

Psychoeducation for Survivors of Trauma

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PURPOSE. *Education about the persistent effects of trauma helps survivors better understand their own stress responses, and knowledge of coping strategies provides a sense of control over these responses. Trauma education for providers can minimize negative countertransference and prevent vicarious traumatization.*

CONCLUSIONS. *This article discusses content areas to be covered in psychoeducation with survivors of acute traumatic events and prolonged trauma and abuse, and reviews resources for trauma psychoeducation with clients and healthcare providers.*

PRACTICE IMPLICATIONS. *Advanced practice psychiatric nurses may provide psychoeducation to people who suffer from complex psychological and behavioral disturbances related to severe and persistent abuse or trauma, especially early in life.*

Search terms: *Coping skills, disaster mental health, psychoeducation, trauma, traumatic stress*

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The quotation that follows is an example of how psychoeducation about long-term effects of traumatic experience can empower trauma survivors by making their symptoms comprehensible and manageable. A trauma survivor states:

Because I've done so much work to heal from my own abuse history, I couldn't understand why I seemed to overreact so badly to situations sometimes. It made me feel kind of defeated, like I could just get dragged back into being crazy at any time. The trauma classes helped me understand that I'm just having symptoms due to my sensitized nervous system, and that if I deep breathe and slow down they'll probably go away. Being symptomatic doesn't take anything away from the fact that I've still experienced tremendous recovery.

This article will discuss educational interventions for use with trauma survivors and members of the healthcare team who work with them, including the rationale for using psychoeducation with trauma survivors, content areas to be addressed when working with survivors of acute traumatic events and longer-term traumatic stress, and resources available to educate health professionals about psychological trauma and its treatment.

Why Is Trauma Education Important?

For clients, education about the effects of traumatic events is important because it provides a cognitive framework for their experience and helps minimize

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adverse responses. For those dealing with acute traumatic stress, understanding of stress responses such as autonomic hyperarousal and intrusive memories can make these responses more understandable, and knowledge of coping strategies can provide a sense of control over these responses. Since unpredictability and uncontrollability are core aspects of what makes stressful experiences traumatic (Allen, 2001), the ability to understand and influence one's own responses can reduce the immediate negative impact of a highly stressful situation. Use of healthy coping strategies, such as relaxation and mobilization of social support, can substitute for unhealthy coping strategies, such as substance use and excessive avoidance, that relieve distress in the short run but prevent necessary processing of the trauma. Understanding the reasons for stress responses can also help to minimize inappropriate self-criticism and damage to self-esteem.

For persons who experience persistent symptomatology as a result of more severe and long-lasting trauma exposure, education about the physiological basis for psychological phenomena, such as mood instability, flashbacks, memory problems, and depression, allows them to see these as symptoms and not as personal failings. Understanding that symptoms such as dissociation or aggression developed from responses that may have been adaptive in the context of an abusive situation helps survivors to feel less crazy and to view their own behavior in a more compassionate light.

Psychoeducation for persons with repeated trauma exposure may also need to address immediate needs for safety and self-care. Clients can be educated about how previous abuse increases risk for revictimization, as well as the importance of safety planning during trauma recovery (Schiraldi, 2000). Clients also need to learn self-monitoring and alternative coping strategies for dealing with high-risk behaviors, such as disordered eating, substance abuse, or self-mutilation. Awareness of how trauma reminders can trigger self-destructive behaviors and practice in using adaptive coping strategies are necessary to create stability in the

client's life before pursuing more intensive trauma treatment.

Education about trauma-focused treatment modalities and the rationale for using them is important to prepare clients for trauma-specific treatment and provide support during the treatment process. Clients who are aware of how avoidance can perpetuate post-traumatic symptoms and understand the potential benefits of exposure-based therapies are more likely to tolerate their initial distress and remain in treatment. In contrast, clients who begin treatment for trauma-related conditions with the unrealistic expectation that catharsis and healing will result from *just getting it all out* need to be educated about pacing of treatment and warned that premature immersion in the details of the traumatic experience may exacerbate some of their symptoms (Allen, 2001).

Trauma education is also important for members of the healthcare team who work with trauma-exposed clients. Understanding of acute trauma responses allows staff to assess client behavior more accurately, intervene more appropriately, and express more empathy. For clients with more severe, long-standing, and complex problems resulting from abuse and trauma, providers need to look beyond the variety of diagnostic labels that may have been applied to the client and respond to the underlying pathological processes that produce behaviors that are otherwise difficult to understand (Herman, 1992).

When working with trauma survivors, it is important not only to understand client behavior but also to understand one's own responses and use them therapeutically. Persons whose histories of severe abuse have led to unstable and intense moods and impaired interpersonal functioning often elicit strong feelings from providers. Staff members need to understand these countertransference responses to avoid unwittingly reproducing the types of abusive interactions with which traumatized clients are most familiar.

Providers also need to be forewarned of the psychological distress that can result from working with traumatized populations. Research (Bride, 2004) on

the mental health consequences of providing services to trauma survivors, which can include “secondary traumatic stress” or “vicarious traumatization,” indicates that hearing repeatedly about the horrific experiences to which clients have been exposed can itself cause symptoms of PTSD, and can be disruptive to providers’ sense of trust and safety in the world. Developing awareness of how to minimize these risks and engage in effective self-care are important goals for staff education.

Psychoeducation in the Aftermath of a Traumatic Event

Advanced practice psychiatric nurses may have many occasions to intervene with persons or groups who have recently experienced or witnessed a potentially traumatic event, such as a disaster, accident, or assault. Nurses may also counsel parents of children who have experienced such events. The goals of psychoeducation in these situations are to help people understand the range of normal responses to such events, use effective coping strategies, and identify responses that warrant more intensive intervention. The following is a statement by a witness to a traumatic suicide attempt.

Beverly, a 42-year-old woman, was waiting for the arrival of her commuter train when a young man stepped in front of the moving train in an apparent suicide attempt. Beverly describes her response to the scene: “It couldn’t have been more than a second, but it seemed like everything was going in slow motion when I saw him step in front of the train. I felt like I should cry out to stop the train, or push him out of harm’s way, but he was a block away. I wanted to look away when the train hit him but I couldn’t move. When I was describing what happened to the police, it felt like I was talking about CSI or something on TV—even though I could see it so vividly in my mind’s eye it didn’t seem like something that had really happened to me.”

Phases

The phases of response to disaster articulated by Raphael and colleagues (Disaster Mental Health Response Handbook, 2000) provide a helpful framework to help clients understand and anticipate how their responses evolve over time. The impact phase occurs at the time of the event, when survivors experience actual or perceived threats to life and bodily integrity, significant losses, or inescapable horror. They may feel a sense of dislocation or disorientation, or may feel overly responsible for the event. During the immediate post-event phase, survivors typically experience an alternation of intrusion and numbing responses. Denial and shock are followed by intrusive memories or flashbacks and vivid nightmares. Autonomic hyperarousal leads to irritability and sleep problems. Children may display continued fear and withdrawal, and temporarily regress to an earlier developmental level. Depending on the nature of associated losses, survivors may experience grief, sadness, and despair. Intense anger is an extremely common response after a traumatic event, and survivors and their families may be able to avoid unnecessary conflict if it is understood as such. Panic or dissociative responses during these early phases indicate elevated risk of psychiatric morbidity and warrant more extensive mental health assessment. Beverly’s description of the event taking place “in slow motion” and her sense of unreality when describing the event suggest dissociation and indicate increased risk of further mental health problems.

Beverly sought help from mental health services 2 weeks later because “I’m not getting over it like I should.” Beverly had experienced a postpartum depression 7 years earlier and was concerned that she might be getting depressed again. In addition to some of the depressive symptoms she had experienced in her earlier episode (depressed mood, decreased interest in normal activities, insomnia, and difficulty concentrating), Beverly also reported

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posttraumatic symptoms, including nightmares, “feeling kind of numb or spacey,” and unpredictable outbursts of anger. “I want to get treatment right away this time and not drag around feeling miserable for months.”

During the prolonged recovery phase, the alternation between denial/avoidance and intrusive thoughts and memories typically becomes less extreme. Fragmented and disjointed trauma memories are integrated with other autobiographical memories, and a reasonably coherent narrative of the traumatic event develops. During this phase, issues related to the meaning of the event and one’s role in it become most significant. For most people, symptoms related to acute stress response diminish and become less troublesome in the first few months after the event.

Promoting resiliency by providing patients with a range of coping strategies is another important function of psychoeducation after a traumatic event. Nurses can use group or individual contacts to help patients identify sources of social and spiritual support, reduce hyperarousal with relaxation techniques, and reestablish routines in a way that takes altered capabilities into account. Since patients may have limited ability to retain important information in the post-trauma period, providing written information to which they can refer later is helpful. Examples of easily accessible written materials are listed in Table 1.

In addition to prescribing a selective serotonin reuptake inhibitor (SSRI), Beverly’s psychiatric nurse practitioner helped her identify coping strategies, using a workbook for people who have been exposed to traumatic events. Techniques that Beverly found especially helpful were progressive relaxation, spending time with her husband and a close friend who were supportive, and prayer for the young man who died.

The Role of Psychoeducation in Treating Persistent Effects of Trauma

In addition to short-term or crisis-oriented work with survivors of recent disasters or other traumatic events, advanced practice psychiatric nurses may provide psychoeducation to people who suffer from complex psychological and behavioral disturbances related to severe and persistent abuse or trauma, especially early in life. Survivors of prolonged interpersonal trauma have a high incidence of problems with affect regulation, impulse control, memory and attention, self-perception, interpersonal relations, somatization, and systems of meaning. Such clusters of problems have been described as “complex PTSD” or disorders of extreme stress (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Herman (1992), whose work on trauma recovery provides the conceptual framework for a number of

Table 1. Informational Resources for the Immediate Aftermath of a Traumatic Event

<i>Tips for survivors of a traumatic event: What to expect in your personal, family, work, and financial life</i> (2005, September). http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/financial.pdf
<i>Tips for talking to children in trauma: Interventions at home for preschoolers to adolescents</i> . http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/intervention.pdf
<i>Tips for talking to children after a disaster: A guide for parents and teachers</i> . http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/parent_teach.pdf
National Child Traumatic Stress Network and National Center for PTSD. (2005, September). <i>Psychological first aid: Field operations guide</i> . http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc_manual_psyfirstaid.html . This manual includes handouts for survivors.

structured trauma treatment approaches, identifies the three stages of trauma recovery as (1) safety and stabilization; (2) remembrance and mourning; and (3) reconnection. Psychoeducation is crucial in the initial safety and stabilization stage because this is when problems related to the trauma history are identified, expectations for future treatment are defined, and coping skills that are necessary for dealing with painful memories or changing risky behavior are taught. Psychoeducation continues to be a valuable support during subsequent intensive treatment. Benham (1995) described the importance of teaching and coaching patients in the use of coping strategies in an inpatient trauma unit.

Treatment approaches differ in the order and timing of when particular topics are addressed, but most include discussion of what makes experiences traumatic, identify examples of types of traumatic experience, and discuss the dose-response relationship between the number and severity of traumatic experiences and the likelihood of pathological consequences (Allen, 2001). Although the target population influences the level of sophistication with which the content is approached, trauma psychoeducation often includes discussion of physiological stress responses and how persistent fear and helplessness can lead to lasting imbalances in these responses. Connections between trauma history and current difficulties are explored, and the origins of current dysfunctional behaviors as attempts to cope with overwhelming stress are identified.

If descriptive information about trauma is presented in the early stages of treatment, it is discussed in general terms without detailed exploration of individual trauma experiences. Group treatments for vulnerable populations, such as substance abusers (Najavits, 2002), or poor and mentally ill women (Harris, 1998), discourage disclosure of trauma specifics until members have developed the coping skills and psychosocial stability necessary to effectively manage the profound distress that can result from this exploration.

Since trauma-related symptoms are likely to lead to self-care deficits, skills to promote healthy behavior,

manage overwhelming distress, and increase safety are taught soon after or in conjunction with didactic material about trauma. The needs of the individual or nature of the population will influence how these content areas are prioritized. Almost all survivors of extreme traumatic stress need to develop skills in emotion regulation and appropriate assertiveness.

Tommy, a 35-year-old man, was referred to a trauma psychoeducation group associated with his court-mandated drug treatment program. Tommy had been abstinent for five weeks, but anxiety and sleep problems originally thought to be due to prolonged drug and alcohol withdrawal were becoming worse instead of better. Tommy complained of being jumpy, appeared hypervigilant, and slept poorly with vivid nightmares. His frequent angry outbursts, including cursing at the judge during his recent trial, were making it difficult for him to obtain necessary services.

Tommy was raised in a large, disorganized family where drug and alcohol use was common. He lived with different family members as he was growing up, and was beaten on a number of occasions by his uncle or his mother's boyfriends. He was sexually abused at age 10 by a male cousin. Tommy joined the military and served briefly, but he was discharged after a brief psychotic episode that followed seeing some of his company killed in a helicopter accident. Tommy began drinking heavily after leaving the military. "It helps me sleep, and I don't have to think too much about my past." For the past year he has also been smoking crack cocaine "to make it so I don't feel so dead inside." After an initial session discussing the relationship between trauma, psychiatric symptoms, and substance use, the group focused on helping members learn skills necessary to avoid substance abuse, achieve personal goals, and improve quality of life. Tommy learned distress tolerance skills such as distraction and grounding (Najavits, 2002) to decrease his desire to use drugs when overwhelmed with unpleasant emotions.

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His sleep improved with use of sleep hygiene techniques, and opportunities to role-play the use of effective interpersonal communication skills helped him avoid explosive outbursts.

Resources for Trauma Psychoeducation

This section will review some current resources for trauma psychoeducation, including books, treatment manuals, and a curriculum developed for training staff who work with trauma survivors. Information will be included about overall content, target audience, and how the resources might be used to educate different populations. Trauma-focused coursework developed by the University of California, San Francisco Psychiatric/Mental Health Nursing graduate program will also be briefly described.

Trauma and Recovery

Judith Herman's *Trauma and Recovery* (1992) is a classic in the field of trauma literature and has provided a foundation for the development of current manualized therapies. Herman describes the contexts and consequences of prolonged interpersonal abuse, and provides a comprehensive overview of the many ways in which interpersonal trauma can damage survivors. *Trauma and Recovery* is written in a manner appropriate for an educated lay audience and can be assigned as bibliotherapy for patients at various stages in treatment. It can also be used to develop educational materials for groups or individuals.

The Post-Traumatic Stress Disorder Sourcebook

This book, subtitled, "A Guide to Healing, Recovery, and Growth," (Schiraldi, 2000) is a well-organized review of information about PTSD and available treatment and self-management approaches written for a lay audience. The book begins with a discussion of the range of occurrences that can trigger PTSD, typical symptoms, and associated behaviors. Principles

of self-care and recovery, as well as essential goals of treatment, are reviewed as a prelude to chapters describing specific self-management techniques such as relaxation and affect management. Specific treatment approaches and techniques commonly used in clinical practice, such as Eye Movement Desensitization and Reprocessing and Thought Field Therapy, are described in the following section. The book concludes with a section on posttraumatic growth and relapse prevention.

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The Post-Traumatic Stress Disorder Sourcebook is a clearly written and comprehensive resource on PTSD and other trauma-related disorders that could be used as bibliotherapy with fairly well-educated clients. The instructions on symptom management techniques are straightforward enough to be useful to self-motivated individuals interested in a self-help approach. Chapters on treatment approaches are recommended for those who want to understand potential treatment options or want education on the rationale and goals of treatment they are currently receiving.

Traumatic Relationships and Serious Mental Disorders

Jon Allen, Senior Psychologist at the Menninger Clinic and author of several other well-known books

on psychological trauma, wrote this text for mental health professionals working with survivors of long-term interpersonal abuse, termed *attachment trauma* by the author (Allen, 2001). Content areas include: the nature of trauma; impact of trauma on personality development using attachment theory; impact of trauma on emotions, consciousness, memory, self and interpersonal relationships; trauma-related psychiatric disorders; and treatment modalities and self-regulation techniques. Allen also summarizes current knowledge on the pathophysiology of complex traumatic stress and associated somatic disorders.

The importance of psychoeducation is emphasized throughout the book—each chapter includes a section on educating clients about the concepts covered in that chapter (reexperiencing phenomena, dissociative states, etc.). In addition, there is a chapter that discusses establishing trauma psychoeducation programs in different settings with adults and adolescents. Allen identifies important principles for educating clients about trauma, such as involving patients as active participants in the educational process and addressing resistance before encouraging change.

BE SMART—Become Empowered: Symptom Management for Abuse and Recovery From Trauma

This workbook for clients (Moller & Murphy, 2001) is used for a group psychoeducation program that utilizes the Murphy/Moller Wellness Model, a nursing model with a rehabilitation focus, and Trauma Reframing Therapy (Moller & Rice, 2006). The workbook is completed as the first step in the treatment process and is followed by an ongoing therapy group.

Chapters in the workbook cover personality development, brain functioning, and other physiological mechanisms that are affected by prolonged traumatic stress. Associated dysfunctional behaviors that may have developed in the aftermath of traumatic abuse are addressed, but are not a major focus. In addition

to psychoeducation, the workbook includes active treatment components such as exposure techniques. Chapter 7 instructs clients on narrating their trauma story. Although some of the chapters are at a fairly high reading level, the material makes frequent use of learning aids—as might be surmised from the title, acronyms are a favorite technique. A program evaluation study of *BE SMART* showed an increase in health-promoting behaviors and improvements in overall wellness in a subset of patients completing the program (Rice & Moller, 2006).

Seeking Safety

This manualized group treatment for clients with both PTSD and substance use disorders is designed to be used as a first stage (safety and stabilization) treatment for this population (Najavits, 2002). Discussion of patients' trauma stories is eschewed, as are any type of exposure techniques, because it is assumed that this will be destabilizing for clients in the early phases of substance abuse recovery. *Seeking Safety* is a structured approach that includes instructions on each session for group leaders as well as handouts for clients. Treatment focuses on developing cognitive/behavioral and interpersonal skills, using standard techniques such as role-play, cognitive restructuring, and homework (referred to by the author as "commitments"). Although some information about the effects of trauma is included, the emphasis of *Seeking Safety* is more on teaching coping skills. An advantage of this manual is that its copyright explicitly permits reproduction of materials for use with clients by qualified mental health professionals.

Seeking Safety is the only resource reviewed here that currently has published empirical support for its effectiveness—abstracts from 11 studies of the manualized treatment are provided on the *Seeking Safety* Web site (*Studies of Seeking Safety*, n.d.). Use of the *Seeking Safety* program demonstrated modest clinical improvements, including reductions in substance use and posttraumatic symptomatology, in a variety

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of populations including male and female veterans, women in prison, women in a dual diagnosis program, and adolescent girls. *Seeking Safety* was also used as a treatment in four of the nine sites in the Women, Co-occurring Disorders, and Violence Study, a multisite, quasi-experimental outcome study with more than 2,000 participants.

Trauma Recovery and Empowerment

The Trauma Recovery and Empowerment Model (TREM; Harris, 1998) was developed for use with poor and disenfranchised women with histories of trauma and substance abuse. The model has an empowerment focus with an explicitly feminist orientation. Core assumptions include the belief that current dysfunctional behaviors or symptoms (avoidance, dissociation, etc.) originated as legitimate coping responses to trauma, and that trauma interferes with the development of necessary coping skills. The treatment consists of 24–29 group sessions, and it is recommended that these be done in the prescribed order. In contrast to other approaches that provide educational material on trauma early in treatment, the first phase in the TREM model focuses on self-care, safety, and building group cohesion before moving into more specific trauma-related material.

The TREM manual is designed for use by clinicians and has explicit directions for group content. These are more process-oriented than didactic—groups include experiential activities such as art projects and discussions of literature. Since TREM does not use written materials like worksheets, this model may be particularly useful for clients with low literacy. The manual includes modifications for women with serious mental illness, incarcerated women, women who perpetrate abuse, and men.

Risking Connection

This training curriculum was developed for professionals and staff working with survivors of interpersonal

trauma (Saakvitne, Gamble, Pearlman, & Lev, 2000). Survivors of trauma played an active role in developing and refining the curriculum, which espouses an empowerment approach. The curriculum's goals are to provide a theoretical framework to guide work with survivors of trauma and abuse, to teach specific intervention techniques, and to focus on the needs of trauma workers as well as clients. The curriculum provides background material for trainers, case scenarios and discussion questions, and a variety of assessment forms to be used with clients and by staff for self-assessment.

UCSF School of Nursing Trauma Curriculum

In recognition of the significant impact of trauma on the lives of many of the patients seen by students in the advanced practice psychiatric nursing program (seriously mentally ill adults, incarcerated youth, etc.), as well as increasing public health concern about the psychiatric morbidity associated with disasters and terrorism, the University of California School of Nursing has implemented a curriculum focusing on the mental health consequences of traumatic experience. This project is supported by an Advanced Education Nursing training grant from the Bureau of Health Professions, *Mental Health Nursing Care for Victims of Trauma*. Courses in the trauma curriculum are taken by all psychiatric nursing students, and may be taken by other students in the School of Nursing and other health science students as well as nurses from the community for a continuing education certificate.

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The trauma curriculum consists of three courses and a trauma-focused clinical experience. *Theories of Human Response to Trauma* examines theories from the social, behavioral, and neurosciences that explicate human responses to different types of trauma and utilizes developmental theories to understand effects of traumatic events on persons across the lifespan. *Assessment and Intervention with Survivors of Abuse and Violence* discusses assessment and treatment of individuals and families with past or current experience of physical, sexual, or emotional violence. *Mental Health Care for Populations Experiencing Disasters* teaches assessment techniques and interventions for both acute and chronic responses to disaster and terrorism. Clinical experiences include evaluating trauma-related symptomatology, providing trauma-specific treatment to particular groups or individuals, or implementing changes in practice settings to provide trauma-informed care.

Although individuals and communities can display great resilience in the face of disastrous events or even ongoing harm and abuse, it is often true that such overwhelming and terrifying occurrences produce lasting distress and psychiatric impairment. Psycho-education can empower trauma survivors by validating their experience, explaining the reasons for apparently uncontrollable responses, and providing coping skills to effectively manage distress. By assisting survivors to develop compassionate self-understanding and emotional self-mastery, we can help to "make the unbearable bearable."

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