed by a group of individuals with SMIs, assessed the feasibility of the psychoeducational program (Pratt et al., 2005). The videotaped sessions were viewed by the group and included predetermined stoppage points during which the group engaged in a discussion based on the information provided. Each session was held for approximately 45 to 60 minutes. A repeated measures analysis of variance (ANOVA) was performed in order to evaluate change in knowledge of PTSD symptoms and available treatment over time and to evaluate whether there were differences in knowledge gain differed as a function of gender and diagnosis. At the conclusion of this psychoeducational program, participants demonstrated significant increases in knowledge about trauma and PTSD and reported high satisfaction with the program (Pratt et al., 2005). Although an important attempt at offering psychoeducation in a group setting to patients while they are in a general inpatient facility, this study was preliminary and did not systematically evaluate changes in posttraumatic symptomatology before and after the psychoeducational group intervention, nor did the analysis involve the use of a control group. In addition, the sample included a homogeneous inpatient population of primarily Caucasian, well-educated participants living in a rural location, which may have limited the generalizability of the study results.

Few studies comparing the efficacy of different formats of psychoeducation for individuals with SMI (Wessely et al., 2008; Xia et al., 2011). Recommendations, however, for additional research in the area of examining preferred formats of delivery of psychoeducational interventions have been offered. Specifically, brief and group format psychoeducation are thought to be preferable, as these types of psychoeducational

intervention may be more cost effective and efficient (Xia et al., 2011). As such, an investigation of the acceptability and impact of a brief psychoeducational intervention in a group format with a heterogeneous patient population in an urban setting would be valuable in order to improve the generalizability of the findings previously demonstrated.

### **Psychoeducation for PTSD in Individuals with SMI.**

Mueser et al. (2002) hypothesized that PTSD is a comorbid disorder that mediates the relationship among trauma, increased symptom severity, and higher use of acute-care services in persons with SMI. These authors offered evidence in support of the idea that the association between PTSD and revictimization may be especially strong among persons with SMI and PTSD, and that this vulnerability to repeated victimization may be related to the ways in which PTSD may interfere with social skills that are necessary in order to avert exposure to interpersonal violence. Psychoeducation, as described here, may offer the opportunity to remediate these lacking skills and abilities and therefore reduce the incidence of retraumatization among individuals with SMI and PTSD. Further, Mueser et al.'s model extrapolates that interpersonal problems related to PTSD may also interfere with patients' ability to establish an effective working alliance during treatment for SMI and/or PTSD. In turn, this poor working alliance may further impact these patients in that they receive fewer illness-related services and experience an increased risk of relapse and rehospitalization as a result. Psychoeducation as remediation for these difficulties with interpersonal interactions may help patients to take better advantage of available treatments.

### **Inpatient Psychiatric Settings**

Inpatient psychiatric care has been deemed appropriate for a significant segment

of the patient population in practice (U. S. Department of Health and Human Services, 1999). Inpatient psychiatric settings, including state and privately funded institutions, as well as general or specialized psychiatric hospitals, are treatment settings in which patients obtain treatment for a wide range of serious concerns. Emphasizing crisis stabilization, ensuring patient safety, and focusing on rapid discharge are critical components of the contemporary short-term acute inpatient psychiatric stay (Bowers et al., 2005), and supporting the patient in obtaining opportunities for continued recovery and integration within the community following discharge have been indicated as secondary goals (Sharfstein, 2009). The typical stay of patients remaining in general acute-care, privately funded inpatient psychiatric settings is often brief, with a median length of stay of 7 days (Compton, Crow, & Rudisch, 2006). Patients who usually seek treatment in inpatient psychiatric settings include a high number of individuals with PTSD and comorbid SMIs (Kessler et al., 2005). Prevalence rates of traumatization in general inpatient psychiatric settings have been estimated at between 51% and 98% for individuals with SMIs (Frueh et al., 2004). The treatments utilized within general acute inpatient psychiatric settings are often driven by market forces rather than empirical evidence for the efficacy of specific acute inpatient treatment interventions (Hutchins et al., 2011). Additionally, most available evidence-based treatments are not well suited for these settings because of the short length of stay and focus on crisis stabilization as a treatment priority. There has been inconsistent use of evidence-based treatments in these settings (Frueh et al., 2004). Rates of rehospitalization after being discharged from these settings are high, with an aggregate cost of readmissions approaching \$2 billion within 2 years of discharge (Wieden & Olfson, 1995). Owing to the nature of the treatment

settings and patient diagnoses, the lack of appropriate treatments available, and the prevalence of relapse within this population, alternative treatments for patients with SMI and PTSD in inpatient psychiatric settings must be developed in order to reduce relapse, increase ability to cope, and increase patient well-being.

While the literature indicates that exposure is an integral component of most empirically supported treatments for PTSD (Cahill, Carrigan, & Frueh, 1999; Davidson & Parker, 2001; Devilly & Spence, 1999), this component of treatment may produce an initial exacerbation of re-experiencing symptoms (Nishith et. al., 2002). This initial exacerbation of symptoms would not be indicated in the acute inpatient setting because it is at odds with the overall goal of short-term stabilization of symptoms. In contrast, psychoeducation interventions provided in the inpatient facility may prompt a decrease in distress and increase the likelihood of continued treatment by increasing knowledge of PTSD symptoms and indicated treatments without exacerbating posttraumatic symptoms while in the inpatient facility (Pratt et al., 2005). Further, psychosocial interventions may help to reduce re-hospitalizations in patients with SMI (Bach & Hayes, 2002). By facilitating the process of crisis stabilization and increasing patient safety, a psychoeducational approach to trauma in the psychiatric inpatient setting fits within already established goals for psychiatric inpatient stay (Bowers et al., 2005).

### **Conclusion**

PTSD and exposure to traumatic events occur at high rates in individuals in the United States, with even greater prevalence among individuals with SMIs. In addition, PTSD is often associated with extremely high rates of service utilization and can be quite costly to systems of healthcare (Frueh et al., 2004). PTSD is believed to not remit over

time without appropriate intervention (Resick et al., 2007). Given the prevalence of traumatic events and potential for development of symptoms as a result, PTSD and other symptoms resulting from trauma are appropriate targets for intervention.

Despite the need for appropriate treatment for PTSD among this population, patients with SMIs and comorbid PTSD have often been excluded from PTSD clinical trials, resulting in a lack of data regarding treatment outcomes within the population of people with PTSD and SMI (Cusak, Grubaugh, Knapp, & Fueh, 2006; Grubaugh et al., 2011;). Cognitive Behavioral treatments for PTSD, including CPT and PE have demonstrated the most empirical support (Foa et al., 1999; Foa et al., 2005; Monson et al., 2006; Mueser et al., 2008; Ponniah & Hollon, 2009; Resick et al., 2008; Tuerk et al., 2011) in group and individual formats and in inpatient and outpatient settings. Owing to the nature of general psychiatric inpatient settings, these treatments are not always feasible. As such, the development of other approaches to addressing PTSD in these settings is indicated (Pratt et al., 2005).

Psychoeducational interventions have shown promise in addressing difficulties experienced by those with SMI (Xia et al., 2011), as well as those with symptoms resulting from traumatic experience. Psychoeducation for trauma, as defined by provision of information about trauma-related symptoms and available treatments for trauma, has been used as a component of empirically supported treatments for trauma. It is believed to be effective with patients, both as a component of a larger treatment package and as a stand-alone intervention, as it may contribute to the reduction of symptoms and an improvement in quality of life. Psychoeducation for SMI has been examined in the literature and demonstrated to be effective in improving family support in patients with

schizophrenia and in improving adherence to treatment in patients with bipolar disorder (Colom et al., 2003; Falloon, 2003; Magliano et al., 2006; Miklowitz et al., 2000; Xia et al., 2011). The impact of psychoeducation for PTSD has been evaluated less frequently (Ehlers et al., 2003; Lubin, Loris, Burt & Johnson, 1998; Oflaz, Hatipoglu, & Aydin, 2008), and only rarely has the impact of psychoeducation for individuals with SMI and PTSD been evaluated. A study by Pratt et al. (2005) examined the feasibility and impact of a psychoeducational approach for individuals with SMI and PTSD and found positive results in increasing knowledge among participants as well as indications that a psychoeducational approach did not significantly increase patients' trauma-related symptoms. Psychoeducation for individuals with PTSD and SMI may help patients to improve knowledge of their disorder and adherence to treatment. More empirical research in this specialized area is needed.

Individuals living with SMI who seek care at acute inpatient psychiatric facilities form an appropriate target group for an acceptable trauma-informed intervention with the goal of increasing knowledge about the impact of trauma. As such, the following will describe a study of the acceptability and impact of a two-session psychoeducational intervention for patients with posttraumatic stress symptoms and comorbid SMI in a general acute inpatient psychiatric facility. First, research questions and study hypotheses will be presented, followed by a description of study methods, results of statistical analyses, and an interpretation and discussion of the obtained results.

### **Chapter 3: Research Questions**

#### **Research Question 1**

Will participants' knowledge of PTSD increase following participation in a two-session psychoeducational group intervention?

##### **Hypothesis 1.**

H<sub>1</sub>: Participants who attend a two-session psychoeducational group intervention will demonstrate significantly greater knowledge of PTSD (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD), as assessed by the Knowledge of PTSD Test (Pratt et al., 2005), than participants who attend general group programming on the inpatient psychiatric unit.

#### **Research Question 2**

Will participants in the two-session psychoeducational group intervention report a greater increase in PTSD symptoms as compared to individuals who attend general group programming on the inpatient psychiatric unit?

##### **Hypothesis 2.**

H<sub>2</sub>: Participants in the two-session psychoeducational group intervention will report statistically similar rates of clinical PTSD symptoms, as assessed by the PCL-C (Weathers, Litz, Herman, Huska, & Keane, 1994) as compared to individuals who attend general group programming on the inpatient psychiatric unit.

**Research Question 3**

Will participants in the two-session psychoeducational group intervention report higher acceptability as compared to participants who attend general group programming on the inpatient psychiatric unit?

**Hypothesis 3.**

H<sub>3</sub>: Participants in the two-session psychoeducational group intervention will rate the intervention as significantly more acceptable, as assessed by the Treatment Acceptability Questionnaire (Hunsley, 1991), than participants who attend general group programming on the inpatient psychiatric unit.

**Research Question 4**

Will gains in knowledge about PTSD differ based on presence of PTSD symptoms?

**Hypothesis 4.**

H<sub>4</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms, as measured by a score of 50 or greater on the PTSD Checklist (Ruggiero, Del Ben, Scotti, & Rabalais, 2003), will gain significantly more knowledge about PTSD (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD), as assessed by the Knowledge of PTSD Test (Pratt et al., 2005) than participants in the two-session psychoeducational group intervention who do not have clinical PTSD symptoms.

**Research Question 5**

Will participants in the two-session psychoeducational group intervention who experience clinical PTSD symptoms report a greater level of acceptability of the

treatment as compared to participants in the two-session psychoeducational group intervention who do not experience clinical PTSD symptoms?

**Hypothesis 5.**

H<sub>5</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms, as measured by a score of 50 or greater on the PTSD Checklist (Ruggiero et al., 2003), will rate the group as significantly more acceptable, as measured by the Treatment Acceptability Questionnaire (Hunsley, 1991), than participants in the two-session psychoeducational group intervention who do not have clinical PTSD symptoms.

**Research Question 6**

Will participants in the two-session psychoeducational group intervention with clinical PTSD symptoms report increased readiness to seek trauma-focused PTSD treatment as compared to participants with clinical PTSD symptoms who attend general group programming on the inpatient psychiatric unit?

**Hypothesis 6.**

H<sub>6</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD), as assessed by the Knowledge of PTSD Test (Pratt et al., 2005), will report greater readiness to seek trauma-focused PTSD treatment, as assessed by the Readiness Ruler (Center for Evidence-Based Practices at Case Western Reserve University, 2010), as compared to participants with clinical PTSD symptoms who attend general group programming on the inpatient psychiatric unit.

## **Chapter 4: Methods**

### **Aim of Study**

The goal of the current study was to examine the acceptability and impact of a two-session psychoeducational group trauma intervention for patients in a general acute inpatient psychiatric hospital. Approval was obtained from the Philadelphia College of Osteopathic Medicine Institutional Review Board on May 8, 2013, and study recruitment began thereafter.

### **Design and Design Justification**

The current study was evaluated using quantitative methods according to the nonequivalent control group design, as described by Campbell and Stanley (1963). The design of the current study was quasiexperimental, in that both experimental and control groups were chosen based on their naturally occurring status within the treatment environment. The rationale underlying this choice of design was based on the realities of the context within which subjects in this study sought treatment. More specifically, given the acute nature of treatment in this environment, random assignment of participants to either treatment or control group was not possible within the length of stay which is typical in the general acute inpatient psychiatric hospital setting. Rather, participants' experience of the treatment studied had to be evaluated based on groups primarily determined by the presenting treatment needs of the individuals within these groups. The inclusion of a nonequivalent control group allowed the experimenter to have some basis for comparison, allowing an initial view of the differential impact of the psychoeducational group as additional to overall psychiatric treatment.

## Participants

A power analysis was conducted using the computer program “G power,” with an effect size of 0.40 and a power of 0.95 in order to determine a sufficient sample size for the proposed analyses. A total sample size of 120 participants would be required in order to demonstrate an effect using the stated statistical analysis. A smaller sample was collected than was proposed. In fact, this rate of response from potential participants is in keeping with findings in a similar study (Pratt et al., 2005). Thus, in the results, effect sizes are reported in order to further explicate any differences shown between groups.

Seventy individuals receiving treatment at a general acute-care psychiatric hospital in the eastern United States volunteered to participate in the current study. Thirty-four individuals (48.6%) were included in the general treatment condition, while 36 (51.4%) were included in the psychoeducational treatment condition. Mean age of participants was 39.48 years ( $SD = 10.41$ ). All participants reported their gender, and 37 (53.6%) were male. The majority of respondents ( $N = 57/85.1\%$ ) who reported race indicated they were Caucasian, and three individuals did not report their race. All respondents (100%) indicated their primary language was English, with six (9.4%) indicating they spoke another language and three respondents not reporting their primary language. The majority of respondents who indicated their educational achievement reported completing some college (39.7%), with two individuals not reporting their level of education. Of those who responded, 50.7% indicated they had received some past treatment (which could include cognitive-behavioral therapy, general psychotherapy, medications, or medication and psychotherapy), with three individuals not reporting whether they had received past trauma-focused treatment (see Table 1).

Table 1

*Demographic Characteristics of Participants (n = 70)*

Characteristic	<i>n</i>	%
<b>Condition</b>		
General group	34	48.6
Psychoeducation group	36	51.4
<b>Age (years)</b>		
20-29	13	18.6
30-39	21	30.0
40-49	22	31.4
50-59	13	18.6
Missing	1	1.4
<b>Gender</b>		
Male	37	52.9
Female	32	45.7
Missing	1	1.4
<b>Ethnicity</b>		
Caucasian	57	66.3
African American	2	2.3
Hispanic	4	4.7
Other	1	1.2
Biracial	3	3.5
Missing	3	3.5
<b>Primary language</b>		
English	67	96
Missing	3	4
<b>Educational achievement</b>		
Before high school	3	4.4
Some high school	6	8.8
High-school graduate	19	27.9

Trade school	6	8.8
Some college	27	39.7
Four year college	7	10.3
Missing	2	3
<b>Past Trauma focused Treatment</b>		
Yes	34	48.6
No	33	47.1
Missing	3	4.3

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*Note.* Totals of percentages are not 100 for every characteristic because of rounding.

The population in the identified hospital was, in fact, more ethnically diverse than the population in the study sample. A large percentage of African American and Hispanic individuals were on identified units, but this was not reflected in the study sample. Mean age of the sample appeared to be similar to the mean age of the hospital population, and gender also appeared to be similarly distributed.

#### **Inclusion Criteria.**

Individuals were selected for participation in the current study based on their admission to an inpatient psychiatric hospital during the timeline of the study. Adults who reported speaking English, demonstrated an ability to give informed consent, demonstrated an ability to read and complete study instruments, and were admitted to the general psychiatric inpatient hospital during the timeline of the study were approached for inclusion in the study. Both individuals with or without a trauma history were

approached for inclusion. Finally, only those individuals who expressed a desire to participate in the current research study were enrolled into the study.

### **Exclusion Criteria.**

Individuals were excluded from the current study if they had not been admitted to the identified inpatient psychiatric hospital during the timeline of the study. Adults older than 60 years and children younger than 17 years were also excluded. Individuals who did not demonstrate an ability to give informed consent and were unable to read and complete study instruments were excluded from the study. In addition, those individuals on the identified psychiatric inpatient unit who did not wish to participate in the research study were excluded from this study.

### **Procedure**

#### **Recruitment.**

Participants were recruited from the patient population at an acute-care inpatient psychiatric hospital in an urban area in the northeastern United States. Potential participants were approached by the researcher, who held a valid certificate in human subjects research awarded by the Collaborative Institutional Training Initiative (CITI). Potential participants were asked about their willingness to participate in the current study during regularly held treatment meetings during the morning of the day in which the researched psychoeducational groups were held. Those individuals who indicated an interest in participating in the research study were explained the nature of the study as well as any risks involved. The researcher then obtained informed consent for participation in the study from these individuals.

Data collection occurred over the course of 1 year, between June 2013 and May 2014, at the study site, and consisted of 17 total days. Data were collected at a maximum of 1 day per week on each unit, and data collection days were spread throughout the year. On each day of data collection, potential participants were informed of the study during a group patient meeting held daily for each psychiatric inpatient as part of regular on-unit programming. Potential participants were verbally provided information about the general goals of the study and requirements for participation by the study investigator. This description was based on a developed script, which detailed the purposes of the research in clear language understandable to each potential participant. Each interested potential participant received a brief overview of study procedures, including the content of each group. Potential participants were informed that participation in the study was on a strictly voluntary basis and that participation in the study would not impact current or future treatment opportunities at the acute-care inpatient psychiatric hospital. Potential participants were asked to think about whether they wished to participate in the study. Interested individuals were asked to congregate in a predetermined location on the acute-care unit after 1 hour. During this hour, the investigator was present in a predetermined location, and individuals were encouraged to ask additional questions. While potential participants were together as a group, informed consent was obtained individually. Consenting individuals as a group were then administered preintervention instruments as a group, contained in deidentified and labeled envelopes and were reminded of the time and location of the psychoeducational and general group sessions. Participants then were invited to attend two group sessions, either within the psychoeducation condition or in the general group session condition. Participants were given the choice as to which group

they attended; attendance in both groups was not possible as groups were held concurrently within the same treatment unit.

Participants who chose not to participate in the study were also given the option to attend either the general group treatment or the psychoeducational group intervention, and approximately 10 individuals, during the course of the study, chose not to participate in the study but did attend the psychoeducational group. All but approximately 3 participants who attended morning groups also attended the afternoon group. After the conclusion of the second group session of each group, measures were readministered to study participants, using deidentified and sealed envelopes. Participants who completed study questionnaires were also offered decaffeinated coffee as compensation for time spent. All participants were provided a subject identification number for the purposes of data collection, and a list of all subject identification numbers was stored along with study data in a locked location at the study site.

#### **General Treatment Group.**

The general group treatment condition included two general group sessions, each with between six and 20 participants. The general group treatment was held for two sessions of 45 minutes each. Topics included in the general group sessions were coping skills for mood management, music therapy, art therapy, general psychoeducation about cognitive-behavioral therapy, drug and alcohol support groups, and supportive general group psychotherapy. Coping skills for mood management included teaching skills for mood regulation. This topic was taught with a focus on safety planning. Music therapy involved the use of music to engage with participants' emotional experiences and help participants to gain insight. Art therapy utilized drawing, painting, and artistic expression

to help participants gain insight into their emotional experiences. Cognitive-behavioral psychoeducation involved teaching the cognitive model of interrelated thoughts, feelings, and behaviors and helping participants to connect this model with the ways in which these aspects of experience may be interrelated with psychiatric difficulties; psychoeducation about PTSD or trauma symptoms was not provided. Supportive general group therapy offered patients the opportunity to share their own personal experiences and process emotions with the support and direction of the group therapist. The content of the general treatment groups varied along with the group therapist, who determined group content based on his own area of expertise, along with the clinical needs of group participants according to patient request or treatment team assessment.

#### **Psychoeducational Treatment Group.**

The psychoeducational treatment group condition included two psychoeducational group sessions, each with between three and eight participants. The psychoeducational group was divided into two 45-minute sessions (see Appendix A for the manual). The group covered common symptoms related to psychological trauma, relaxation skill development, a discussion of participant questions about the material presented, and safety planning. Each psychoeducational group session was facilitated by the same mental-health professional, who had earned a masters degree in psychology including coursework in the area of psychological trauma, its treatment, and typical symptoms. A recommendation for the facilitator to have trauma-specific training came as a result of the high level of acuity of patients at an inpatient treatment hospital and the specific needs of patients who may have experienced traumatic events in their lives.

The goals of Session 1 were to present an overview of the treatment group, develop appropriate group goals, conduct a breathing retraining experiential exercise, and provide information related to the definition of PTSD and symptoms related to trauma exposure. Session 2 included review of didactic material from Session 1, discussion of participant questions from Session 1 material, discussion of safety planning and identifying sources of crisis support for participants, and review of all information provided during the two-session intervention.

## **Measures**

### **Demographic Measure.**

A measure of general participant demographics developed for this study was included (see Appendix B). This measure asked participants to share basic demographics, such as age, gender, race, past involvement in psychological treatment for trauma, and primary language spoken. This measure was used in order to determine equivalency of groups across these areas.

### **The Treatment Acceptability Questionnaire.**

The Treatment Acceptability Questionnaire (TAQ; Hunsley, 1991) was developed in order to evaluate the acceptability of a treatment for adult patients. In the context of this study, the questionnaire was used to assess the acceptability of either the general group treatment or the psychoeducation for trauma treatment from the participant's perspective. The measure consists of six items scored on a Likert scale between 1 and 7, with 1 being *very unacceptable* and 7 being *very acceptable*. Possible scores range from 6 to 42, with a higher score indicating higher acceptability of treatment. The content of items asks about acceptability, ethics, effectiveness, negative

side effects, and the treatment provider's knowledge and trustworthiness. Previous samples of individuals using this measure have reported an internal consistency (Cronbach's  $\alpha$ ) of .81 (Hunsley, 1992). Concurrent validity between the TAQ and the Treatment Evaluation Inventory (TEI; Kazdin, 1980) was evaluated to be high at .87 (Hunsley, 1992). Test-retest reliability for this measure has also been demonstrated to be high over a 2-week period and was evaluated to be .78 (Hunsley, 1992). The current sample yielded an internal consistency (Cronbach's  $\alpha$ ) of .99.

#### **Knowledge of PTSD Test.**

Knowledge of PTSD was measured through the use of the Knowledge of PTSD Test (KPTSD; Pratt et al., 2005). This test was initially developed for use in a study of psychoeducation for trauma in an inpatient psychiatric facility. The KPTSD measures the areas of knowledge targeted in the current study, namely the definition of trauma, common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD. This 15-item, multiple-choice measure has been shown to be sensitive to the effects of education about PTSD in clients with SMI (Pratt et al., 2005). However, no other psychometric data have been reported at this time.

#### **PTSD Checklist – Civilian Version.**

The PTSD Checklist - Civilian Version (PCL-C; Weathers et al., 1994) is a self-report instrument that is designed to assess symptoms of PTSD. The PCL-C has been indicated for use as a screening instrument for PTSD and related symptoms. This instrument includes 17 items including diagnostic criteria B, C, and D of PTSD. Possible scores range from 17 to 85. Each item on the scale is rated by a score of 1 through 5, with

1 being *not at all*, 2 being *a little bit*, 3 being *moderately*, 4 being *quite a bit*, and 5 being *extremely*. The PCL-C has demonstrated a high level of internal consistency for total scores, re-experiencing, avoidance, and hyperarousal clusters scores (.94, total; .85, re-experiencing; .85, avoidance; .87, hyperarousal). A cutoff score of 50 is recommended for screening in inpatient treatment settings and was used for the purposes of this analysis. Internal consistency (Cronbach's  $\alpha$ ) for this measure within this sample was measured at .99. For the purposes of statistical analysis in this study, individuals were considered to not have clinically significant PTSD symptoms when the overall score on the PCL-C fell below the cutoff score at either Time Point 1 or Time Point 2 (50 or greater). The cutoff score of 50 was used based on an examination of the literature and PCL-C recommended use in similar settings (inpatient psychiatric, high-prevalence treatment environments).

#### **Readiness Ruler.**

The Readiness Ruler (Center for Evidence-Based Practices at Case Western Reserve University, 2010) was developed as a tool for use in therapy to help individuals explore their current likelihood to change behavior. The Readiness Ruler has been shown to predict adherence to psychological treatment for obsessive compulsive disorder (Maher et al., 2012). A modified version of this measure was used in this study in order to measure patient readiness to engage in outpatient treatment for PTSD.

## Chapter 5: Results

The goals of this study were to investigate the acceptability and impact of a two-session psychoeducational group intervention for trauma in an acute psychiatric inpatient setting. The aims of the study included a) to assess the impact of the group intervention on patient knowledge of posttraumatic stress disorder (PTSD) and its clinical correlates, b) to understand the acceptability of this intervention from the patient perspective, and c) to further explicate the relationship among presence of PTSD symptoms, acceptability of this treatment, and readiness to engage in trauma-related clinical treatment. Patients in the acute-care inpatient psychiatric hospital were recruited for participation in the study and, independent of current diagnosis, chose to participate in one of two groups: (a) a general inpatient psychiatric group or (b) the two-session psychoeducational group for trauma. Each group participated in both pretest and posttest measure completion.

### Missing Data

Missing data were managed in the way that best captured the goal of each measure and most accurately represented the reported data. For instance, on the KPTSD test, when an item was left blank, the item was assumed incorrect. As this instrument was a multiple-choice test, one could reasonably assume that participants left items blank to which they did not know the answer. Alternatively, in the demographic questionnaire, when the participant did not complete an item, the item was removed from the analyses. For the TAQ measure, when an item was not completed, the entire measure was eliminated from the analysis. This was done as the TAQ was measured on a Likert scale and the full numerical score was used. The same steps were undertaken for the PCL-C measure and the Readiness Ruler (i.e., the measures were eliminated from the analysis).

### **Preliminary Analyses**

Preliminary analyses for H<sub>1</sub> through H<sub>6</sub> were conducted using SPSS version 22 for the sample of 70 participants.

Chi-square analyses were conducted to evaluate differences on categorical demographic variables. First, the two treatment conditions used for H<sub>1</sub> through H<sub>3</sub> were evaluated, grouping participants by treatment group (i.e., two-session psychoeducational group and the general group treatment condition). These findings revealed no significant difference in the distribution of male and female participants across treatment conditions,  $X^2(1, N = 69) = 1.80, p = .179$ . Similarly, there were no significant differences in the distribution of race across the two treatment conditions,  $X^2(4, N = 67) = 1.22, p = .875$ . Additionally, there were no significant differences found in past treatment history,  $X^2(1, N = 67) = .015, p = .901$ , or level of education,  $X^2(5, N = 68) = 9.25, p = .100$ , between the two treatment conditions. Results for chi-square analyses for demographic variables by treatment condition are shown in Table 2.

In addition, a preliminary independent samples *t*-test was conducted to compare the distribution of age (a continuous variable ranging from ages 20 - 58 years) across the two conditions. No significant difference was found in mean participant age across the two treatment conditions,  $t(67) = 1.90, p = .061$ . Results of the independent samples *t*-test for participant age are shown in Table 3.

Table 2

*Participant Demographic Variables by Treatment Group*

Variable	General Group (n=34)		Psychoed Group (n=36)		X <sup>2</sup>
	n	%	n	%	
Gender					1.80
Male	20	29	16	23	
Female	13	19	20	29	
Missing	1	1	0	0	
Race					1.22
Caucasian	28	40	29	41	
Af. Amer.	1	1	1	1	
Hispanic	2	4	2	4	
Biracial	1	1	2	4	
Other	0	14	1	1	
Missing	2	4	1	1	
Past Trauma-Focused Treatment					.015
Yes	16	23	17	24	
No	17	24	17	24	
Missing	2	4	2	1	
Educational Achievement					9.25
Bef. H.S.	1	1	2	4	
Some H.S.	2	4	4	6	
H.S.	15	21	5	7	
Trade school	3	4	2	4	
Some college	10	14	17	24	
4 yr. Coll.	2	4	5	4	
Missing	1	1	1	1	

\*p&lt; .05, \*\* p&lt; .01, \*\*\*p&lt;.001

Table 3

*Participant Demographic Variables by Treatment Group*

Variable	General Group ( <i>n</i> =34)		Psychoed Group ( <i>n</i> =36)		<i>df</i>	<i>t</i>	<i>p</i>
	<i>M</i>	SD	<i>M</i>	SD			
Age	37.14	10.0	41.9	10.5	67	1.90	.061

Chi-square analyses were also conducted to evaluate differences on categorical demographic variables for H<sub>4</sub> and H<sub>5</sub>, when participants in the two-session psychoeducational condition were grouped by presence of PTSD symptom levels. These findings revealed no significant difference in the distribution of male and female participants across the two groups (i.e., high and low PTSD symptoms),  $X^2(1, N = 32) = 3.69, p = .055$ . Similarly, there were no significant differences for race,  $X^2(4, N = 32) = 2.79, p = .594$ , across the two groups (i.e., high and low PTSD symptoms). Additionally, there were no significant differences in past treatment history,  $X^2(1, N = 31) = 3.21, p = .073$ , or level of education,  $X^2(5, N = 32) = 3.34, p = .647$ , between the two groups. Results for chi-square analyses for demographic variables by PTSD symptom severity are shown in Table 4.

Table 4

*Psychoeducation Group Participant Demographic Variables by PTSD Symptom Severity*

Variable	High PTSD		Low PTSD		X <sup>2</sup>
	n	%	n	%	
Gender					3.69
Male	12	38	3	10	
Female	8	25	9	28	
Missing	0	0	0	0	
Race					2.79
Caucasian	15	47	11	34	
Af. Amer.	1	3	0	0	
Hispanic	2	6	0	0	
Biracial	1	3	1	3	
Other	1	3	0	0	
Missing	0	0	1	3	
Past Trauma-Focused Treatment					3.21
Yes	11	34	3	10	
No	8	25	9	28	
Missing	1	3	0	0	
Educational Achievement					3.34
Bef. H.S.	1	3	1	3	
Some H.S.	2	6	2	6	
H.S.	4	13	1	3	
Trade school	2	6	0	0	
Some college	10	31	6	18	
4 yr. Coll.	1	3	2	6	
Missing	0	0	0	0	

\*p&lt; .05, \*\* p&lt; .01, \*\*\*p&lt;.001

In addition, a preliminary independent samples *t*-test was conducted to compare the distribution of age (a continuous variable ranging from ages 20 - 58 years) across the two groups of two-session psychoeducational group participants (high and low PTSD). No significant difference was found in mean participant age across the two treatment conditions,  $t(30) = 1.87, p = .071$ . Results of the independent samples *t*-test for participant age are shown in Table 5.

Table 5

*Psychoeducation Group Participant Demographic Variables by PTSD Symptom Severity*

Variable	High PTSD ( <i>n</i> =20)		Low PTSD ( <i>n</i> =12)		<i>df</i>	<i>t</i>	<i>p</i>
	<i>M</i>	SD	<i>M</i>	SD			
Age	39.90	8.30	33.08	12.38	30	1.87	.071

Chi-square analyses were also conducted when participants with high PTSD symptoms were grouped by treatment condition ( $H_6$ ). These findings also revealed that there was not a significant difference in the distribution of male and female participants across treatment conditions,  $X^2(1, N = 46) = .141, p = .708$ . There were similarly no significant differences for race across treatment conditions,  $X^2(4, N = 45) = 5.59, p = .232$ . Additionally, there were no significant differences in past treatment history,  $X^2(1, N = 45) = .606, p = .436$  or level of education,  $X^2(5, N = 46) = 4.62, p = .464$  across treatment conditions. Results for chi-square analyses for demographic variables for participants with high PTSD by treatment condition are shown in Table 6.

Table 6

*Participant Demographic Variables by Treatment Group for Participants with High PTSD Symptom Severity*

Variable	<u>General Group (n=26)</u>		<u>Psychoed Group (n=20)</u>		X <sup>2</sup>
	n	%	n	%	
Gender					.141
Male	17	37	12	26	
Female	9	20	8	17	
Missing	0	0	0	0	
Race					5.59
Caucasian	24	52	15	33	
Af. Amer.	1	2	1	2	
Hispanic	0	0	2	4	
Biracial	0	0	1	2	
Other	0	0	1	2	
Missing	1	2	0	0	
Past Trauma-Focused Treatment					.606
Yes	12	26	11	24	
No	14	54	8	17	
Missing	0	0	1	22	
Educational Achievement					4.62
Bef. H.S.	1	2	1	2	
Some H.S.	1	2	2	4	
H.S.	13	28	4	9	
Trade school	2	4	2	4	
Some college	8	17	10	22	
4 yr. Coll.	1	2	1	2	
Missing	0	0	0	0	

\*p< .05, \*\* p< .01, \*\*\*p<.001

In addition, a preliminary independent samples *t*-test was conducted to compare the distribution of age (a continuous variable ranging from ages 20 - 58 years) across the two groups of two session psychoeducational group participants (high and low PTSD). No significant difference was found in mean participant age across the two treatment conditions,  $t(44) = .005$ ,  $p = .996$ . Results of the independent samples *t*-test for participant age are shown in Table 7.

Table 7

*Participant Demographic Variables by Treatment Group for Participants with High PTSD Symptom Severity*

Variable	<u>General Group (n=26)</u>		<u>Psychoed Group (n=20)</u>		<i>df</i>	<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Age	39.90	8.30	39.88	10.5	44	.005	.996

Overall, the preliminary analyses revealed no significant differences between the various groups (i.e., treatment conditions, high and low PTSD symptoms) on several relevant demographic variables. These findings support the comparability of these two groups across gender, race, past treatment history, level of education, and age.

Descriptive statistics for measure results for all participants are included in Table 8.

Descriptive statistics for measure results by treatment condition for each participant included in analyses are included in Table 9, Table 10, and Table 11.

Table 8

*Participant Scores by Measure*

	<i>M</i>	<i>SD</i>	<i>N</i>
<b>KPTSD</b>			
Pre Score	11.00	3.27	69
Post Score	11.48	3.12	54
Change Score	.81	3.80	54
<b>PCL-C</b>			
Pre Score	59.74	12.74	53
Post Score	55.92	12.91	52
Change Score	-3.33	8.13	42
<b>TAQ</b>			
	34.40	5.93	63
<b>Readiness</b>			
	7.61	2.53	56

*Note.* KPTSD = Knowledge of PTSD test; PCL-C = PTSD Checklist- Civilian Version; TAQ = Treatment Acceptability Questionnaire; Readiness = Readiness Ruler.

Table 9

*Participant Scores by Treatment Condition*

	<u>General Group (n=34)</u>				<u>Psychoed Group (n=36)</u>			
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>
KPTSD Pre	25	11.68	2.30	9	29	9.79	3.41	7
KPTSD Post	25	12.28	3.36	9	29	10.79	2.77	7
PCL Pre	19	63.58	11.34	15	23	56.00	13.85	13
PCL Post	19	58.11	10.26	15	23	54.43	14.14	13
TAQ	31	32.90	5.99	3	32	35.84	5.58	4
Readiness	28	7.64	2.25	6	28	7.57	2.82	8

*Note.* KPTSD = Knowledge of PTSD test; PCL-C = PTSD Symptom Checklist- Civilian Version; Pre = measurement prior to intervention; Post = measurement after the intervention; TAQ = Treatment Acceptability Questionnaire; Readiness = Readiness Ruler

Table 10

*Psychoeducation Group Participant Scores by PTSD Symptom Severity*

	<u>High PTSD (n=20)</u>				<u>Low PTSD (n=12)</u>			
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>
KPTSD Pre	16	10.19	3.51	4	11	10.09	3.24	1
KPTSD Post	16	10.94	2.72	4	11	11.64	1.43	1
TAQ	17	35.84	5.58	3	12	35.00	6.62	0

*Note.* KPTSD = Knowledge of PTSD test; Pre = measurement prior to intervention; Post = measurement after the intervention; TAQ = Treatment Acceptability Questionnaire

Table 11

*High PTSD Symptom Severity Participant Score with by Treatment Condition*

	<u>General Group (n=26)</u>				<u>Psychoed Group (n=20)</u>			
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Missing</i>
Readiness	23	8.09	1.93	3	15	7.20	2.78	5

*Note.* Readiness = Readiness Ruler

**Primary Analyses.**

Tests of the six primary hypotheses were conducted using Bonferroni adjusted alpha levels of .0083 per test (.05/6). Results are described for each hypothesis in the following.

The first hypothesis (H<sub>1</sub>) stated that participants attending the trauma psychoeducational treatment condition would gain more knowledge about trauma as compared to the knowledge gained by those attending the general group treatment condition:

H<sub>1</sub>: Participants who attend a two-session psychoeducational group intervention will demonstrate significantly greater knowledge of PTSD (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD), as assessed by the KPTSD (Pratt et al.,

2005), than participants who attend general group programming on the inpatient psychiatric unit.

A one-way analysis of covariance (ANCOVA) was conducted, with KPTSD post-treatment scores as the dependent variable and treatment group as the independent variable, with the pre-treatment score as a covariate. The ANCOVA was not significant,  $F(1, 51) = 1.47, p = .231; d = .10$ .

The second hypothesis (H<sub>2</sub>) was related to severity of PTSD-related symptoms among study participants, and hypothesized that each treatment condition would similarly influence symptoms of PTSD; in other words, neither treatment would increase PTSD symptoms significantly more than the other:

H<sub>2</sub>: Participants in the two-session psychoeducational group intervention will report statistically similar rates of clinical PTSD symptoms, as assessed by the PCL-C (Weathers et al., 1994), as compared to individuals who attend general group programming on the inpatient psychiatric unit.

A one-way ANCOVA was conducted in order to compare means of total PTSD symptom severity, with posttreatment PCL-C score as the dependent variable, treatment condition as the independent variable, and pretreatment PCL-C score as covariate. The ANCOVA was not significant,  $F(1, 39) = .865, p = .358$ . This result indicates that the means between treatment groups for PTSD symptom severity did not differ significantly from one another, and lends support for Hypothesis 2.

The third hypothesis (H<sub>3</sub>) stated that participants would rate the psychoeducational treatment group to be more acceptable when compared to acceptability ratings of those who attended the general treatment group:

H<sub>3</sub>: Participants in the two-session psychoeducational group intervention will rate the intervention as significantly more acceptable, as assessed by the TAQ (Hunsley, 1991), than participants who attend general group programming on the inpatient psychiatric unit.

An independent samples *t*-test was conducted to compare acceptability scores in psychoeducational treatment and general group treatment conditions. A significant difference was found for psychoeducational group and general group conditions,  $t(61) = 2.02, p = .048; d = .51$ . Cohen's effect size value for change score indicates a medium effect.

The fourth hypothesis (H<sub>4</sub>) addressed whether there was a significant difference in change of knowledge between the two groups based on presence of PTSD symptoms:

H<sub>4</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms, as measured by a score of 50 or greater on the PCL-C (Weathers et al., 1994), will gain significantly more knowledge about PTSD (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD), as assessed by the KPTSD (Pratt et al., 2005) than participants in the two-session psychoeducational group intervention who do not have clinical PTSD symptoms.

A one-way ANCOVA was conducted in order to compare means of KPTSD posttreatment scores, with posttreatment score on the KPTSD as the dependent variable, presence or not of a score of 50 or greater for those in the psychoeducational group as the independent variable, and pretreatment score on the KPTSD as a covariate. The ANCOVA was not significant,  $F(1, 24) = .719, p = .405$ . There were no significant

differences between psychoeducational group participants with PTSD as compared to those without PTSD for knowledge of PTSD.

The fifth hypothesis (H<sub>5</sub>) stated that those participants in the psychoeducational group condition with high PTSD symptom severity will find the group to be significantly more acceptable than those psychoeducational group participants without high PTSD symptom severity:

H<sub>5</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms, as measured by a score of 50 or greater on the PCL-C (Weathers et al., 1994), will rate the group as significantly more acceptable, as measured by the TAQ (Hunsley, 1991), than participants in the two-session psychoeducational group intervention who do not have clinical PTSD symptoms.

An independent samples *t*-test was conducted to compare acceptability scores for participants with high and low PTSD symptom severity in the psychoeducational treatment condition. There was not a significant difference in scores for high PTSD severity and low PTSD severity conditions,  $t(27) = 1.01$ ,  $p = .320$ ,  $d = .37$ . Cohen's effect size value indicates a small effect.

The sixth hypothesis (H<sub>6</sub>) stated that participants with high PTSD symptom severity in the psychoeducational treatment condition would report greater readiness to seek trauma-focused PTSD treatment as compared to participants with high PTSD symptom severity in the general treatment condition:

H<sub>6</sub>: Participants in the two-session psychoeducational group intervention with clinical PTSD symptoms (i.e., common clinical correlates of PTSD, symptoms of PTSD, events that may cause PTSD, and available empirically supported treatments for PTSD),

as assessed by the PCL-C (Weathers et al., 1994), will report greater readiness to seek trauma-focused PTSD treatment, as assessed by the Readiness Ruler (Center for Evidence-Based Practices at Case Western Reserve University, 2010), as compared to participants with clinical PTSD symptoms who attend general group programming on the inpatient psychiatric unit.

An independent samples t-test was conducted to compare readiness scores for participants with high PTSD symptom severity in the psychoeducational treatment and general group treatment conditions. There was not a significant difference in scores for participants with high PTSD symptom severity in the psychoeducational group and general group conditions,  $t(36) = 1.16, p = .253, d = .37$ .

## Chapter 6: Discussion

This study sought to determine the acceptability and impact of a two-session psychoeducational intervention for trauma in the acute inpatient psychiatric setting. A discussion of the findings of this study, including study strengths, limitations, recommendations for future directions, and implications, is included in the following.

First, consistent with the study's hypotheses, results suggest that the participants' PTSD symptom severity scores did not significantly differ between the two-session psychoeducational group condition and the general group condition ( $H_2$ ) after engagement in the group interventions.

Contrary to the study's hypotheses, results indicated that participants in the two-session psychoeducational group intervention did not rate that group as significantly more acceptable than the ratings of participants in the general treatment condition. Significant differences were also not found in participant knowledge of PTSD between participants who attended the two-session psychoeducational group intervention and participants who attended the general group treatment ( $H_1$ ). Further, no significant differences on knowledge of PTSD were found between participants with high PTSD symptom severity and low PTSD symptom severity within the two-session psychoeducational condition ( $H_4$ ). In addition, acceptability scores for participants with high and low PTSD symptom severity in the two-session psychoeducational intervention did not significantly differ ( $H_5$ ). Finally, trauma-focused treatment readiness did not significantly differ for participants with high PTSD symptom severity who participated in the two-session psychoeducational group intervention as compared to participants with high PTSD symptom severity who attended the general group condition ( $H_6$ ).

With regard to the finding in support of study hypotheses, participants' PTSD symptom severity score did not significantly differ between the two-session psychoeducational group treatment and the general group condition. This finding is in keeping with a previous investigation of psychoeducation for trauma in the inpatient setting (Pratt et al., 2005), which also found no increase in PTSD symptoms post treatment. The current findings further the evidence in support of this result in that specific symptoms of PTSD were measured systematically in this study and a control group was used. These findings increase the strength of previous findings and suggests that psychoeducation for trauma may not increase symptoms of PTSD for patients in an acute inpatient psychiatric setting. This finding lends further support for the use of psychoeducational groups for trauma in the inpatient setting in that it addresses the concern that discussing PTSD symptoms with individuals who have PTSD symptoms may exacerbate those symptoms.

Participant ratings in the two-session psychoeducational group were not significantly more acceptable than the participants ratings of the general group condition, although a medium effect size was detected ( $d = .51$ ). This finding is of note because previous research has emphasized positive relationships between treatment acceptability and effective implementation of intervention (Girio & Owens, 2009). The findings in relation to treatment acceptability should take into account past evidence supporting the assertion that treatment choice may influence treatment preferences and overall acceptability of treatment (Swift & Callahan, 2009). Participants were given the choice to attend the psychoeducational group condition (a novel option) or the general treatment group condition (treatment-as-usual option), and acceptability scores may be accounted

for in part by a treatment choice effect and not by factors associated with the intervention itself.

With regard to the two hypotheses related to knowledge of PTSD, outcomes for knowledge indicated both a small effect and no significant differences between treatment groups on knowledge scores and also a small effect and no significant difference between those with high and low PTSD symptom severity within the psychoeducational treatment group. Previous research, although limited, found a psychoeducational approach for trauma in the inpatient setting to increase knowledge among participants (Pratt et al., 2005). Two main differences between the current study's identified intervention and the previous investigation's intervention may account for some of the differences in this finding. First, the intervention in the previous study occurred over a longer period of time than that of the current study, specifically three sessions on 3 days instead of two sessions during 1 day. Because of the acute nature of treatment at the current study site, the intervention in this study was developed to occur over a shorter amount of time in order to explore whether a similar intervention could be effective in such an environment. However, a longer amount of time than was given in this study possibly is needed for participants to acquire new knowledge. Second, the previous study's intervention utilized multiple modalities of delivery, including a video presentation and handouts, whereas the current study used facilitator information presentation and discussion without a video or handout. These multiple modalities possibly assisted learning in the previous study.

In addition, scores on the knowledge measure (KPTSD) were rather high before intervention delivery for both groups, indicating knowledge level among the study sample was already high, or the content of the questions asked was too basic for study

participants. In addition, the analyses for knowledge were underpowered. Differences in knowledge gain were detected between psychoeducational and general groups, although this difference was with a small effect size ( $d=.10$ ) and did not represent a statistically significant difference. Given past research, significant differences may be detected with a larger sample size. This area needs further investigation.

The current study also did not find a significant difference between those with high and low PTSD for acceptability of the psychoeducational treatment. Given the underpowered nature of this analysis ( $N = 29$ ), the effect size ( $d = .37$ ) is of note, in that it indicates a difference between means despite a finding of no statistically significant difference between means. Previous literature has indicated that providing psychoeducation related to PTSD may increase sense of competence, which positively impacts acceptability of treatment (Bryant et al., 2008), and taking into account the significant findings found here for acceptability of treatment in the overall sample, results for this analysis may be explained by the underpowered nature of the analysis.

Finally, no significant effects were found for treatment readiness in those with high PTSD in the psychoeducational treatment when compared with those with high PTSD in the general treatment ( $N = 38$ ), although a small effect size was found ( $d = .37$ ). While one-item Likert scale measures have shown some promise in predicting future adherence to treatment (Maher et al., 2012), the one-item measure used to detect readiness to change in this study was included on a separate page as part of a larger battery of measures, and as such, this measure was not completed by many study participants.

In summary, findings indicated high acceptability for the two-session

psychoeducational treatment, and apparently PTSD symptoms did not significantly increase after the two-session psychoeducational intervention. Knowledge did not significantly increase after the two-session psychoeducational intervention when all individuals in the two treatment conditions were compared nor were significant differences found when those with high and low PTSD severity were compared within the psychoeducational treatment condition. Differences in acceptability scores were not detected between those with low and high PTSD, and differences in treatment readiness for those with high PTSD scores in general and psychoeducational conditions were not found.

### **Relevant Anecdotal Clinical Observations**

During the psychoeducational and general groups themselves, opportunity was ample for study participants to formally or informally report on their thoughts about the group or the content presented. One should note that many group participants shared their support both for the opportunity to engage in a treatment group, that specifically addressed a particular concern (trauma and PTSD) and for the perceived appropriateness of this group treatment for the treatment setting. These remarks are corroborated by data systematically collected in the form of the TAQ measure. Additionally, unit staff members made many informal comments reflecting views that the opportunity to recommend the treatment group facilitated overall treatment in that it helped support patient choice on the unit. Responses about exacerbation of PTSD symptoms did not arise as a concern for staff members after the groups began. Staff members reported on many occasions that the psychoeducational group was facilitative of symptom stabilization.

**Limitations and Future Directions**

The results of this study should be considered with the following limitations in mind.

First, a small sample size was used in this study, which may have resulted in underpowered analyses. This small sample size likely made the detection of an effect increasingly difficult to detect an effect should one have existed. Overall, the study would have benefited from the use of an increased sample size in order to detect possible effects. Future studies should attempt to include more participants in each group.

A second limitation included a low response rate to some of the measures. This low response rate may have been impacted by methods of measure administration. The measures were distributed and collected in sealed envelopes in order to maintain participant privacy. While maintenance of participant privacy was important, this made it difficult for the researcher to confirm the completion of all measure items. A potential modification to increase the response rate could involve including a third-party individual who is unfamiliar with the research but known to the participants to quickly review data for completion as they were collected. This approach would allow privacy to be maintained, but also would allow someone to check the measures in order to encourage completion. Further, including questions on only one side of the paper (thereby reducing the likelihood that participants would miss the question) and including a written reminder at the end of each questionnaire prompting participants to double check their answers would likely have also helped increase the response rate. Future research should consider the use of these strategies in order to increase response rate.

An additional limitation involved the assignment of participants to groups.

Specifically, individuals were not randomly assigned to treatment groups; rather, participants chose the group they wished to attend. Data regarding the reasons for participant choice were not collected, although, anecdotally, such factors as participant diagnosis, familiarity with the concept of psychological trauma, and past exposure to psychoeducational groups, may have impacted choice of group. The lack of random assignment constitutes a threat to internal validity, thus potentially limiting the strength of statistical conclusions. Modifying the study design in order to incorporate random assignment for future investigations would address this limitation.

In addition, the study was conducted on an acute-care psychiatric unit within which a number of treatments may have been occurring concurrently, including pharmacotherapy, milieu therapy, and individual therapy. This constitutes a threat to internal validity, in that it increases difficulty in ascertaining whether any treatment effects were the result of factors outside of the control of study design. While the inclusion of a control group reduced the potential impact of this limitation, the author still recommends that future investigations involve systematic collection of additional data about the various treatments in which participants are currently engaged, along with other specific data of participant diagnoses as these data would assist in the analysis of the possible relationships among these factors, the studied intervention, and study outcomes. Data regarding participant diagnoses were not collected; however, diagnoses of participants in an acute-care treatment setting are often provisional in nature and subject to changes over the course of the patient's short-term stay in the hospital. In an acute-care setting, medication regimens are also often likely to change over time. The impact of medication overall as well as the impact of ongoing changes in medication, may have

interfered with participant learning.

Further, self-report was used as the method of data collection for this study; this method may introduce threats to validity of study responses based on exaggerated symptoms, under reported symptoms, or errors in completion of study instruments. Response bias may explain some of the variability in participant responses in that participants may have answered questions based on their overall thoughts about the group as opposed to responding specifically to individual question areas. In order to address this specific limitation, multiple methods of measurement, including behavioral observations, may help to further explicate the treatment experience and knowledge gain of participants.

Finally, measurements were also taken over a short period of time; just before and just after the groups were held. This limits the ability to make assertions about long-term treatment effects. Including measurement at different time points would allow for more in-depth understanding of changes that occurred as a result of intervention as well as of long-term impact.

Still, the current study presents a number of improvements in terms of design as compared to previous investigations and provides valuable additions to previous findings in this area of study. First, previous limited investigation in the area of psychoeducation for trauma in the inpatient setting found significant differences in knowledge after a psychoeducational group, but did not include a control group (Pratt et al., 2005), which significantly limits assertions about the impact of this intervention. The current study, on the other hand, did include a quasiexperimental control group, which offered the opportunity for comparison with treatment as usual. Second, potentially relevant

demographic variables were collected from study participants, which allowed preanalysis comparison of treatment conditions across a number of relevant demographic variables. Results suggested that these factors contributed similarly to the outcomes of the two treatment groups and that along these measured variables, the two groups were similar. Third, the psychoeducational group was facilitated by the same doctoral student throughout all groups. This consistency positively contributed to the uniformity of group delivery.

### **Implications**

The current study provides support for a highly acceptable psychoeducational group treatment for trauma in the acute inpatient psychiatric setting without using procedures with the potential to exacerbate PTSD symptoms, as may happen with some empirically supported treatments for PTSD (Nishith et al., 2002). The current study may form the basis for further development of a more effective short-term psychoeducational treatment for trauma in the acute-care psychiatric inpatient facility, although results indicate the need for further investigation into ways in which knowledge increases and readiness for future trauma-focused psychological treatment can be facilitated in such a treatment setting.

Current results for PTSD symptoms ( $H_2$ ) support the further study of specific components from established empirically-supported treatments, such as psychoeducation, and the evaluation of their potential for exacerbating PTSD symptoms in acute-care settings, where conducting complete empirically supported PTSD treatments may not be clinically indicated. The addition of specific skills for management of symptoms to the intervention described in this study may also further expand the repertoire of patient

behaviors and further the overall goals of treatment for these individuals.

Findings related to treatment acceptability are valuable in that they indicate that the studied psychoeducational treatment was highly acceptable, but future investigations that control for participant choice and more accurately compare to treatment as usual would be helpful in order to further evaluate the findings of this study related to treatment acceptability. Varying facilitators delivering the intervention while ensuring high treatment integrity as part of the study design would also improve on the current study by reducing the impact of facilitator factors on acceptability. Alternatively, a prescreening process may offer the possibility to match participant choice of group to need of the participant.

Regarding findings related to PTSD knowledge, it will be important in future investigations should modify the method of intervention delivery in order to increase the potential for retention of information and learning to occur within such a dynamic environment. Potential methods for overcoming barriers to learning in this setting include varying modalities of information delivery, including supplemental materials, such as a video, handout, or other learning aid; extending the amount of time spent on the intervention itself or providing additional sessions for questions and discussion. Some of these modifications, such as using a video to provide information, may also serve to further improve treatment integrity, and thus reliability of intervention.

In addition, current movements in the field of mental-health treatment indicate that a trauma-informed approach to patient care is indicated as an overarching emphasis in high-quality treatment. As such, the current study may form the foundation from which to expand the ways in which trauma is addressed within a larger system, such as a general

acute-care psychiatric hospital. Conducting educational groups with staff members both informally and formally may have the potential to increase the trauma knowledge of unit-based staff, as well as the awareness of the impacts of trauma on overall treatment progress.

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## APPENDIX A

### Two-Session Psychoeducational Group Intervention Manual

#### **Brief Orientation for Group Facilitators**

When working with patients who may have been traumatized, it is important to maintain an awareness of group members' reactions to topics discussed through both verbal and nonverbal communication. The following suggestions are offered in order to maintain the safety of group members participating in the group:

- Offer the opportunity to help group participants with emotional regulation, including teaching breathing retraining, which should be taught before discussing trauma or PTSD.
- The group therapist must be acutely aware of possible reactions and current state of emotion of group members. This means having awareness that the trauma history of some patients will be unknown or only partially known to the clinician.
- Specific trauma histories will not be detailed in this group. It may be necessary for the therapist to use group management skills to prevent group members from volunteering their own personal story, and a focus on safety and emotional regulation should be incorporated into each group session.

#### **Modality of Treatment**

- The treatment described here is a two-session, group intervention that is designed to be delivered during already established timeframes within a short-term acute care psychiatric treatment hospital. Included are didactic presentation of

information related to Posttraumatic Stress Disorder and its treatment, discussion, and experiential modalities.

### ***Goals of intervention***

#### **1) Knowledge**

*At the conclusion of the following two-session intervention, participants will be able to:*

- Identify that a ‘car accident’, ‘child abuse’, and ‘seeing someone else get seriously hurt’ may be types of events that meet criteria for a ‘criterion A’ trauma according to DSM-IV-TR
- Identify three symptoms of PTSD
- Identify exposure as a possible treatment for PTSD
- Identify drug and alcohol problems, depression, and anger as common co-occurring conditions with PTSD
- Assert that there are outpatient treatments available for PTSD

#### **2) Skills**

*At the conclusion of the following two-session intervention, participants will:*

- *Be able to participate in a group diaphragmatic breathing exercise*
- *Identify at least one source of support in their life. If an individual is not able to identify an appropriate social support, he or she will be referred to a unit staff member to brainstorm potential future sources of support.*

#### **Session Components:**

This group will be divided into 2 sessions of 45 minutes each. The main purpose of the group sessions are to provide patients with appropriate information about PTSD

and trauma experience and to raise awareness that effective treatments exist for reducing symptoms arising as a result of trauma.

### *Session 1*

#### **A) Overview of Group Treatment and Discussion**

\*This part of session one is the first opportunity to frame the group for group members. It is important that the group leader be proactive and assertive in stating that personal trauma histories will not be described as part of this group for two reasons: 1) to maintain that person's safety and not feel group pressure to share with the group, and 2) to ensure that the telling of personal stories does not 'trigger' any other group member.

Example:

*Today's group will cover general symptoms that some people who have experienced a traumatic event may or may not have. I will be very careful to make sure that no group member shares his or her story for two reasons: I want to make sure that no one feels pressure to have to tell a story to others while in the group, and I also want to make sure that no one experiences a 'trigger' that may be uncomfortable to another group member. Does this make sense to everyone here? I may interrupt you if you forget this and start to tell a story. I am not interrupting you because I want to cut you off, I just want to make sure that we all feel safe and supported when we talk about trauma in general. Can we all agree to this?*

\*Key points to be made

- There will be two group meetings today
- Each meeting will last for 45 minutes
- We will cover the impact of trauma in some peoples' lives, but we will not discuss any group member's personal trauma history. This is better accomplished in another treatment setting because this is a short-term treatment setting and longer term, one-on-one support would be more beneficial and safe for this purpose.
- Safety and confidentiality

Outcome: 1) A set of 3-4 group understandings (rules) about the way this group will run.  
2) Each group member introduces him/herself to other group members

#### **B) Breathing Retraining – Diaphragmatic Breathing with Practice**

\*Breathing retraining will help individuals to calm down if they feel unsettled at any time during this group. It is also a skill that can be used outside the group in order to help individuals to maintain an even mood throughout the day whether or not stressful events occur.

Example:

*We often don't notice our breath as we do things during the day. Sometimes we breathe quickly, and sometimes we breathe more slowly. If we pay attention to how we breathe, however, we can help ourselves to calm down if we are feeling stressed, or if we notice that we are starting to be stressed. The best time to practice this is when we are not stressed, though, and in this way we can become very good at this skill, and can then practice it whenever it is needed. Let's give this a shot, and then afterwards I'd like some feedback as to how this exercise was for you. Ready?*

\*The following will first be demonstrated, then practiced by the group together. This will continue until it appears that group members are able to complete the exercise. This is followed by a brief discussion of the experience of breathing, focusing on the ways in which this may have been helpful.

- Inhale through your nose and exhale slowly through your mouth. Take normal breaths.
- While you exhale, try to exhale very slowly and evenly. Do this more slowly than you normally would.
- Pause after exhaling before taking your next breath.
- Repeat this sequence 5 times, and each time breathe a little more slowly and evenly.
- Sometimes it is helpful to think of a calming word or a pleasant location while you do this. If you want, think of a calming word or a pleasant location.

### **C) Present Information, Then Ask for Questions and Feedback.**

\*Information about PTSD and trauma is presented in order to show participants that they may not be alone with their symptoms, and that many other individuals in the world also may experience these symptoms. When describing this information, it is important for the group leader to maintain an even tone of voice in order to show group members that these are not 'weird' or 'bizarre' reactions to a traumatic event. They are in fact a quite typical reaction to an experience that was unexpected or outside of their control.

Example:

*Now I'd like to go through some basic information about the types of experiences some people have after a traumatic event. These symptoms have occurred many times for many people, and I will say in general what some of those types of experiences are. If you have any questions along the way, please let me know or you can also ask after I have described some of this information. Any questions before I start?*

*Key pieces of information for review:*

- What is PTSD? Two things experienced: Life threatening event and feeling of fear, or Witnessing a life threatening event

- Stands for Posttraumatic Stress Disorder
- Not everyone who experiences a trauma will have PTSD, and some may still experience difficult reactions to the trauma but not be diagnosed with PTSD
  - Examples of traumatic events include: car accident, child sexual abuse or child physical abuse, sexual violence (rape), witnessing another person experience violence or experiencing violence (shooting, physical fighting, etc...), war
- Can experience nightmares, flashbacks, memories
- There are three general categories of symptoms of PTSD – Hyperarousal, re-experiencing, and avoidance symptoms
- Those who experience trauma may also have problems with addiction, relationships, depression, and anxiety, and they might be seen by others as ‘irritable’
- There are effective treatments for PTSD that have been studied extensively and shown to work
- One of the treatments that have been shown to work includes exposure. This involves addressing the traumatic event in therapy when the person is ready to do so
- As always, the type of treatment someone uses should be decided based on discussion between the person and his or her treatment provider(s)

Outcome: 1) presentation of all of this information  
 2) time for questions as they occur during the session

## *Session 2*

### **A) Review of Session 1, with Opportunity for Questions**

\*This part of session two gives participants the opportunity to clarify questions related to the information delivered during the first group session. It is important to first offer a very brief review of the main pieces of information delivered, while providing the opportunity for questions to arise.

Example:

*As we talked about this morning, our group meetings today are about general symptoms that some people may experience after a traumatic event. We agreed that we won't talk about specific experiences that some people in this group may have had [as we talked about traumatic events are very common], but we can talk about general symptoms or types of symptoms that some individuals with PTSD may have. I may interrupt you if you forget this and start to tell a story in order to make sure that everyone feels safe and supported when we talk about trauma in a general way. So, we have some time to ask questions about this morning. Does anyone have a question about the topics we discussed earlier?*

\*Make sure to review key pieces of information, and answer questions as they come up from group members. In the absence of questions, elicit general reactions from group members related to information provided and breathing exercise conducted.

*Key pieces of information for review:*

- What is PTSD? Two things experienced: Life threatening event and feeling of fear, or Witnessing a life threatening event
- Stands for Posttraumatic Stress Disorder
- Not everyone who experiences a trauma will have PTSD, and some may still experience difficult reactions to the trauma but not be diagnosed with PTSD
  - Examples of traumatic events include: car accident, child sexual abuse or child physical abuse, sexual violence (rape), witnessing another person experience violence or experiencing violence (shooting, physical fighting, etc...), war
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- There are three general categories of symptoms of PTSD – Hyperarousal, re-experiencing, and avoidance symptoms
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- There are effective treatments for PTSD that have been studied extensively and shown to work
- One of the treatments that have been shown to work includes exposure. This involves addressing the traumatic event in therapy when the person is ready to do so
- As always, the type of treatment someone uses should be decided based on discussion between the person and his or her treatment provider(s)

## **B) Presentation of Safety Planning and Available Treatments for PTSD**

\*This part of session two offers participants the opportunity to explore potential sources of support related to difficult symptoms and suffering that may occur as a result of trauma. Participants will be asked to identify at least one person who may be able to offer support when and if symptoms become unbearable. It should be stated during this discussion that if individuals feel that they are at imminent risk of harming or killing themselves or someone else, then they should immediately contact the closest crisis response service, including the current inpatient hospital admissions department. It will also be important to reinforce the value of inpatient hospitalization at a time of need and also to applaud the efforts that each patient has already made toward his or her own safety and care while in the hospital.

*Let's now take a few minutes to discuss how to plan for safety while thinking about how trauma might impact how we feel. Many people in this group completed a safety plan when they came into this hospital, and many have also done this type of exercise before.*

*We won't be discussing specific safety plans that you may already have established with your social worker, therapist, or psychiatrist. We do, though, wish to talk briefly about how to ensure that these safety plans can be most effective in preventing irreversible harm from coming to anyone in this group, and we think this can be a good opportunity to identify an important support person or two and to chat briefly about how to be supported by others and to ask for help when we need it.*

*Key pieces of information for review:*

- Go around the group and ask each person to identify one way he or she can seek out support from another person, one source of support in his or her life, or something positive he or she can look forward to.
- Discuss the importance of having at least one individual that one can go to for help in the event of feeling hopeless or suicidal.
  - Have each person write down on a slip of paper who that person is by the end of the group session.
- Open the conversation up to ideas about how to ensure safety given the information that has been discussed during today's groups.
- It may be helpful to think about your own warning signs and triggers and your own social supports, and to come up with a clear crisis plan that you are confident will work.
  - It is important to develop this plan when you are feeling ok, so that when you really need to follow through with the plan, you can do this without thinking. It will already be established

### **C) Group Wrap-up Opportunity for Final Questions and Review of Coping Skill**

\*This part of session two helps to provide closure to the two group meetings from today and to offer one last chance for participants to ask questions. The group ends with a brief discussion of diaphragmatic breathing and one more chance to practice this skill.

Example:

*We've talked a lot today about how common trauma can be, what some of the symptoms can be as a result of experiencing a traumatic event, and some of the things that can be done to help address the symptoms that people sometimes experience after trauma.*

*We're now coming to the end of our time together, and I'd like to start to wrap up the group by asking if anyone has any final thoughts or reactions to the two group sessions we've had, and also to do one more round of deep breathing as a group.*

\*Key points

- offer each member of the group the opportunity to ask final questions as they arise.

- *If a question comes up that will most likely take longer to answer than time allows, or if it is beyond the scope of this intervention, the group leader should refer that participant to the appropriate treatment team member on his or her inpatient unit*
- *Complete one round of diaphragmatic breathing as described in session 1*

APPENDIX B

Demographic Questionnaire

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Race:

White, Non-Hispanic

African American

Hispanic

Asian Pacific Islander

Native American

Other:

\_\_\_\_\_

1) Have you sought treatment for Posttraumatic Stress Disorder in the past?

a. Yes

b. No

2) If yes, what type of treatment did you attend (select all that apply)?

a. Cognitive behavioral therapy

i. Cognitive processing therapy

ii. Prolonged exposure

b. Another psychotherapy: \_\_\_\_\_

c. Medication alone

d. Medication with psychotherapy

3) Are you a native English speaker?

a. Yes

b. No

4) Are you fluent in any language other than English?

a. Yes

b. No

c. If so, which one(s)? \_\_\_\_\_

5) How far did you get in school?

Some high school

HS graduate

Trade school

- Some college
- Bachelor's degree/4 year college
- Graduate school/medical school