Using Psychoeducation to Teach Female Clients about Interpersonal Trauma
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A thesis submitted to the School of Community Services in partial fulfillment of the requirements for the degree of Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada
April 2015
Dedication

I would like to dedicate this thesis to all women who have experienced interpersonal abuse and the hope for a brighter future with effective and successful interventions for women with PTSD.
Abstract

This research study evaluated the effectiveness of using psychoeducation and supportive therapy to reduce sub-clinical symptoms of Post Traumatic Stress Disorder, and increase coping ability using a pre-post-test design. The participants of the study were four women ranging from 20-52 years of age, who had various mental health diagnoses in addition to experiencing PTSD symptoms due to interpersonal trauma. Three of the four participants completed the full research study. The treatment took place over 6-weeks and consisted of 1-hour weekly sessions of 30 minutes of trauma related psychoeducation, followed by 30 minutes of supportive therapy. The treatment was provided at the community agency and was implemented by the student researcher and case manager. Two questionnaires were administered throughout the study: The PTSD Checklist Civilian Version for DSM-IV (Weathers, Litz, Huska, and Keane, 1994) and the Brief COPE (Carver, 1997). The questionnaires were administered to participants at the beginning of the study and after treatment to evaluate changes in PTSD symptoms and coping ability over the 6-week treatment period. Results indicated that all of the three participants’ PTSD symptoms were shown to decrease based on the changes in their pre-post treatment scores on the PCL-C. The results indicated that all of the participants demonstrated a clinically reliable change in scores, and two of the three participants demonstrated both clinically reliable and clinically meaningful change in scores from pre-treatment to post treatment. Each of the participants’ coping ability changed from pre-post treatment on the Brief COPE, however the change was not always positive. This study’s implications, multilevel challenges to the field of behavioral psychology and future recommendations were discussed.
Acknowledgements

To my college supervisor, Jordan Maile who has assisted me throughout this whole process. Without your patience and support throughout all of the drafts and rewrites, this thesis would not be complete. I cannot thank-you enough, the end result of this thesis is due to both of our hard work and dedication. Cheers to this thesis being completed.

To my agency supervisor, Hopper Hopkins, you are a shining light in a very dark world. Thank-you for being my mentor and teaching me about working in a community mental health setting. I truly grew as a person while working with you and am honored to have been your last student before your retirement. I have been a witness to the difference you have made in so many lives, thank-you for your work over the years. I wish you well, enjoy your retirement.

To my parents, thank-you for always believing in me and supporting me. Your unconditional love and support has brought me to where I am today. To Liz, Mike, William, and Ava, thank-you for supporting and loving me throughout this process. Without my family I would be lost, they are truly my anchor in life. I love you all.

To my boyfriend Danon, thank-you for always loving me. When I feel like the world is caving in you stabilize me and remind me of what I am working towards. Thank-you for listening to the endless discussion, complaining, and of course tears. You believe in me and that means the world to me. I love you.
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Chapter I: Introduction

A high prevalence of interpersonal trauma is seen in community mental health settings and approximately one in three women experience interpersonal trauma in adulthood (Kubany, Hill, and Owens, 2003). Interpersonal trauma is defined as “any form of emotional abuse, emotional neglect, physical abuse, physical neglect, and/or sexual abuse in childhood and/or adulthood” (Mauritz, Goossens, Draijer, and Achterberg, 2013). Research and evidence-based treatments for adults who have experienced interpersonal trauma are limited (Dorrepaal et al., 2010).

Many individuals are unaware of the mental, emotional, and physical damage interpersonal trauma causes and how this can contribute to the development of psychiatric disorders (Kubany et al., 2003). Interpersonal trauma that is not treated can develop into psychiatric disorders such as: post-traumatic stress disorder (PTSD), mood disorders, eating disorders, psychotic disorders, dissociative identity disorder (DID), borderline personality disorder (BPD), anxiety disorders, and substance use disorders (Rice & Moller, 2006, pg.94). Individuals who are exposed to consistent interpersonal trauma can experience further deficits in memory, affect, and social skills (Dorrepaal et al., 2010).

Many victims of interpersonal trauma often do not know much about the effects of interpersonal trauma or how it is typically treated. Phoenix (2007) states that women gain more understanding about their physiological and psychological symptoms when they participate in psychoeducational classes. It was noted that psychoeducation provides a cognitive framework for understanding symptoms and knowledge about managing these symptoms through coping skills (p.123). Women also learn how trauma is typically treated and what to expect during the therapeutic process. As a result, women feel like they have some control over their symptoms because; they understand why they are experiencing these symptoms, they learn positive ways to cope, and they know what to expect throughout the therapeutic process (Phoenix, 2007).

Providing psychoeducation about trauma and supportive therapy could positively change the way adult women receive treatment. Focusing on education offered in conjunction with supportive therapy provides a safe environment for adult women to discuss their personal experience with interpersonal trauma and their mental health-related concerns (Phoenix, 2007; Roe-Sepowitz, Bedard, Pate, and Hedberg, 2012). Psychoeducation may empower women who have experienced interpersonal trauma with understanding and coping skills to manage their symptoms. In addition, psychoeducation may motivate these women to move forward with therapy, so that they receive the help they need to recover (Phoenix, 2007; Roe-Sepowitz et al., 2012).

This study took place at Frontenac Community Mental Health and Addictions Services in Kingston, Ontario. The student researcher worked with 20 clients that had experienced severe interpersonal trauma. These clients experienced a variety of trauma related concerns such as; physical abuse, childhood sexual abuse, emotional abuse, sexual abuse, and verbal abuse. An agency case manager noted that many of the clients who have trauma have not had any psychoeducation specifically about their trauma. It was noted by the agency case manager that these clients could benefit from trauma psychoeducation as well as participating in supportive therapy. Six different psychoeducational lessons were identified through research and by discussing the needs
of the agency clients with her case manager. These six psychoeducational lessons are: the symptoms of trauma, attachment styles, belief systems, coping when triggered, acceptance of the past, and a review. Based on empirical research, the present study hypothesized that adding a psychoeducational component to existing individual supportive therapy would increase the clients’ understanding of her own symptoms and build coping skills. In addition, it was hypothesized that sub-clinical symptoms of PTSD would decrease as psychoeducation was delivered. If the results of this research study indicated that psychoeducation does lead to decreases in symptoms and increases in coping skills, then this could assist in advocacy for the need of trauma psychoeducation within community mental health settings.

Within the current project, a review of the existing research literature is provided. The topics covered in this review include: empirical research that supports the need for trauma psychoeducation, a clear definition of trauma and psychoeducation, a review of three empirically supported forms of therapy for trauma, and a critical analysis of the current research literature. Furthermore, the method of how trauma psychoeducation was delivered in this study is described. The results of this research study will be presented, followed by; a discussion of the results, provision of recommendations for further research, and a conclusion.
Chapter II: Literature Review

The current literature review discusses how psychoeducation is used as a treatment for interpersonal trauma. The literature review will first provide a definitions of psychoeducation, a traumatic event, and the two main forms of trauma: complex and interpersonal. The literature review will cover three empirically supported forms of therapy used to treat trauma: Prolonged Exposure Therapy (PET), Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT). In addition, research studies that have used psychoeducation as a form of treatment for interpersonal trauma for women will be reviewed. The final section of the literature review will discuss why adding an additional component of psychoeducation to pre-existing therapy may benefit the therapeutic process as a whole.

What is Psychoeducation?

Psychoeducation is a competence-based approach with the main goal of psychoeducation being to improve the client’s overall functioning through education about their illness and ways to proactively cope (Lukens & McFarlane, 2004). While many critics of psychoeducation assert that it is ineffective, this criticism is largely based on studies investigating the effectiveness of self-help psychoeducation-based interventions (Wessely, Bryant, Greenberg, Earnshaw, Sharpley, & Hughes, 2008). In contrast, didactic or non-self-help interventions has been found to be an effective form of intervention in both clinical and community settings (Lukens & McFarlane, 2004).

Psychoeducation has been used to treat a wide range of mental illnesses and has developed from many other theories and models including: “ecological systems theory, cognitive-behavioral theory, learning theory, group practice models, stress and coping models, social support models, and narrative approaches” (Lukens & McFarlane, 2004, p. 206). Psychoeducation removes the barriers that prevent individuals from understanding their illness and their complex responses to daily life. Adding psychoeducational components to interventions have been shown through empirical research to decrease symptomology, improve functioning, and overall quality of life (Lukens & McFarlane, 2004).

Swaminath (2009), defined psychoeducation by separating it into three components: therapeutic interaction, clarification, and increasing coping competence. Therapeutic interaction evolves creating strong therapeutic rapport between the client and care provider; this includes providing the client with respect in a non-judgmental environment (Swaminath). Clarification involves providing clear and understandable information about the facts of their illness; this is the educational component (Swaminath). Increasing coping competence focuses on ways in increase coping skills. This component includes “optimized crisis management behavior, modification of life plan, and transforming patients into “experts” of their illness (Swaminath, p. 171).

What is Considered Trauma?

Landes, Garovoy, and Burkman (2013), define a traumatic event as “an event that involves actual or threatened death, serious injury, or threat to the physical integrity of self or others” (p.523). Complex trauma is the clinical term for repeated exposure to a
traumatic event, this includes “psychological maltreatment, neglect, physical abuse, sexual abuse, and domestic violence” (Landes et al., p.523). Interpersonal trauma is defined as “any form of emotional abuse, emotional neglect, physical abuse, physical neglect, and/or sexual abuse in childhood and/or adulthood” (Mauritz et al., 2013).

Empirically Supported Treatment Options for Trauma

**Prolonged Exposure Therapy.** Prolonged Exposure Treatment (PET) is a cognitive and behavioral form of therapy that was created to treat Post Traumatic Stress Disorder (PTSD; Foa, 2011). Exposure therapies are utilized to reduce fear and debilitating emotions surrounding the individual’s traumatic event (Foa). During exposure therapy, the individual is encouraged to face their feared situation through identifying surrounding traumatic thoughts, triggers, and memories (Foa). There are three forms in which exposure therapy can be delivered: in vivo (i.e., in real life), imaginal (i.e., focuses on thoughts in one’s mind), and interoceptive (i.e., physiological or internal cues related to the traumatic event; Foa). Commonly more than one form is used in an exposure therapy intervention for PTSD (Foa). PET is typically conducted over 8 to 15 sessions depending on the severity of PTSD, each session is 60 to 90 minutes in length (Foa).

Many individuals who have experienced trauma avoid these negative emotions and reactions to the triggering stimuli which in turn reinforces their anxiety, symptoms and negative emotions attached to the trauma (Foa, 2011). The major goal of PET is for the individual to expose themselves to the negative emotions, reactions, and triggering stimuli in their environment that are associated with the trauma (Foa). Through exposure the individual is able to decrease their emotional reaction to triggering stimuli in their environment (Foa). In addition, as the individual’s ability to process emotions improves; false beliefs and destructive emotions due to PTSD can be identified throughout the process of PET (Foa).

Harned, Korslund, and Linehan (2014) compared two different treatment options for women who were diagnosed with both Borderline Personality Disorder (BPD) and PTSD. The researchers compared the effectiveness of a DBT treatment group alone in comparison to a DBT treatment with an added PET component (Harned et al.). The goal of the study was to identify what treatment group would stabilize PTSD symptoms and reduce the likelihood of self-harm behaviors and suicide (Harned et al.). The participants were randomly selected into the two different groups: DBT alone or DBT with an added PET component (Harned et al.). Both groups received one year of therapy. The DBT alone component consisted of: 1- hour individual psychotherapy sessions weekly, group skills training for 2.5-hours weekly, phone consultation as needed, and weekly therapist consultation meetings (Harned et al.). The DBT group with an added PET component followed the same format at the DBT-alone, however they received an additional therapeutic component of PET (Harned et al.). The results indicated that women in the DBT group with the added PET component had a greater reduction in PTSD symptoms compared to the women in the DBT only group (Harned et al.). In addition, women in the DBT group with the added PET component were 2.4 times less likely to commit suicide, and 1.5 times less likely to self-injure when compared to the DBT alone group (Harned et al.). This study demonstrates that adding PET to pre-existing DBT can reduce
PTSD symptomology, self-harm, and suicide in a group of women with BPD and PTSD (Harned et al.).

Cognitive Behavioral Therapy (CBT). Cognitive Behavioral Therapy (CBT) focuses on the individual’s thoughts, feelings, and behaviors (Spector et al., 2012). CBT has been used to treat many clinical diagnoses rooted in anxiety and depression, CBT is a present-focused therapy that focuses on the individual’s current situation (Spector et al.). The individual is encouraged to make realistic, specific, and time-limited personalized goals with the counselor (Spector et al.). These goals are to be practiced in between sessions independently (Spector et al.) Success of the CBT intervention would be identified through achievement of the goals and witnessing continuous growth in these goals overtime (Spector et al).

Feather and Ronan (2006) studied the effectiveness of using Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) in reducing symptoms in four children, age 9-14 years who had been abused and were diagnosed PTSD. The TF-CBT focused on four main phases of treatment: psychosocial strengthening, development of coping skills, trauma processing, and special issues and completion of therapy (Feather & Ronan). The results indicated that after treatment the symptoms of PTSD had decreased and that coping skills had increased and these results were maintained throughout a 12-month follow up period (Feather & Ronan). Psychoeducation is commonly used in CBT intervention; however it is typically delivered relatively briefly (i.e. one to two lessons; Feather & Ronan). Adding more sessions of psychoeducation throughout CBT therapy interventions may have a greater effect in decreasing symptoms and increasing coping ability (Feather & Ronan, 2006).

Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy (DBT) was developed by Marsha Linehan (1993) and was created to treat individuals with Borderline Personality Disorder (BPD). DBT is usually delivered over a one-year time frame consisting of: skills training group therapy, individual therapy, telephone contacts, and team meetings for the therapists treating the individuals (Linehan, 1993; Hodgetts, Wright, & Gough, 2007). There are four different stages of the DBT process for clients with BPD. Stage 1 of DBT involves the client gaining behavioral control over their actions; DBT aims to reduce life threatening behaviors, behaviors that interfere with therapy, and behaviors that affect the individual’s life negatively (Linehan; Hodgetts et al.). Stage 2 of DBT addresses the individuals past life traumas, psychotherapy is used to help the individual find the root of their problems (Linehan; Hodgetts et al.). Stage 3 of DBT addresses how the individual can develop self-esteem in their life (Linehan; Hodgetts et al.). In the final stage of DBT the individual is pursuing the “capacity for optimum experience”. Individuals are encouraged to set goals for the future and work experiencing joy in their day to day lives (Linehan; Hodgetts et al.).

Bohus et al. (2013) examined the treatment efficacy of DBT-PTSD (a DBT protocol modified specifically to treat PTSD) with a sample of residential women who experienced childhood sexual abuse. An additional trauma-focused cognitive and exposure-based intervention was added to normal DBT practice for treatment (Bohus et al). The researchers noted that the normal format of DBT does not focus on trauma symptoms or behaviors, thus possibly limiting the effect of treatment for individuals who
have PTSD and BPD (Bohus et al.). Therefore, an additional trauma-focused cognitive and exposure-based intervention was added (Bohus et al.). The participants were randomly placed into either the DBT-PTSD group or a Treatment as Usual- Waitlist group (TAU-WL) (Bohus et al.). The participants in the TAU-WL group were allowed to take part in any treatment groups that the residential setting offered with the exception of the DBT-PTSD group (Bohus et al.). Treatment was provided to both groups at the residential setting for a 12-week period (Bohus et al.). Results indicated a significant reduction in PTSD symptoms for the participants that were in the DBT-PTSD group (Bohus et al.).

**Would More Psychoeducation Make These Treatments More Effective?**

Most empirically validated treatments for trauma traditionally incorporate psychoeducational elements to their treatment. Most of the time these psychoeducational elements are very brief and simplistic. This position is exploratory, however there is a possibility that adding a more in-depth and structured psychoeducational component to these traditional treatments for trauma could provide further benefits to individuals who have experienced trauma. These therapies have been demonstrated to be highly effective on their own; however, it would be interesting to evaluate if adding a more in-depth and structured psychoeducational component provides further positive treatment outcomes. Landwehr & Baker (2012), wrote an article on “Psychoeducation’s Role in Integrated Healthcare” and stated that most short-term psychoeducational programs are under-funded and under-researched.

There is a lack of research on psychoeducation and the effect it has when added to pre-existing empirically validated therapies. Benefits of psychoeducation have been identified through research on providing psychoeducation programs to mental health patients alone. Landwehr & Baker (2012) noted that psychoeducation has provided the following benefits for individuals with long-term mental health diagnoses (e.g., schizophrenia): “reduced psychiatric symptoms, improved treatment adherence, improved functional and vocational status, and greater satisfaction with treatment” (p.220). Even though presently there is minimal research on how adding a more in-depth and structured psychoeducation component would affect these presently existing treatments for trauma, it would be interesting to see if these benefits found through psychoeducation would positively increase the overall effect of treatment.

**Could Psychoeducation Cause Further Emotional Distress?**

Individuals who have had experience with a traumatic event must experience three clusters of symptoms: re-experiencing, avoidance/numbing, and hyperarousal for one month following the traumatic event in order to be diagnosed with PTSD (Yeomans et al., 2010). Every adult experiences some variations of traumatic events within their life time, however this does not mean that they will experience these symptoms for the rest of their life (Yeomans). In fact, only 20-30% of the US population with a diagnosis of PTSD develop PTSD symptoms that continue throughout their lifespan (Yeomans). Many people who experience trauma heal naturally or never develop fullscale PTSD (Yeoman et al.).
There is little research on the effect that psychoeducation has on individuals who have PTSD individually as it is typically combined with another form of therapy. In addition, how psychoeducation affects individuals who have experienced different types of trauma (sexual, physical, verbal, environmental). PTSD psychoeducation normally provides individuals with information about the common symptoms of trauma and some methods of coping in order to reduce distress (Phoenix, 2007). There has been a great debate on whether providing psychoeducation is beneficial for all victims who have PTSD and if this form of treatment exacerbates symptoms and prevents natural healing and resilience (Yeomans et al., 2010).

Yeomans et al., (2010), conducted a study that evaluated the effects of PTSD psychoeducation within a sample of adults living in Burundi. All of the adults within this study had a severe trauma history witnessing and experiencing murder, rape, threats, and war (Yeomans et al.). The researcher evaluated the effects of PTSD psychoeducation by comparing three treatments: trauma-healing workshop with psychoeducation, trauma healing-workshop without psychoeducation, and a waitlist control group (Yeomans et al.). The results indicated that two weeks post-intervention both the trauma-healing workshop with psychoeducation and trauma-healing workshop without psychoeducation has reported significant decreases in traumatic stress (Yeomans et al.). It was also found that the participants in the trauma-healing workshop without psychoeducation reported a greater decrease in traumatic stress than the trauma-healing workshop with psychoeducation (Yeomans et al.). The author’s noted that the inclusion of the psychoeducation about PTSD may have reduced the beneficial effects of the healing section of the workshop, the information about trauma may have increased PTSD symptoms and vulnerability (Yeomans et al.).

More research is required in order to truly test the effects of psychoeducation as a treatment for trauma. Even though in some cases psychoeducation has been shown to exacerbate symptoms, many other clinicians have found it to be beneficial (Phoenix, 2007; Roe-Sepowitz et al., 2012). Studies have found that psychoeducation may empower women who have experienced interpersonal trauma with understanding and coping skills to manage their symptoms (Phoenix; Roe-Sepowitz et al.). In the following section, studies that have used psychoeducation alongside supportive therapy will be discussed in further detail.

Psychoeducation as a Treatment for Women Who Have Experience Interpersonal Trauma

Kubany et al. (2003) used Cognitive Trauma Therapy for Battered Women (CTT-BW) to treat the symptoms of PTSD in battered women. The CTT-BW focused on five targets: psychoeducation about PTSD and cognitive dysfunctions, exposure to triggers, cognitive therapy surrounding guilt, teaching coping skills, and avoiding victimization (Kubany et al.). The results indicated that 94% of the women who completed the CTT-BW treatment did not meet the PTSD diagnostic criteria post-treatment and significant increases in self-esteem were also identified post-treatment (Kubany et al.). This study suggests that psychoeducation alongside therapy can reduce symptomology of PTSD and increase self-esteem (Kubany et al.).

Roe-Sepowitz et al. (2012) implemented an abuse-focused psychoeducation intervention to a group of incarcerated women. The goal of this study was to decrease
trauma related symptoms due to interpersonal trauma. The abuse-focused psychoeducation group had three principle goals: education, support, and empowerment (Roe-Sepowitz et al.). A one-group pretest–posttest design was used, results demonstrated significant improvements in decreasing trauma-related symptoms (Roe-Sepowitz et al.).

Rice and Moller (2006) conducted a study to determine if a psychoeducational course provided with supportive therapy would change the wellness scores in men and women who were diagnosed with different trauma related disorders (e.g., PTSD, DID, BPD). The program focused on the wellness outcomes of participants and focused on four main domains: health, attitudes/behavior, environment/relationship, and spirituality (Rice & Moller). The results showed significant improvements on all four domains; subjects also felt like their overall health had improved by the end of treatment (Rice & Moller).

Dorrepaal et al. (2010) conducted a study on the benefits of adding a psychoeducational component and cognitive behavioral stabilizing group treatment for complex PTSD offered in conjunction with supportive individual treatment. Two groups were compared: the supportive individual treatment plus psychoeducational and cognitive stabilizing group and supportive individual treatment alone (Dorrepaal et al). The results demonstrated that the scores of participants in both groups improved; however the individuals who participated in the added psychoeducational and cognitive behavioral stabilizing group focused were significantly higher than supportive individual treatment alone (Dorrepaal et al.). This suggests that the added psychoeducational component may have further reduced symptoms and provided more life skills. (Dorrepaal et al.).

Sperlich et al. (2011) designed a psychoeducational program for pregnant women who have experienced interpersonal abuse and were at risk for developing mental health and physical concerns during pregnancy and post-child birth. Results demonstrated a reduction in symptoms and an increase in coping skills (Sperlich et al.). The authors noted that the participants valued the tutoring aspect of the program. The authors also stated that their psychoeducation program would likely be beneficial and realistic to implement in a community mental health setting with limited resources (Sperlich et al.).

Seeking Safety is an evidence-based therapeutic intervention for comorbid mental health diagnoses and trauma (Patitz, Anderson, and Najavits, 2014). Seeking Safety has been used in both urban and rural populations with the focus of treatment being to provide psychoeducation and coping skills. Patitz et al. conducted a study that investigated the effectiveness of Seeking Safety in a rural setting with 23 women who had comorbid substance abuse and trauma. The authors stressed that there is a need for professionals to provide both psychoeducation and coping skills in rural settings because the clients within these settings are more likely to meet the diagnostic criteria for having a diagnoses and less likely to have access to any form of treatment (Patitz et al.). The results indicated that from pre-post treatment all of the 23 participants demonstrated a reduction in trauma symptoms as indicated by the Trauma Symptom Inventory (Patitz et al.). This study demonstrated that Seeking Safety was effective in reducing trauma symptoms in women within a rural community (Patitz et al.).

The studies discussed above provide empirical evidence for the use of psychoeducation for women who have experienced interpersonal trauma. All of these
studies demonstrated that psychoeducation alongside supportive therapy can decrease sub-clinical and clinical symptoms due to trauma and increase coping skills.

Discussion

There are very few studies on providing psychoeducation alone as a treatment for PTSD. As this thesis is specifically focused on women and interpersonal trauma, psychoeducational practices for this group have been identified as most beneficial when they are being provided directly by the professional in combination with another form of therapy such as CBT. Trauma-related psychoeducation as a practice is adaptable, competence-based, and provides clients with an understanding about the psychological, cognitive, and physical reactions to trauma.

Psychoeducation is adaptable to many settings and formats of delivery, psychoeducation as a whole is an evidence-based practice that has been reviewed in both clinical and community settings (Lukens & McFarlane, 2004). Psychoeducation can be used for individuals, families, groups, or training purposes. In addition, Sperlich et al. (2011) noted how psychoeducation is feasible for community settings to utilize because it is not an expensive form of therapeutic practice for professionals to be trained in or to provide to clients.

Trauma-related psychoeducation is a competence-based form of therapy for women who have experienced interpersonal trauma because it provides information to clients about what they are experiencing, provides an opportunity to learn about new coping skills, and builds on their pre-existing competencies (Phoenix, 2007). Many women with sub-clinical and clinical symptoms of PTSD do not know how to manage their symptoms and cannot cope (Phoenix). Providing different healthy coping strategies can replace the common unhealthy coping strategies that follow trauma (Phoenix). Psychoeducation provides individuals understanding of their psychological, cognitive, and physical reactions to their trauma. Phoenix states that providing education about mood dysregulation, loss of memory, flashbacks, and depression allows the individual to identify that these difficulties are not personal failing, but rather a bodily reaction to what they have experienced. Clients who receive education about the treatment and the benefits of the treatment prior to beginning therapy tend to understand, and tolerate the initial distress they feel when treatment begins (Phoenix).

Psychoeducation prepares the individual for treatment and provides understanding about their symptoms, what treatments are available, what commonly occurs during treatment, and the benefits of participating in treatment (Phoenix, 2007). Psychoeducation about trauma provides transparency for the individual to discuss unrealistic expectations prior to beginning therapy with a professional (Phoenix). Individuals are then able to participate in therapy with a better understanding of themselves, the therapy, and their illness (Phoenix).

Conclusion

Empirically supported treatments for PTSD due to interpersonal trauma for women have been identified in this literature review. Overall, the literature on psychoeducation for interpersonal trauma is limited. The research available has shown that adding a psychoeducational component to pre-existing therapy can reduce sub-
clinical and clinical symptoms of PTSD while increasing coping ability (Kubany et al., 2003; Roe-Sepowitz et al., 2012; Rice & Moller, 2006; Dorrepaal et al., 2010; Sperlich et al., 2011; and Patitz et al., 2014). Psychoeducation has been shown to be adaptable and competence-based form of therapy that provides understanding for the individual about their symptoms of PTSD (Phoenix, 2007).
Chapter III: Method

Participants

This study was designed for adult women over the age of 18, who experience subclinical symptoms of PTSD as a result of being a victim of interpersonal trauma. Subclinical symptoms of PTSD are shown in individuals who have experienced trauma and display PTSD symptoms, however these individuals have not been formally diagnosed with PTSD. Inclusion criteria to participate in the study was that participants must display subclinical PTSD symptoms and have a history of interpersonal trauma. The participants were required to be clinically stable and clinical stability was defined as being on the same dosage of medication for the past month and having no suicide attempts in the past six months. Individuals who did not meet this criterion were not included in the research study.

A case manager at the agency was made aware of the study via a meeting with the student researcher that was held prior to the study beginning. The case manager identified the need for psychoeducation in therapy and referred four of his clients who were specifically seeking him for supportive trauma therapy.

The current study had four adult women as participants; all of who had been victimized due to interpersonal trauma, and experienced subclinical symptoms of PTSD. These women were clients of the case management team at the community agency. Three of the four women completed the study. One of the women initially included in the study did not continue with the study. The individual participant characteristics and needs will be discussed below.

Participant 1. Participant 1 was a White Female in her early 50’s, diagnosed with BPD and reported subclinical symptoms of PTSD due to interpersonal trauma. During the initial interview with the participant, she disclosed that she had been sexually abuse by her babysitter when she was 6 years old and raped when she was in her 20’s while attending college. She said that she received treatment after the second incident but never recovered completely. She reported that she married a very “powerful” and “strong” man who she felt could protect her. He ended up sexually, physically, and emotionally abusing her for a 10-year period. She left him with their children just over a year ago and sought out protection and help from a women’s shelter. She is currently in the process of divorcing her husband.

This participant did not participate in the study any further then the initial interview as she did not want to follow the procedure for the study that was clearly explained to her. The student researcher decided that this participant needed unstructured supportive therapy rather than the intervention being provided as part of the present study. Although the participant did not participate in the study, she continued with her regular 1-hour weekly sessions of supportive therapy with her case manager.

Participant 2. Participant 2 was a White female in her early 50’s who reported symptoms of anxiety and Major Depressive Disorder. She also experienced subclinical symptoms of PTSD due to interpersonal trauma. During the initial interview with the participant, she disclosed that she experienced a great deal of interpersonal abuse in her childhood. She was sexually abused by her older brother and physically abused by her
parents. Due to her sexual abuser being her brother and her not disclosing until later in her adult life, she consistently saw her abuser. In addition, her parents continued to physically and emotionally abuse her as an adult. When the participant was asked about her strengths she identified that she was very successful in her past career in medicine. She was also proud of the fact that as single mother she raised her son on her own. When she was asked what her goals were for therapy, she identified symptom management and “healing” from her trauma as priorities. In addition, she wanted to establish a new support system and find “the courage” to meet new friends.

**Participant 3.** Participant 3 was a White female in her early 20’s, diagnosed with Obsessive Compulsive Disorder (OCD) and reported symptoms of anxiety and depression. During the initial interview with the participant she disclosed that she recently had found out that she was pregnant. She disclosed that her ex-partner also struggles with mental health issues and he was abusing her verbally and emotionally. She said that he became violent very quickly and has struggled with anger issues for a long time. She decided that ending the relationship was best for herself and the baby when she discovered she was pregnant. She also said that she was raped at the age of 16 and had never fully recovered. In addition, she grew up in a home where domestic abuse was present. Her father and mother were both alcoholics and abused her physically and emotionally as a child. When asked about her strengths she mentioned that she was a musician and enjoyed writing song lyrics and poems. When she was asked what her goals were for therapy, she said that she would like to manage her symptoms surrounding her trauma and that she wants to create a safe environment for herself as she is going to be a mother.

**Participant 4.** Participant 4 was a White female in her late 20’s, diagnosed with Schizoid Affective Disorder and reported symptoms of depression. She also displayed many traits of BPD and experienced sub-clinical symptoms of PTSD due to interpersonal trauma. During the initial interview with the participant, she disclosed that she had been raped on two occasions. She also describes that she continues to experience a lot of verbal and emotional abuse from her parents at home. When asked about her strengths she discussed how she is very artistic and sells her art pieces on social media. She also said that she volunteers at an agency that helps victims of sexual assault. When she was asked what her goals were for therapy, she noted her main goals as symptom management and finding healthier ways to cope. In addition, she would like to start pursuing a romantic relationship again.

**Setting/Materials**

The study was conducted at a community mental health agency that specialized in addictions and mental health counselling. The student researcher specifically worked with clients who were connected with the case management team. All therapy sessions were conducted individually with each participant in a private therapy room at the agency with the student researcher and case manager present. Materials were provided to the participant by the student researcher each week. Materials included a printed PowerPoint presentation with the full lesson and participants were allowed to keep the materials.
Design

A within subjects, pre-test and post-test design was used to investigate changes before and after the addition of the trauma psychoeducation component to the existing supportive trauma therapy. Both the student researcher and case manager implemented treatment. The student researcher provided trauma psychoeducation component and the case manager who specializes in trauma, provided the participant with supportive trauma therapy. Both the case manager and student researcher were present at all sessions with each of the three participants. The target behaviors of treatment included a reduction in PTSD symptoms (e.g., flashbacks, dissociation, triggering, avoidance, sleep disturbances, bursts of emotion) and an increase in coping skills (i.e., trauma knowledge, self-care practices, self-soothing practices). The same treatment was delivered to each of the participants independently.

Treatment was delivered over a period of six-weeks. Each participant met with the student researcher and case manager at the agency once a week for a 1-hour session for six weeks. The research study was evaluated and approved by the St. Lawrence College Research Ethics Board prior to treatment beginning.

Confidentiality/ Informed Consent

Participants were required to sign a consent form from St. Lawrence College (Appendix A) prior to participating in the study. Within a two-week time frame prior to the study start date, potential participants were approached by the student researcher at the end of their regular individual counselling sessions with their case manager and student researcher. The consent form was distributed to the potential participants and explained fully by the student researcher. The consent form was to be signed if the participant wished to take part in the study. The consent form notified them of their rights as participants and the potential risks and benefits of participating in the study. They were notified of their right to withdraw from the study at any point during treatment with no consequences from the agency. They were informed that consent forms and questionnaire would be kept in a locked filing cabinet in a private secured location at the agency that only the student researcher and case manager had access to. Participants were advised that they would not identified by name in any reports resulting from this study and a participant code was provided on questionnaires to ensure their confidentiality. All information on the computer in regards to the participants would be password protected and will be stored for 7 years following the study.

Procedure

After consent forms were signed, each participant was required to schedule an initial meeting with the student researcher. During the initial meeting, an unstructured interview was performed by the student researcher. The unstructured interview was to determine why the participant agreed to participate and included a brief overview of their past history with interpersonal trauma. Each participant was provided with the PTSD Checklist - Civilian Version for DSM- IV (Appendix B; Weathers et al., 1994) and the Brief COPE Scale (Appendix C; Carver, 1997) to complete. The PTSD Checklist – Civilian Version assessed their sub-clinical symptoms of PTSD and the Brief COPE assessed their current coping ability prior to treatment. The participants were given as
much time as needed to complete the questionnaires and were able to ask questions in regard to any questions they did not understand. All of the participants completed the two questionnaires in under 20 minutes.

Treatment consisted of weekly one-hour sessions for six weeks. Each participant followed the same trauma psychoeducation format developed by the student researcher. Each one-hour session was separated into two components: the participant first had 30 minutes of trauma psychoeducation with the student researcher, followed by 30 minutes of individual supportive trauma therapy with the case manager. Both the case manager and student researcher were present for both components of every session (i.e., for the entire 60 minutes). Different topics were chosen as psychoeducational targets for each of the six sessions. These psychoeducational targets were: the symptoms of trauma and creating safety, attachment styles, coping mechanisms, belief systems, self-soothing practices, and a review. Content for these lessons was taken from academic journals, online resources, and different manuals for trauma therapy treatment. As shown in Appendix G, participants were provided with a copy of the PowerPoint lesson at the beginning of each session. The method of delivery for each of the six sessions is described below.

**Session 1 – The Symptoms of Trauma and Creating Safety.** During the first session, the student researcher introduced the first psychoeducational topic: symptoms of trauma and creating safety, and provided them with a copy of the lesson PowerPoint. The student researcher discussed the different symptoms of PTSD and how it affects the person psychologically, physiologically, and emotionally. Discussion was encouraged throughout the session; the participant was asked what symptoms they can relate to currently and what they have experienced in the past. The topic of safety was discussed in detail. The student researcher went over a definition of safety and how it applies to trauma. Safety was defined as the experience of being protected from danger. The student researcher explained that this concept is difficult for individuals who have only known abuse, however they must strive to make their environment as safe as possible while working on their trauma (Davis, 1990). The student researcher asked the participant to look at different aspects of their lives where abuse is taking place and separate themselves from it. The student researcher told the participant that it will be difficult to move forward with treatment if they are still being abused (e.g., living in an unsafe environment where physical, sexual, and emotional abuse can still take place). The participant was asked to describe a situation where they felt safe and to describe what they would need in their environment to feel safe. At the end of the psychoeducation component the student researcher asked the participant to think about their symptoms and what symptoms they would like to manage over the next week. In addition, they were asked to evaluate their current living context/situation and to think of ways in which they can make themselves safer. The participant was then allowed to discuss anything that happened that week, or their thoughts and feelings in regards to the lesson.

**Session 2 – Attachment Styles.** The student researcher taught the participant that our attachment styles are established within our first two years of life (Bee, Boyd, and Johnson, 2002). The different attachment styles were discussed in detail and discussion followed. The participant was asked what attachment style they thought they had as a child. In addition, the lesson noted how our attachments as children form our personalities as adults. The different adult personality styles were defined. The
participant was asked to reflect on their adult personality and what category they think suits them best today. At the end of the psychoeducation component, the student researcher asked the participant to complete an online attachment styles questionnaire at home over the next week. The results would be discussed in session 3. The participant was then allowed to discuss anything about their week, or their thoughts and feelings in regards to the lesson.

**Session 3 – Coping Mechanisms.** First the student researcher asked the participant if she had completed the online attachment styles questionnaire. If it was completed results were discussed briefly then student researcher continued with lesson 3. If it was not completed the student researcher did not address the incompletion and moved forward with the current lesson. The student researcher described what coping mechanisms are and then provided the participant with a list of coping mechanisms. The participant was asked to check beside the coping mechanisms that they use frequently. Discussion followed about the different coping mechanisms the participant uses today verses the different coping mechanisms they used as a child. The student researcher went over three cognitive-behavioral exercises with the participant: forgiving yourself, sorting coping mechanisms, and identifying the need and a healthier way to cope (Davis, 1990). At the end of the psychoeducational component the participant was encouraged to think of the need behind an unhealthy coping mechanism and to brainstorm healthier ways to meet this need over the next week. The participant was then allowed to discuss anything about their week, or their thoughts and feelings in regards to the lesson.

**Session 4 – Belief Systems.** The student researcher described what belief systems are and provided the participant with examples of different belief systems. The student researcher explained to the participant how belief systems are formed and how society and the people who are close to us (e.g., like our family members; Curie & Arons, 2011). The participant was asked to identify a belief that they have struggled with over their life. Further discussion surrounding how belief systems affect self-esteem took place. At the end of the psychoeducational component, the participant was asked to think about how their belief systems and close relationships (from childhood to adulthood) have affected their sense of self over the next week. The participant then was allowed to discuss anything about their week, or their thoughts and feelings in regards to the lesson.

**Session 5 – Self-Soothing Practices.** The student researcher defined self-soothing and explained to the participant how self-soothing can be utilized in times of distress. Self-soothing was defined as being comforting, nurturing, and kind to yourself. The student researcher explained that self-soothing practices access the body’s five senses (e.g. vision, hearing, smell, taste, and touch) and imagination. The student researcher provided examples of self-soothing practices for each of the five senses and imagination to the participant (Linehan, 1993) The participant was then asked what they currently do it times of distress, and if they thought utilizing self-soothing practices could assist in calming them down in times of distress. The student researcher then provided information on the benefits of deep breathing to reduce symptoms of anxiety to the participant. The student researcher then led the participant in a simple deep breathing exercise. After the exercise the participant was asked what she thought of the exercise and if she would utilize it in times of distress. At the end of the psychoeducational component, the student researcher asked the participant to utilize a self-soothing
technique in a time of distress and to practice the deep breathing exercise over the next week. The participant was then allowed to discuss anything about their week, or their thoughts and feelings in regards to the lesson.

**Session 6 – Review.** The student researcher provided the participant with a brief review of all of the different psychoeducational lessons covered over the past five weeks. The student researcher then asked the case manager to leave while she administered the PTSD Checklist – Civilian Version for DSM-IV and the Brief COPE in the same format as the initial meeting for a second time. The participants were given as much time as needed to complete the questionnaires and were able to ask questions in regard to any questions they did not understand. All of the participants completed the two questionnaires in under 20 minutes.

The student researcher asked the case manager to come back into the therapy room and then engaged the participant in an informal exit interview. The participant was asked what they thought of the trauma psychoeducation component and what lessons had benefitted them the most. The student researcher thanked the participant for taking part in the study. The participant was then allowed to discuss anything about their week, or their thoughts and feelings in regards to the study being completed.

**Measures**

Two questionnaires were administered: the PSTD Checklist Civilian Version for DSM-IV (Weathers, Litz, Huska, and Keane, 1994; Appendix B) and the Brief COPE (Carver, 1997; Appendix C).

The PTSD Checklist- Civilian Version for DSM-IV is a 17-item scale based on the DSM-IV criteria for a PTSD diagnosis (Weathers et al., 1994). Participants are asked how much they have been bothered by a problem/symptom in the past month, and rate the problem on a likert-type scale of one (low) to five (high). The PTSD Checklist- Civilian Version is scored by adding up all of the 17-items for a total cut-off score. However, in addition to a total-cut off score, individual symptoms are considered to be present (i.e., in terms of providing a diagnostic screen) if they are rated at a score of 3 or higher. Participants who score one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17) have a possible diagnosis of PTSD. A total cut-off score of 50 and above assesses a probable diagnosis of PTSD (Weathers et al.).

Past research using this measurement has shown that a 5-10 point change is reliable (not due to other factors other than the treatment effect; (Weathers et al., 1994). A 10-20 point change is deemed “clinically meaningfully”; this means that the changes in scores reflect an improvement in overall functioning on the individual (Weathers et al.). When compared to a non-clinical sample, clinically meaningful scores are more close to a non-clinical sample (Weathers et al.). If participants demonstrate a 5-10 point difference, it is likely that a response to treatment occurred, however the change may not be big enough to notice a meaningful change in their daily lives (Weathers et al.). Participants who demonstrate a 10-20 point difference in scores are more likely to show changes that reflect in their overall functioning (Weathers et al.). These changes are big enough to notice a meaningful change in their daily lives; and this would be the ultimate goal of treatment.
The Brief COPE is a 28-item scale that assesses different aspects of the individuals coping ability (Carver, 1997). The 14 aspects of coping assessed within this scale are: self-distraction, active coping, state of denial, use of substances, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame (Carver). The Brief COPE has 28 specific questions related to these 14 different coping aspects; the participant is asked to rate if they have been engaging in each item on a scale of one (I have not been doing this) to four (I frequently do this; Carver).

There is no overall score for The Brief COPE and each of the 14 aspects of coping is assessed individually (Carver, 1997). Each aspect of coping has two items that correspond specifically to that aspect from the 28-items (Carver). The Brief COPE is used to assess both adaptive and maladaptive coping skills. Five of the different coping aspects relate to maladaptive coping (i.e., denial, substance use, and behavioral disengagement, venting, self-blame) and nine of the different coping aspects related to adaptive coping (i.e., self-distraction, active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion; Carver).

The scores of both pre- and post- questionnaires were analyzed further and presented in graphs to evaluate the effect of adding a trauma psychoeducational component to pre-existing supportive trauma therapy. The results are further discussed in the following section.
Chapter IV – Results

The main hypothesis was that through participating in six weeks of psychoeducation alongside supportive therapy, PTSD symptoms would be reduced and coping ability would be increased. The PTSD Checklist-Civilian Version for DSM-IV (PCL-C; Weathers, Litz, Huska, and Keane, 1994) and the Brief COPE (Carver, 1997) were provided to participants before treatment and after treatment to assess for any post-treatment changes in these domains.

The PTSD Checklist- Civilian Version for DSM-IV

Participant 1. Participant 1 only completed the PCL-C prior to the study beginning as she did not participate in the treatment. The student researcher decided that this participant needed unstructured supportive therapy rather than the invention included in this present study. She had the highest pre-treatment score of 74 and was 24 points above the measurement’s cutoff score of 50 (US Department of Veterans Affairs National Center for PTSD, 2014). She also identified scores of 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17); this identified that she may have had a possible diagnosis of PTSD.

Participant 2. Participant 2 had a pre-treatment score of 62 which was the lowest pre-treatment score on the PCL-C in comparison to the other participants. Her pre-treatment score was 12 points above the measurement’s cutoff score of 50. She also identified scores of 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). This identified that pre-treatment, she may have had a possible diagnosis of PTSD.

After treatment her score decreased from a 62 to a 54, an 8-point reduction on the measure based on her symptoms. This change from pre-treatment to post treatment is clinically reliable (i.e., a change in scores of between 5-10 points). This means that the change was not due to random factors however is still not big enough to display a meaningful difference (i.e., a change in scores of between 10-20 points). Post-treatment she was 4 points above the measurement’s cutoff score of 50 and still scored one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). Even though Participant 2 did show an 8-point reduction on the measure post-treatment, she still was above the severity score and met all of the items that identify a possible diagnosis of PTSD.

Participant 3. Participant 3 had a pre-treatment score of 71 on the PTSD Checklist Civilian Version for DSM-IV. Her pre-treatment score was 21 points above the measurement’s cutoff score of 50. She also identified scores of 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). This identified that pre-treatment, she may have had possible diagnosis of PTSD.

After treatment her score decreased from a 71 to a 46, a 25-point reduction, and fell 4 points below the measurements cutoff score of 50. This change from pre-treatment to post-treatment is considered to be clinically meaningful; Participant 3 demonstrated the greatest reduction in symptoms in comparison to the other participants. Even though Participant 3’s post-treatment was 4 points below the measurement’s severity score, she still scored 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). Participant 3 still reported the presence of the same symptoms at
post-treatment as she did pre-treatment, however she reported these symptoms as much less impairing at post-treatment. Her post-treatment results demonstrate that she may no longer meet the diagnostic criteria for PTSD as defined by the PCL-C.

**Participant 4.** Participant 4 had a pre-treatment score of 67 on the PTSD Checklist Civilian Version for DSM-IV. Her pre-treatment score was 17 points above the measurement’s cutoff score of 50. She also identified scores of 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). This means that pre-treatment, she may have had possible diagnosis of PTSD.

After treatment her score decreased from a 67 to a 56, an 11-point reduction. This change from pre-treatment to post-treatment is considered to be clinically meaningful. Post-treatment she was 6 points above the measurement’s cutoff score of 50, and she still scored 3 and above on one B item (items 1-5), three C items (items 6-12), and two D items (items 13-17). Participant 4 still reported the presence of the same symptoms post-treatment as she did pre-treatment, however she reported these symptoms as much less impairing post-treatment. Her post-treatment results demonstrate that she may no longer meet the diagnostic criteria for PTSD as defined by the PLC-C.

As shown in Appendix D and below, all of the participants that completed the study showed a reduction in symptoms based upon their post-treatment scores on the PTSD Checklist Civilian Version for DSM-IV.

**Table 1: Table of Pre-Post Scores on the PTSD Checklist Civilian Version for DSM-IV**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre-Score</th>
<th>Post-Score</th>
<th>Difference Score</th>
<th>Cutoff Score (50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>62</td>
<td>54</td>
<td>8*</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>71</td>
<td>46</td>
<td>17**</td>
<td>-4</td>
</tr>
<tr>
<td>4</td>
<td>67</td>
<td>56</td>
<td>11**</td>
<td>6</td>
</tr>
</tbody>
</table>

*Identifies a clinically reliable difference
** Identifies both a clinically reliable and clinically meaningful difference

**The Brief COPE**

There is no overall score for The Brief COPE and each of the 14 aspects of coping is assessed individually. Each aspect of coping has two items that correspond specifically to that aspect from the 28 items. As shown in Appendix E, the two items for each of the 14 aspects were averaged to provide one score for each of the 14 aspects of coping for each participant.

**Participant 1.** As noted above, Participant 1 did not engage in treatment and only completed the Brief COPE prior to treatment beginning. As shown in Appendix E, Participant 1 had an average pre-score of 4.4 on the maladaptive forms of coping and an average pre-score of 7.2 on the adaptive coping items. Participant 1’s scores on the maladaptive coping items (i.e., denial, substance use, and behavioral disengagement, venting, self-blame) were quite low overall; her highest scoring items were self-blame at
3.5 and denial at 2.5. Her scores on the adaptive coping items (i.e., self-distraction, active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion) were very high. She scored “4” for self-distraction, active coping, use of emotional support, use of instrumental support, planning, and religion. As shown in Figure 1, this identified that Participant 1 used self-blame and denial to cope; however she also frequently used many of the adaptive coping strategies.

**Average Score For Each Form of Coping on the Brief COPE:**

**Participant 1** - Pre-Treatment Score Only

![Graph showing average pre-treatment scores for each form of coping on the Brief COPE.]

Different Aspects of Coping Assessed

*Figure 1: Participant 1’s average pre-treatment score for each form of coping on the Brief COPE.*

**Participant 2.** As shown in Appendix E, Participant 2’s adaptive coping score changed from 6.4 pre-treatment to 5.7 post-treatment. Her average maladaptive coping score changed from 5.2 pre-treatment to 4.6 post-treatment Participant 2’s pre-post treatment scores on the maladaptive coping items (i.e., denial, substance use, and behavioral disengagement, venting, self-blame) decreased since pre-treatment on three items: denial was decreased from 2.5 pre-treatment to 1 post-treatment; behavioral disengagement was decreased from 3 pre-treatment to 2 post-treatment; and self-blame had a slight decrease from 4 pre-treatment to 3.5 post-treatment. Venting was increased from 2.5 pre-treatment to 4 post-treatment. Substance use remained the same pre-treatment to post-treatment at a score of 1.

Participant 2’s pre-post treatment scores on the adaptive coping items (i.e., self-distraction, active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion) decreased on four items, increased on one item, and four items remained the same. Four items decreased: positive reframing decreased from 3 pre-treatment to 2 post-treatment, planning decreased from 3.5 pre-treatment to 2.5 post treatment, humor decreased from 3 pre-treatment to 1 post-treatment, and religion slightly decreased from 3 pre-treatment to 2.5 post-treatment. Emotional support increased from a 2.5 pre-treatment to a 4 post-treatment. Four items
remained the same from pre-treatment to post-treatment: self-distraction, active coping, instrumental support, and acceptance. As shown in Figure 2, this identified that Participant 2’s greatest increase pre-treatment to post-treatment was in emotional support. In addition, treatment may have had a negative effect or no effect at all on her adaptive coping as four items decreased and four items did not change pre-treatment to post-treatment.

Figure 2: Participant 2’s greatest increase pre-treatment to post-treatment was in emotional support.

Participant 3. As shown in Appendix E, Participant 3’s adaptive coping score changed from 5.3 pre-treatment to 5.2 post-treatment. Her average maladaptive coping score changed from 4.8 pre-treatment to 4 post-treatment, and her adaptive coping score changed from 5.3 pre-treatment to 5.2 post-treatment. Participant 3’s pre-post treatment scores on the maladaptive coping items (i.e., denial, substance use, and behavioral disengagement, venting, self-blame) identified a reduction; four of the five items were decreased. Denial was slightly decreased from 2.5 pre-treatment to 2 post-treatment, substance use was decreased from 2 pre-treatment to 1 post-treatment, behavioral disengagement was decreased from 3 pre-treatment to 2 post-treatment, and self-blame was slightly decreased from 3.5 pre-treatment to 3 post-treatment. Venting increased from 1 pre-treatment to 2 post-treatment.

Participant 3’s pre-post treatment scores on the adaptive items (i.e., self-distraction, active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion) decreased on three items, increased on three items, and three items remained the same. Three items decreased: self-distraction decreased from 4 pre-treatment to 3 post-treatment, planning slightly decreased from a 3 pre-treatment to 2.5 post-treatment, and humor slightly decreased from 3 pre-treatment to 2.5 post treatment. Three items increased: emotional support was
slightly increased from 2.5 pre-treatment to 3 post-treatment, instrumental support increased from 2 pre-treatment to 3 post-treatment, and positive reframing slightly increased from 2.5 pre-treatment to 3 post-treatment. Three items remained the same from pre-post treatment: active coping, acceptance, and religion. As shown in Figure 3, it is possible that the decrease of items in the maladaptive coping category could be due to treatment. In addition, treatment may have had small effect on the adaptive coping items as three decreased, three increased, and three remained the same from pre-post treatment.

Average Score for Each Form of Coping on the Brief COPE: Participant 3

![Average Score for Each Form of Coping on the Brief COPE: Participant 3](image)

Figure 3: Participant 3’s average pre-post treatment score for each form of coping on the Brief COPE.

**Participant 4.** As shown in Appendix E, Participant 4’s average maladaptive coping score changed from 4.8 pre-treatment to 4.4 post-treatment, and her adaptive coping score changed from 4.8 pre-treatment to 5.5 post-treatment. Participant 4’s pre-post treatment scores on the maladaptive items (i.e., denial, substance use, and behavioral disengagement, venting, self-blame) identified an increased on two items: denial increased slightly from 1.5 pre-treatment to 2 post-treatment, and self-blame increased from 1.5 pre-treatment to 2.5 post-treatment. Two items were decreased: substance use was slightly decreased from a 3.5 pre-treatment to 3 post-treatment. Venting remained the same from pre to post treatment.

Participant 4’s pre-post treatment scores on the adaptive items (i.e., self-distraction, active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion) identified an increase on 7 of the 9 items: self-distraction slightly increased from 2.5 pre-treatment to 3 post-treatment, active coping slightly increased from 2.5 pre-treatment to 3 post-treatment, emotional support increased from 2 pre-treatment to 3 post-treatment, instrumental support slightly increased from 2.5 pre-treatment to 3 post-treatment, positive reframing increased from 2
pre-treatment to 4 post-treatment, planning increased from 2.5 pre-treatment to 3.5 post-treatment, and religion increased from 1.5 pre-treatment to 2 post treatment. Her score on humor slightly decreased from a 3 pre-treatment to a 2.5 post treatment, and her acceptance score of 2.5 did not change pre-treatment to post-treatment. As shown in figure 4, it is possible that her increase in 7 of the 9 adaptive coping items could be a result of the treatment. Participant 4’s positive reframing score showed the largest increase from a 2 pre-treatment to a 4 post-treatment.

**Average Score for Each Form of Coping on the Brief COPE:**

![Average Score for Each Form of Coping on the Brief COPE: Participant 4](image)

**Figure 4: Participant 4’s average pre-post treatment score for each form of coping on the Brief COPE.**

**Summary**

All of the three participants’ symptoms were shown to decreased based upon the change in their pre-post treatment scores on the PCL-C. As shown in Appendix F, each of the participants’ coping ability changed from pre-treatment to post-treatment on the Brief COPE, however the change was not always positive. Participant 2 showed a decrease on four adaptive items and Participant 3 showed a decrease on three adaptive items. Participant 4 showed the greatest increase in adaptive coping as an increase was shown in 7 of 9 adaptive coping items. The results of this study will be further discussed in detail in the following section.
Chapter V – Discussion

Summary of Research

The main hypothesis of this research study was that participating in six weeks of PTSD-focused psychoeducation in addition to supportive therapy would reduce PTSD symptoms and increase coping ability. As identified in the results, participants that completed treatment reported a decrease in their pre-post treatment scores on the PCL-C and therefore these findings support the research study’s hypothesis. The results identified from the Brief COPE were variable as each of the participants’ coping ability changed from pre-treatment to post-treatment on the Brief COPE, however the change was not always positive. Participants 2 and 3 demonstrated a decrease in adaptive coping skills from pre-post treatment. This deviates from the research study’s hypothesis that coping skills would be increased post treatment. Participant 4 did show increase on 7 of 9 adaptive coping items assessed, however this change could be due to outside variables rather than treatment. A pre-and post-test design was used to measure reported symptoms of PTSD and coping ability before and after providing six week of 1-hour session of psychoeducation alongside supportive therapy. The results from the PCL-C demonstrate a clear relationship between treatment and reports of experiencing PTSD symptoms at less impairing level.

Strengths and Limitations

Some strengths have been identified through completion of this research study. First, of the participants reported during our final session that they did find the psychoeducation component (six lessons) interesting, relevant, and helpful. The participants noted that the lessons were thought provoking in reference to their past experience with trauma, and promoted the use of new coping skills. Participant 2 noted that having the supportive therapy component after the psychoeducation component provided some safety as triggering thoughts did occur sometimes due to the lesson. She noted that it was helpful that the triggering thoughts could be explored further with the student researcher and case manager immediately following the lesson. Overall, all participants reported that treatment was beneficial and specific to their mental health needs. Each participant was provided copies of all of the six lessons so that they could reference them after treatment was completed. This was also to help them generalize the skills taught and practiced in session to the home environment, and help to maintain the gains made during the six weeks of sessions.

There were some limitations to this study. The sample was very small; it is unclear if the same results would be obtained with a larger sample. All of the participants were white and lived in the same community and so it is unclear if the same results would be obtained with a more diverse sample from many different communities. All of the participants had resources in the community in addition to the community mental health agency. It is unknown what effect these outside resources may have had on the participants reported symptoms of PTSD and coping ability over the six-week treatment period and therefore any increases in coping abilities or reductions in PTSD symptoms may have been due to other factors/variables. Both of the measures used were self-report measures, therefore the results cannot be confirmed as reliably strong as other types of measures were not used to confirm the results. Due to time constraints of the research
study, follow-up was not conducted with the participants. Therefore, it is unknown if PTSD symptoms were maintained at a less impairing level after treatment was completed.

**Comparison of Results to Existing Literature**

As mentioned in the literature review, the results of this research study are somewhat similar to those discussed. As found by Kubany et al. (2003), Roe-Sepowitz et al. (2012), and Dorrepaal et al. (2010), psychoeducation provided in addition to supportive therapy decreased sub-clinical and clinical symptoms of PTSD due to interpersonal trauma. The results were not consistent with the study conducted by Sperlich et al. (2011), which demonstrated that the addition of psychoeducation with supportive therapy increased coping ability. Two participants’ coping ability actually decreased post-treatment and there are no relevant studies which show the same kinds of effects.

The reason for this discrepancy is not completely clear. Several reasons are: the participants did not like the homework and overall motivation to practice the homework exercises at home was low as many participants mentioned that they became triggered. Homework was an important component in some of the studies noted in the literature review (Kubany et al., 2003; Dorrepaal et al., 2010; Sperlich et al., 2011). Incorporating more time to practice these exercises in session may have increased coping ability as they would be able to practice in an environment where they feel safe and supported. In comparison to Sperlich et al. (2011), individual therapy was utilized instead of a group therapy format and so it is possible that using a group format may affect the motivation of group members as homework is discussed publically.

Overall, a comparison of the existing literature and the results of the present study show that there is an identifiable relationship between psychoeducation treatment and reported decreases in the severity of PTSD symptoms. It is still unclear if psychoeducation and supportive therapy increases coping ability in women who have PTSD due to experiencing interpersonal trauma.

**Contribution to the Field of Behavioral Psychology**

This study furthered research on adding psychoeducational components to pre-existing supportive therapies for women who have experienced interpersonal trauma. This study demonstrated a relationship between psychoeducation and the reduction of symptoms displayed by individuals with possible diagnoses of PTSD. In addition, the use of psychoeducation was shown to be successful in reducing the severity of PTSD symptoms in individuals with secondary diagnoses (e.g. BPD, MDD, OCD, and SAD), and who report a high level of anxiety and depression. The six topics discussed could also be easily applied to many different settings with more diverse populations of individuals who have experienced interpersonal trauma.

**Multilevel Challenges to Treatment Implementation**

There are many challenges present when providing supportive therapy to clients in a community mental health setting. These problems occur more in settings where clients have experienced severe abuse and as a result have trauma. These challenges
occur at a variety of different levels including: client level, program level, organizational level, and societal level.

**Client Level.** It can be challenging to work with clients who have trauma, specifically from severe sexual abuse because they experience sub-clinical/clinical symptoms of PTSD. In relation to the current study, the clients’ motivation and views towards therapy changed over the course of treatment. As they worked on their trauma, the sharing of past memories did evoke unpleasant feelings and emotions for a period of time. All of the clients also had other diagnoses that the student researcher had to work with in addition to the trauma. This meant that the student researcher had to adapt their counselling style to meet each of the clients’ individual needs.

**Program Level.** These clients understand that throughout therapy they will be discussing their abuse and that past memories will arise throughout therapy. However, the client’s expectation of how they will manage their symptoms and how quickly the therapeutic process takes may be unrealistic. This can harm the therapeutic relationship if the client is not fully aware of how difficult trauma work is and that there is no time frame to determine how long it will take to recover. They may become frustrated with the process and stop participating in the treatment program if the counsellor does not discuss these expectations at the beginning of treatment.

**Organizational Level.** Professionals who are providing trauma therapy consistently hear abuse stories on a daily basis. It is important for these professionals to feel supported by their agency by providing consistent opportunities for them to discuss their work and emotional reactions to their work in a safe place. Burn-out is common for professionals working with these clients, it is important that staff members also communicate how they are feeling towards the therapeutic process and clients.

**Societal Level.** Many clients feel like they cannot come forward and receive treatment for trauma for fear of being judged. Many women in society do not report sexual abuse because there is a stigma that society places on these individuals. Society places the blame of the abuse on the victim instead of the abuser. Many individuals feel guilty for seeking treatment due to stigma surrounding mental illness and abuse against women. Many clients believe these things that society states and are very pessimistic towards the effectiveness of therapy.

**Future Directions**

It is highly recommended that more studies be conducted using psychoeducation and supportive therapy to assess their combined effects on decreasing PTSD symptoms and increasing coping ability in women who have experienced interpersonal trauma. Due to the variable results found in this research surrounding psychoeducation, supportive therapy, and coping ability, it would be beneficial for future studies to target specific coping items instead of coping overall.

If this study were to be replicated, the addition of a follow-up component would help assess of the true success of this study. Information regarding the reported PTSD symptoms would be important to know how long the effects of treatment were maintained. In addition, it may be beneficial for future studies to add a control group to
compare and evaluate the overall effect of treatment in reducing PTSD symptoms and increasing coping skills.

It is also suggested that replications of this study should be done with a larger and more diverse sample of women affected by interpersonal trauma and display symptoms of PTSD. This may reveal stronger effects of psychoeducation with supportive therapy to decrease PTSD symptoms and increase coping ability. The initial results of this study have demonstrated a positive relationship between providing psychoeducation with supportive therapy as participants reported less impairing PTSD symptoms post-treatment. This study also identified that the relationship between providing psychoeducation with supportive therapy and reported increases in coping ability was not demonstrated. Implementing the above suggestions to future studies may increase knowledge about providing psychoeducation and supportive therapy to decrease severity of PTSD symptoms, and increase coping ability in this population.
REFERENCES


Carver, C.S. (1997). You want to measure coping but your protocol’s too long: Consider the Brief COPE. *International Journal of Behavioral Medicine, 4*, 92-100


Intervention, 4, 205-225. doi:10.1093/brief-treatment/mhh019


Appendix A: Consent Form

INVITATION:

You are being invited to take part in a research study. I am a student in my 4th year of the Behavioral Psychology program at St. Lawrence College. I am currently on placement at Frontenac Community Mental Health and Addiction Services (FCMHAS). As part of placement, I am completing a research study called an applied thesis. I would like to ask for your help to complete this project. The information in this form will help you understand my project. Please read the information carefully and ask all of the questions you might have before you decide if you want to take part.

WHY IS THIS STUDY BEING DONE?

Many people who have experienced trauma are not aware of why they feel the way they do. Trauma affects the whole individual mentally, physically, and emotionally. The purpose of this study is to provide some education for individuals who have experienced trauma. I believe that this education is useful for women who have experience trauma and want to understand more about trauma to help them move forward. I want to see if this education will help decrease your difficulties related to trauma and increase coping skills (positive ways to deal with these difficulties).

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

If you agree to take part in this study you will be asked to allow me the opportunity to get to know you better. I will need to know basic information surrounding your trauma (e.g., age when it started and what kind of abuse: physical, sexual, emotional, and mental). At the end of this initial interview you will be asked to fill out a two different measures: the PTSD Checklist - Civilian Version for DSM- IV and the Brief COPE Scale. This will take about 20 minutes to complete.

After this initial interview we would meet on a weekly basis with your current Case Manager for your supportive therapy. You will still be receiving supportive therapy with your Case Manager, but instead of 60 minutes you would be receiving 30 minutes of education about trauma with me followed by 30 minutes of supportive therapy with your case manager. Your Case Manager and myself will be present in all of your sessions throughout the study. During the session we will be able to discuss current and past problems that you are working through. The education component will have a different focus each week with lessons to help you further understand your trauma and provide beneficial coping skills. The six lessons on trauma psycho-education will be: the symptoms of trauma, attachment styles, belief systems, coping when triggered, acceptance of the past, and goals for the future. I will be providing all the material for the lessons and you will receive a printed copy of the lesson each week. The lessons will be held at the FCMHAS building. On the sixth week you will be asked to fill out the PTSD Checklist - Civilian Version for DSM- IV and the Brief COPE Scale a second time.
WHAT ARE THE POTENTIAL BENEFITS?

Benefits of taking part in this research study include:

- A better understanding of trauma and how past trauma can affect you physically, emotionally, and mentally
- A better understanding of belief systems and how the way you think about yourself and your life is influenced by the past
- A better understanding of attachment styles and how your attachment style in the past affects how you relate to others now
- Coping skills to help you work through the symptoms you experience
- A chance to accept the past and set goals for the future

WHAT ARE THE POTENTIAL RISKS?

Risks of taking part in this research study include:

- Discussing your past trauma could make you experience emotions such as; sadness, anger, fear, and shame
- Your current symptom could initially become worse as you remember past events and discuss your experience with trauma

WHAT HAPPENS IF SOMETHING GOES WRONG?

Everybody is different and if you do have any strong reactions to the education, please talk to me and your Case Manager. If you are having difficulties after session, please leave a message with the Case Manager. You can reach Hopper Hopkins at 613-544-1356 ext: 2245, you may also leave messages for me at that extension. You are encouraged to be open and honest with me throughout this study. If you are having difficulty with the lessons please let us know. Please be reminded of the resources available via the Crisis Line. You can reach FCMHAS’ 24 hour crisis line at 613-544-4229.

WILL ALL OF THE INFORMATION YOU COLLECT FROM ME IN THIS STUDY BE KEPT PRIVATE?

I will make every attempt to keep any information that identifies you strictly confidential unless required by law. You will be assigned a number to put on the PTSD Checklist - Civilian Version for DSM- IV and the Brief COPE Scale instead of a name; this number will not be linked to these consent forms. The completed questionnaires will be kept in a locked filing cabinet at the agency until the report is written. Your coded questionnaires will be stored at St. Lawrence College for a period of 7 years as required by their policies. The consent forms will be kept in a locked filing cabinet at St. Lawrence College for at least 10 years as required by law. Any information on the computer will be password protected. You will not be identified by name in any reports, publications, or presentations resulting from this project.
DO I HAVE TO TAKE PART?

Taking part is voluntary. It is up to you to decide whether or not to take part in this research study. If you do decide to take part, you will be asked to sign this consent form. If you do decided to take part in this study, you are still free to withdraw at any time. If you decide to withdraw from the study you can still continue therapy with your case manager. You may also ask for your data to not be used in the study at all. You are freely allowed to withdraw from the study without giving any reason, and without incurring any penalty, or negative effects.

CONTACT FOR FURTHER INFORMATION

This project has been approved by the Research Ethics Board at St. Lawrence College. The study will be developed under the supervision of Hopper Hopkins, my agency supervisor and Jordan Maile, my college supervisor from St. Lawrence College. I really appreciate your cooperation, and if you have any additional questions or concerns feel free to email me at amaddocks29@student.sl.on.ca. You may also contact the Research Ethics Board at reb@sl.on.ca.
CONSENT

If you agree to take part in this research study, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location at St. Lawrence College.

By signing this form, I agree that:

✓ The study has been explained to me
✓ All my questions were answered
✓ Possible harm and discomforts and possible benefits of this study have been explained to me
✓ I understand that I have the right to not participate and the right to stop participation at any time
✓ I am free now, and in the future, to ask questions I have about the study
✓ I have been told that my personal information will be kept confidential
✓ I understand that no information that would identify me will be released or printed without asking me first
✓ I understand that I will receive a signed copy of this consent form
✓ I hereby consent to take part

Participants Name
(mm/dd/yyyy)  Signature  Date

Students Name
(mm/dd/yyyy)  Signature  Date
Appendix B: PTSD Checklist - Civilian Version for DSM-IV

Participant Number: ____________

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully. Circle the response that indicates how much you have been bothered by that problem in the past month.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?

2. Repeated, disturbing dreams of a stressful experience?

3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

4. Feeling very upset when something reminded you of a stressful experience?

5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?

6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
7. Avoiding activities or situations because they reminded you of a stressful experience?

8. Trouble remembering important parts of a stressful experience?

9. Loss of interest in activities that you used to enjoy?

10. Feeling distant or cut off from other people?

11. Feeling emotionally numb or being unable to have loving feelings for those close to you?

12. Feeling as if your future will somehow be cut short?

13. Trouble falling or staying asleep?

14. Feeling irritable or having angry outbursts?

15. Having difficulty concentrating?
16. Being “super-alert” or watchful or on guard?

17. Feeling jumpy or easily startled?

*Note: Created by Weathers, Litz, Huska, and Keane (1994); National Center for PTSD – Behavioral Science Division. This is a government document in the public domain. Modified with permission from authors.
Appendix C: The Brief COPE

INSTRUCTIONS: These items deal with ways you've been coping with the stress in your life. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

1. I've been turning to work or other activities to take my mind off things.

2. I've been concentrating my efforts on doing something about the situation I'm in.

3. I've been saying to myself "this isn't real."

4. I've been using alcohol or other drugs to make myself feel better.

5. I've been getting emotional support from others.

6. I've been giving up trying to deal with it
7. I've been taking action to try to make the situation better.

8. I've been refusing to believe that it has happened.

9. I've been saying things to let my unpleasant feelings escape.

10. I've been getting help and advice from other people.

11. I've been using alcohol or other drugs to help me get through it.

12. I've been trying to see it in a different light, to make it seem more positive.

13. I've been criticizing myself.

14. I've been trying to come up with a strategy about what to do.

15. I've been getting comfort and understanding from someone.

16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.

18. I've been making jokes about it.

19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

20. I've been accepting the reality of the fact that it has happened.

21. I've been expressing my negative feelings.

22. I've been trying to find comfort in my religion or spiritual beliefs.

23. I've been trying to get advice or help from other people about what to do.

24. I've been learning to live with it.

25. I've been thinking hard about what steps to take.

26. I've been blaming myself for things that happened.
27. I've been praying or meditating.

28. I've been making fun of the situation.
Appendix D: PTSD Checklist – Civilian Version for DSM-IV: Pre-Post Graph

PTSD Checklist - Civilian Version for DSM-IV
Pre-Post Scores

Participants

0 10 20 30 40 50 60 70 80

Score

Pre-Scores
Post-Scores
Appendix E: The Brief COPE: Data Charts

The Brief COPE - Pre-Scores:

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Appendix F: The Brief COPE: Graph

Average Pre-Post Maladaptive/Adaptive Score for Each Participant on the Brief COPE

Each Participants Pre-Post Maladaptive/Score on the Brief COPE

- Participant 1
- Participant 2
- Participant 3
- Participant 4
Appendix G: PowerPoint Lessons

Lesson 1: The Symptoms of Trauma and Creating Safety

WHAT IS TRAUMA?

By: Abigail Maddocks
BAA Behavioral Psychology

DEFINITION OF TRAUMA

**Traumatic Event:** An event that involves actual or threatened death, serious injury, or threat to the physical integrity of self or others.

**Complex trauma:** Is the clinical term for repeated exposure to a traumatic event.

This includes all:
- psychological maltreatment
- neglect
- physical abuse
- sexual abuse
- domestic violence
- verbal abuse
DEFINITION OF TRAUMA

Interpersonal Trauma: Any form of emotional abuse, emotional neglect, physical abuse, physical neglect, and/or sexual abuse in childhood and/or adulthood

COMMON SYMPTOMS OF TRAUMA

• Re-experiencing the traumatic event
• Avoiding reminders of the trauma
• Increased anxiety and emotional arousal
• Intrusive, upsetting memories of the event
• Flashbacks (acting or feeling like the event is happening again)
• Nightmares (either of the event or of other frightening things)
• Feelings of intense distress when reminded of the trauma
• Intense physical reactions to reminders of the event (e.g. pounding heart, rapid breathing, nausea, muscle tension, sweating)
COMMON SYMPTOMS OF TRAUMA

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance (on constant “red alert”)
- Feeling jumpy and easily startled

COMMON SYMPTOMS OF TRAUMA

- Avoiding activities, places, thoughts, or feelings that remind you of the trauma
- Inability to remember important aspects of the trauma
- Loss of interest in activities and life in general
- Feeling detached from others and emotionally numb
- Sense of a limited future (you don’t expect to live a normal life span, get married, have a career)
DISCUSSION

• What is your experience with these symptoms?

• How do you currently cope?

• Do you feel like this coping strategy helps soothe the symptoms?

CREATING SAFETY

• Safety is the experience of being protected from danger

• Within a safe environment, we can relax and be ourselves because we know our well-being is secure

• When you begin to talk honestly about your life in a safe environment, healing naturally begins.

• Thinking about safety when you have only known danger, hurt, and betrayal can be terrifying
CREATING SAFETY

- Before you start on your journey of healing, safety must be established.
- Identify different aspects of your life where abuse is taking place, and separate yourself from it.
  - For example: unsafe living environment, still being in a relationship with the person who abuses you, being around people who emotionally or physically abuse you.
- Create boundaries for yourself to protect yourself from abuse.
- Creating a safe place in your home is important.
- Your safe place is an area for you, no one else can enter this area without your permission.

DISCUSSION

- Described one time you felt safe.
- What about that experience made you feel safe?
- For me to feel safe, I would need …
- If you were to imagine your ideal “safe place” what would it look like?
- What does safety mean to you?
OVER THE NEXT WEEK....

1. I would like you to think about your symptoms and what symptoms you would like to manage.
2. I would also like you to think about how you typically cope in these distressed times.
3. I would like you to think about safety and how you can make your current living situation MORE safe.

This could include:
- Removing things from your home that are negative reminders of the past.
- Separating yourself as much as possible from people who consistently abuse you.
- Creating a safe place.

HOW DO YOU FEEL?

For the next 30 minutes we will be having supportive therapy time. You can discuss anything in regards to the lesson OR what has been happening in your life this week.

This time is for you.
REFERENCES


What is an Attachment Style?

- Attachment refers to how you respond and relate to other people
- Attachment styles are formed in the first two years of life
- The attachment style that is formed during childhood effects how you relate to others in intimate relationships as an adult
Childhood Attachments

1. **Secure Attachment**
   - Child is confident that their caregiver will take care of their needs and protect them
   - Child trusts the caregiver
   - Child feels safe
   - Caregivers of children with secure attachments responded appropriately and consistently to their children’s needs.

Childhood Attachments

2. **Avoidant Attachment**
   - Caregivers discourage crying and encourage independence
   - Caregivers are unaware of the child’s needs and have little or no response when the child is distressed
   - These children stop relying on their caregivers to meet their needs and are self-contained
Childhood Attachments

3. Ambivalent/ Anxious Attachment
   • Caregivers are inconsistent
   • Sometimes they are nurturing whereas other times they are intrusive and insensitive to the child’s needs
   • Child is left confused and insecure not knowing how their caregiver will respond to their needs
   • The child does not trust their parent

Childhood Attachments

4. Disorganized Attachment
   • Caregiver is abusive
   • The child's instincts are telling them to flee to safety
   • The child is confused because the person who is suppose to be “safe” is hurting them
   • Children typically dissociate from themselves and detach from what is happening to them
   • Block what is happening to them from their consciousness
Discussion

1. When thinking about your childhood, which one of these attachment styles do you identify with?
2. What characteristics in your childhood make you identify with that attachment style?

Adult Personality Styles

- Our attachment style as a child “sets the stage” to what type of personality style we will have as adults
- As a result how we responded to our caregivers as children will predict how we will respond as adults in intimate relationships
Adult Personality Styles

1. Secure Personality
   - Those who are have a secure attachment to their caregivers will have a secure personality as an adult
   - Strong sense of self
   - Desire to connect with others
   - Self-confident
   - Secure by themselves and in a partnership with another person
   - Able to trust and be confident in their relationship

2. Dismissive Personality
   - Avoidant as a child = dismissive as an adult
   - Do not want close relationships
   - Think of themselves and their emotions as unimportant
   - Suppress feelings
   - Avoid conflict
   - Distance themselves from others
Adult Personality Style

3. Pre-Ocuppied Personality
   - Ambivalent/ anxious as a child = Pre-occupied as an adult
   - Self Critical
   - Insecure
   - Seek approval from everyone else
   - Not trusting in their relationships
   - Fear of rejection
   - Clingy and overly dependent on their partners

Adult Personality Styles

4. Fearful- Avoidant Personality
   - Disorganized as a child = Fearful- Avoidant as an adult
   - Detached from themselves because of trauma
   - Desire relationships however emotional closeness evokes feeling from repressed childhood trauma
   - The person re-lives their past trauma
Discussion

1. When thinking of your personality as an adult, which of these personality styles do you identify most with?

2. Do you notice how your attachment to your caregiver affects how you respond to intimate relationships as an adult?

Over the next week.....

◦ If you would like to find out what type of attachment style you have you can take a questionnaire through this website: http://www.web-research-design.net/cgi-bin/crq/crq.pl
◦ It would be interesting to hear what attachment style you have
How do you feel?

For the next 30 minutes we will be having supportive therapy time. You can discuss anything in regards to the lesson OR what has been happening in your life this week.
This time is for you.

Reference

Lesson 3: Coping Mechanisms

Coping Mechanisms
Abigail Maddocks
BAA Behavioral Psychology

What are Coping Mechanisms?

- Can also be described as “survival skills”
- Strategies that help us deal with stressful situations, pain, and natural changes we experience in our day to day life
- Learned patterns of behavior to help us cope
- Everyone uses coping mechanisms
- A problem does exist with coping mechanisms → not all are good
- Many coping mechanisms are self-destructive, and become consistent patterns that we resort to whenever we are triggered and feel discomfort
### Identifying Coping Mechanisms

*Check off the different coping mechanisms that apply to you*

- **Denial**
- **Rationalizing**
- **Creating Chaos**
- **Repeating Abuse**
- **Fantasizing**
- **Perfectionism**
- **Self-harm**
- **Compulsive eating**
- **Compulsive exercising**
- **Shoplifting**
- **Abusing others**
- **Avoiding intimacy**

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### Discussion

- When I look at the different coping mechanisms, I identify most with ....
- Do you notice coping mechanisms you may have used as a child, however no longer use as an adult?
- How have your coping mechanisms changed over the years? Have you established any new coping mechanisms in the past 5 years?
Forgiving Yourself

- Many survivors of trauma feel like they have lost many years of their life
- They feel stuck in their destructive forms of coping
- Fear, shame, and low self-esteem can block you from moving forward
- You were traumatized, isolated, and frightened, but you SURVIVED!
- You now have the ability to reexamine your life and stop being ashamed due to these destructive forms of coping
- You do not have control over your past, however you are able to work on your changing your behavior and start working towards healing
- You must forgive yourself for the things you’ve done in order to cope

Example of Forgiving Yourself

**Identify the destructive coping mechanism:**
Promiscuity

**I can forgive myself for doing this because:**
- My abuser made me feel like my only value was sexual
- No one ever told me I could say “no”
- Being sexual was the only way I knew to feel cared about. I needed to feel cared about in order to survive
Your Turn to Practice

Identify the destructive coping mechanism:

I can forgive myself for doing this because:

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Pros and Cons of Coping Mechanisms

- Many people who are in the journey of healing categorize their coping mechanisms are either completely good or bad

- Some coping mechanisms are neither completely good or bad

For example: denial

- To develop healthier ways of coping, you will have to sort through the coping skills you use on a daily basis to work through which ones help and which ones don’t

- Once this has been established you can target certain behaviors for change
Example of Sorting Current Coping Mechanisms

Coping Mechanism: Staying busy

Ways this coping mechanism can still be useful to me: I can keep my mind off things that cause me to think about my past. This stops me from getting stuck in my mind and being triggered.

Ways this coping mechanism is damaging to me: Sometimes I avoid my feelings towards my trauma. I keep so busy that I become burnt out because I have so much on my plate and my mind is not at rest.

Your Turn to Practice

Coping Mechanism:

Ways this coping mechanism can still be useful to me:

Ways this coping mechanism is damaging me:
Finding Healthier Ways to Cope

- Underlying each coping mechanism is a need
- You have to identify the need before you can effectively replace a self-destructive coping pattern with a healthy one
- With love for yourself and respect for your needs, you can make these changes last

Example of Identifying Need and Healthy Coping

*Coping Mechanism:* Self-Harm → cutting my arms

*The needs I am meeting with this behavior:* I get a release, I get to feel and see the pain I am experiencing. My scars on my arm worry my family and friends and I get attention.

*Healthier ways to meet these needs:* Instead of harming my body through cutting to get out how I feel I could journal what I am feeling in the moment. When I am feeling “stuck in my head” and alone I could reach out to my support system and tell them I need some attention and love.
Your Turn to Practice

Coping Mechanism:

The needs I am meeting with this behavior:

Healthier ways to meet these needs:

Over the Next Week ....

I want you to think of one more example of identifying a need of your unhealthy coping and how you can meet the need with healthy coping behavior
How do you feel?

For the next 30 minutes we will be having supportive therapy time. You can discuss anything in regards to the lesson OR what has been happening in your life this week.

This time is for you.

REFERENCE

WHAT ARE BELIEF SYSTEMS?

- Belief systems are a set of beliefs that we live out in our daily life that govern our thoughts, words, and actions
- Our belief systems can influence how we feel about ourselves and how we feel about other people in society
- Our belief systems are heavily influenced by the environment that we are raised in
- Deep rooted beliefs are the core beliefs of our belief system
- If the deep rooted beliefs are negative and are never discussed, they may take control of our self-esteem
**EXAMPLES OF NEGATIVE DEEP ROOTED BELIEFS**

| • I am unlovable   | • I am a woman, therefore I should be caring for the men in my life |
|                    | • It is all in my head                                          |
| • I am needy       | • I am annoying                                                |
| • I am difficult   | • I am a family member                                         |
| • I am emotional   | • I am annoying                                                |
| • Nobody could ever love me | • I am broken                                                   |
|                    | • I will never be normal                                       |
|                    | • I am stupid/incapable of reaching my goals and desires       |
|                    | • I do not have a bright future                                 |

* A few examples of negative deep rooted beliefs that are often heard in sessions with clients who are survivors of interpersonal trauma

**DISCUSSION**

❖ Do you recall any beliefs that were taught to you by your caregivers growing up? Ex: Women should be the ones to cook and clean, whereas men should be the workers

❖ What deep rooted beliefs could you relate to? Can you identify any that are not included on the list?

❖ Do you remember having worse self-esteem as a child or more so as an adult?
HOW CAN I CHANGE MY BELIEFS?

- It is not easy, however identifying that you have negative deep rooted beliefs is the first step.
- Every person has a belief system and deep rooted beliefs and many of these beliefs are established in childhood.
- As we discussed last week, you now have something that you did not have as a child: CHOICE!
- Even though it is not easy, you do have choice regarding your belief system and what you believe to be true.

THINKING OPPOSITE

1. What are the biggest problems or issues in achieving your goals and desires?
   I desire to have more positive relationships in my life, however I believe that no one would like to be around me because I have a lot of baggage and problems.

2. Identify all the deep-rooted beliefs that may be limiting and write them down
   - "I am not good enough"
   - "I am unlovable"
   - "I am mean and dramatic"

3. Thinking Opposite
   - I am becoming the best version of myself.
   - I am human, I make mistakes and I have emotions.
   - I am a victim of abuse, however this will not define my identity anymore.
   - I am kind and social, I have a lot to offer the world.

4. Focus on the new beliefs daily by repeating and affirming the new beliefs.
   CAUTION: It will take some time and repetition to accept the new belief.
YOUR TURN TO PRACTICE

1. What are the biggest problems or issues in achieving your goals and desires?

2. Identify all the deep-rooted beliefs that may be limiting and write them down

3. Thinking Opposite

4. Focus on the new beliefs daily by repeating and affirming the new beliefs

SELF-ESTEEM

✧ Our belief systems and negative deep rooted thoughts affect our self-esteem
✧ Self-esteem is confidence is one’s worth or abilities; self-respect
✧ Low self-esteem is a symptom of depression
✧ There are things that we can do on a daily basis NOW to raise our self-esteem
✧ The journey to healing is not fast, however you can CHOOSE to practice self-care and improve self-esteem
IMPROVING SELF-ESTEEM

- Pay attention to your needs and wants
- Take good care of your body: exercise and eat healthy
- Take time to do things that you enjoy
- Take note of your special talents and abilities; engage in an activity that showcases this
- Spend time with “safe” people who make you feel good
- Create a safe place in your home, a place that is your own
- Separate and protect yourself from people who make you feel bad
- Repeat positive affirmations to yourself about yourself

DISCUSSION

- What do you find improves your self-esteem when you are feeling low?

- Have you tried any of the ideas on the list? Were they effective?
AFFIRMING WHO I AM

- You are human; you are worthy of respect and love.
- Every human being has insecurities due to negative deep rooted beliefs, however these beliefs do not need to be attached to you forever.
- Even though it may be hard to do at first, repeating positive affirmations to ourselves does “fight against” our negative deep rooted beliefs.

For example:

Negative deep rooted belief: I am worthless, I have nothing to offer today.

Affirming who I am: I am human. I have made mistakes and have been through hell and back. I am strong and believe in my recovery. I am not perfect. My trauma is not my identity. I am strong and able. I am worthy of love and respect. I have so much to offer the world.

YOUR TURN TO PRACTICE

Negative deep rooted thought:

Affirming who I am:
OVER THE NEXT WEEK....

❖ I would ENCOURAGE you to use positive affirmations when you are feeling down about yourself
❖ Think about how often your negative deep rooted thoughts take control of your day and what triggers them
❖ Look back to the positive affirmations in the exercises we did together and REPEAT them to yourself - even if you don’t believe it currently

You are MORE than your negative deep rooted beliefs!

You are on a journey to recovery; your trauma and negative deep rooted beliefs do not define you anymore! You have a choice as to what you believe about yourself!

HOW ARE YOU FEELING?

The next 30 minutes is set aside for supportive therapy time. You may discuss anything in regards to your week OR the lesson.

This time is for you!
REFERENCE

Lesson #5: Self-Soothing Practices

Self-Soothing and Deep Breathing
Abigail Maddocks
BAA Behavioral Psychology

What is Self-Soothing?

- **Self soothing** has to do with comforting, nurturing, and being kind to yourself.
- Self soothing techniques access the body's five senses: vision, hearing, smell, taste, and touch.
- Imagination is also used.
- These techniques can be used at distressing or triggering times to calm down both the physical and mental reactions to stress.
Examples of Self-Soothing

VISION:
Walk in a pretty part of town. Look at the nature around you. Go to a museum with beautiful art. Buy a flower and put it where you can see it. Sit in a garden. Watch the snowflakes decorate the trees during a snowfall. Light a candle and watch the flame. Look at a book with beautiful scenery or beautiful art. Watch a travel movie or video.

HEARING:
Listen to beautiful or soothing music, or to tapes of the ocean or other sounds of nature. Listen to the environment that you are in and be mindful of the sounds you are hearing.

Examples of Self-Soothing

SMELL:
Smell your food as it is being cooked at home. Notice all the different smells around you. Walk in a garden or in the woods, maybe just after a rain, and breathe in the smells of nature. Light a scented candle or incense. Bake some bread or a cake, and take in all the smells.

TASTE:
Have a special treat, and eat it slowly, savoring each bite. Cook a favorite meal. Drink a soothing drink like herbal tea or hot chocolate. Let the taste run over your tongue and slowly down your throat.
Examples of Self-Soothing

Touch:
Take a bubble bath. Pet your dog or cat or cuddle a baby. Put on a silk shirt or blouse, and feel its softness and smoothness. Sink into a really comfortable bed. Float or swim in a pool, and feel the water caress your body.

Imagination:
Allow yourself to imagine a setting that gives you a feeling of peace, safety, and joy. Anything that evokes a sense of calmness and security.

Why self-sooth?

The purpose of using self-soothing practices is to do something that gives you pleasure and comfort in times of distress, rather than engaging in an activity that harms you (e.g., self harm, isolation, drugs, alcohol).
Discussion

- When you are in a state of distress, what do you do to calm yourself down?
- Have you used self-soothing techniques before?
- Which of the five senses do you focus on when distressed to calm yourself down?
- Do you think self-soothing would help you?

Deep Breathing

Deep breathing effects the body:
- reduces stress and anxiety
- increases our ability to focus
- decreases heart rate
- decreases blood pressure

* In times of distress we usually take shallow breaths and this can exacerbate the physiological symptoms of anxiety and decrease our ability to focus.
Deep Breathing Exercise

The 4-7-8 (or Relaxing Breath) Exercise

Although you can do the exercise in any position, sit with your back straight while learning the exercise. Place the tip of your tongue against the edge of tissue just behind your upper front teeth, and keep it there through the entire exercise. You will be exhaling through your mouth around your tongue, try pursing your lips slightly if this seems awkward.

Exhale completely through your mouth, making a whoosh sound.
Close your mouth and inhale quietly through your nose to a mental count of four.
Hold your breath for a count of seven.
Exhale completely through your mouth, making a whoosh sound to a count of eight.
This is one breath. Now inhale again and repeat the cycle three more times for a total of four breaths.

Discussion

- Do you use deep breathing when you are distressed?
- Do you find it effective?
- What did you think of the exercise?
Over the next week…

1. I would like you to use one of the self-soothing techniques we went over.
2. I would like you to practice deep breathing using the exercise we did together.

How do you feel?

For the next 30 minutes we will be having supportive therapy time. You can discuss anything in regards to the lesson OR what has been happening in your life this week.

This time is for you.
Reference


Lesson #6: Review

Review
Abigail Maddocks
BAA Behavioral Psychology

Week #1: What is Trauma

• Learned definitions of trauma: traumatic event, complex trauma, interpersonal trauma
• Common symptoms of trauma
• Definition of safety
• Creating Safety
• Do you have any questions regarding lesson #1?
Week #2: Attachment Styles

- Learned the different types of attachment (secure, avoidant, ambivalent/anxious, and disorganized)
- Learned how these childhood attachments affect our adult personalities
- Learned the different adult personality styles (secure, dismissive, preoccupied, and fearful-avoidant)
- Do you have any questions regarding lesson #2?

Lesson #3: Coping Mechanisms

- Learned what coping mechanisms are and that they can be both good and bad
- Learned about forgiving yourself and went through the “I can forgive myself” exercise
- Learned to sort the “good” and “bad” of each coping mechanism and went through the “sorting current coping mechanisms” exercise
- Learned how to identify the need behind a coping mechanism and brainstorming more positive ways to meet that need.
- Went through the “identifying a need and healthy coping” exercise
- Do you have any questions regarding lesson #3?
Lesson #4: Belief Systems

- Learned what belief systems are and how they effect our self-esteem
- Learned how to identify a negative deep-rooted belief and how to think opposite
- Went through the “thinking opposite” exercise
- Learned about self-esteem and ways in which self-esteem can be boosted
- We went through the “affirming who I am” exercise
- Do you have any questions in regards to lesson #4?

Lesson #5 Self Soothing and Deep Breathing

- Learn what self-soothing is and was provided with examples
- Learned why self-soothing is important
- Learned about the benefits of deep breathing
- Practices the “4-7-8” deep breathing exercise together
- Do you have any questions in regards to lesson #5?
ASSESSMENTS

We are now going to go over the PTSD Checklist-Civilian Version and the Brief COPE again.

After the assessments are completed we will engage in supportive therapy time!

THANK-YOU

Thank-you for allowing me to work with you!

I hope my work with you has benefitted you!

I wish you the very best on your journey to recovery!

Abigail Maddocks