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## The use of psychoeducation in the treatment of PTSD with military personnel and their family members : an exploratory study from a clinician's perspective

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Mary E. Fisher  
The Use of Psychoeducation  
in the Treatment of PTSD  
with Military Personnel and  
their Family Members: An  
Exploratory Study from a  
Clinician's Perspective

## ABSTRACT

This qualitative study explores clinician's use of psychoeducation in the treatment of Posttraumatic Stress Disorder (PTSD) with military personnel and their family members. Seven clinicians working with military personnel or in a military setting were asked a series of questions about psychoeducation and its use in the treatment of PTSD. Utilizing interviews, clinicians provided rich and detailed narratives outlining the following questions: (1) Is psychoeducation an appropriate intervention method in the treatment of PTSD? If so, when is it appropriate to use or incorporate psychoeducation in the treatment process with military personnel and/or their family members? and (2) What have been the outcomes in using psychoeducation as a form of treatment for PTSD with individual military personnel and/or their family members? How do you measure the effectiveness of this intervention?

Participants gave descriptive narratives of their experience and outcomes, exploring their meaning and understanding of psychoeducation, its use during the therapeutic relationship as a stand-alone entity or in conjunction with another therapy, and their perceptions on psychoeducation's effectiveness in the treatment of PTSD. Major findings revealed that psychoeducation was used by all of the participants in this study; however treatment modality, timeframe and settings of use with psychoeducation varied. The data collected from the study supported the need for more research to be

conducted on the effectiveness and best practices of the use of psychoeducation in the treatment of PTSD.

THE USE OF PSYCHOEDUCATION IN THE TREATMENT  
OF PTSD WITH MILITARY PERSONNEL  
AND THEIR FAMILY MEMBERS:  
AN EXPLORATORY STUDY FROM A CLINICIAN'S PERSPECTIVE

A project based upon an independent investigation,  
Submitted in partial fulfillment of the requirements  
For the degree of Master of Social Work.

Mary E. Fisher

Social Work Research Methods  
Smith College, School for Social Work

2008

## ACKNOWLEDGEMENTS

I have fought a good fight, I have finished my course, I have kept the faith.

- 2 Timothy 4:7

Lord, I thank you for your mercy, forgiveness, understanding, guidance and favor. You are the head of my life and the basis of my understanding. Without you, none of this would have been possible.

In a world full of negative stereotypes and misconception, I must acknowledge all the strong and positive African American men in my life that have influenced and guided me to the path that I stand on today.

To the head of the family, Grandpa, I thank you for always supporting me and reminding me that learning and growing is not always easy. Dad, thank you for your constant love and support. I truly believe that you are my #1 fan. To my husband, who knows me better than I know myself. Thank you for supporting me through the career change and believing that through it all I would always be victorious. I look forward to a new phase together in life and in love. To my children, on this earth and in heaven, never be afraid to step out on faith or to try the unexpected. I will always support you in all that you do. To my first born, I love you and thank you for being steadfast and courageous through the many moves and lifestyle changes. You are strong, intelligent and brilliant. Never believe anything less. To my youngest, your innocence and unconditional love is a blessing. Continue to be strong willed and determined. Never let anyone stifle your voice or opinions.

To the rest of my family, friends and loved ones, thank you for the support, encouragement and love. I could not have made it this far without the good, the bad and the indifferent. To the friends I have made at Smith, you will not be forgotten. While I will not see you next summer, I will see you again.

To my thesis advisor, Dr. Narviar C. Calloway, thank you for the constant support and understanding. Continue to bless the lives of the students you touch.

Dedicated to the one I love,

CNB

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## CHAPTER I

### INTRODUCTION

Soldiers throughout history have had to deal with the mental, physical and emotional stress associated with combat. Not until World War I (WWI) when the terms “shell shock” and “war neurosis” became synonymous with describing psychiatric conditions that plagued returning soldiers, was the concept of combat related stress associated with a clinical diagnosis. During WWII era, psychiatric casualties were diagnosed with terms such as “exhaustion” and “combat fatigue” (Williams, 1987; Figley, 1978; Binneveld, 1997) to describe diagnosed behaviors and symptomology from the combat experience. Shell shock was a physical and psychological disorder. It was described as brain trauma resulting from the exploding shells (Grinage, 2003) and as a psychological disorder resulting from air blast from artillery fire. Symptomology included but was not limited to paralysis, pseudoconfusion, blindness, anxiety, freezing, irritability, tremors, restlessness, insomnia, nightmares and battle dreams. Lingering persistent symptoms, also known as war or traumatic neuroses, were also seen in returning soldiers from WWI.

Due to the vast numbers of Soldiers diagnosed with a psychiatric diagnosis, more research was generated by clinicians in the civilian and military psychiatry field. Most of the literature and personal opinion of the professional dealing with combat soldiers returning from the war portrayed the psychiatric disorder as premorbid or as a personality disorder, thus attributing this phenomenal as a character flaw rather than a condition

caused by traumatic events and incidents of the war (Figley, 1978). During WWII era, clinicians often tried to minimize the effects of combat on the psychological and psychiatric function of returning Soldiers. Exhaustion was used to describe “all psychiatric disorders from the combat zone- regardless of the presentation” (Figley, 1978, xvii). The term combat stress was first introduced during the Vietnam War, “expressed of the tension involved in the jungle fighting...” (Binneveld, 1997, p. 83). Combat stress was used “to avoid stigma and to imply that soldiers would recover naturally with food and rest” (Committee, 2008, p. 75). The stigma of combat stress was still “associated with ineffective commanders and low unit morale” (Figley, 1978, p. xvii). As the understanding of the presentation and symptomology of war related trauma began to evolve, so did the name and diagnostic criteria.

The Diagnostic and Statistical Manual (DSM) I & II referred to combat stress as “gross stress reaction” and “Adjustment reaction of late life,” respectively. The DSM I was published in 1952 during the Korean War. Gross stress reaction was defined as...

Patterns of reactions to deal with overwhelming fear...in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat... In many instances this diagnosis applies to previously more or less “normal” persons who have experienced intolerable stress (Everly & Lating, 1995, p. 16).

Gross stress reaction was attributed to fear after experiencing “emotional” or “intolerable” stress and was “normalized” as a typical reaction to the events. In the DSM II, published in 1968, “adjustment reaction of late life” was used to describe combat related stress. The term described combat related stress as “[f]ear associated with military combat and manifested by trembling, running and hiding” (APA, 1968, p. 49). While the description associated the disorder with fear, it carried a negative undertone,

which further exacerbated the existing stigma. After much debate regarding the duration, onset, and symptoms of combat related trauma from scholars and researches in the psychiatric field, the term Posttraumatic Stress Disorder (PTSD) was formally introduced in 1980 in the DSM III (Post Traumatic, 2008).

Many of the returning Soldiers from the Iraq War have symptomology of combat related stress or are diagnosed with PTSD. Col. Charles Hoge, M.D., Chief of Psychiatry and Behavior Services at the Walter Reed Army Institute of Research, spoke to the U.S. House Committee on Veterans Affairs' Health Subcommittee in 2005 and 2007. He stated that...

19% to 21% of troops who have returned from combat deployments meet criteria for PTSD, depression or anxiety. Of these, 15% to 17% of troops who served in Iraq and 6% of those who served in Afghanistan had PTSD symptoms when surveyed three to 12 months after their deployments. In general, PTSD rates were highest among units that served deployments of 12 months or more and had more exposure to combat (Kaplan, 2006, p.1).

Dr. Hoge suggested that the longer Soldiers are deployed or involved in combat, the greater their chances of having some symptoms of PTSD. He reported similar statistics in the 2007 Hearing, specifically reporting findings from two major studies. His report from the study published in the Journal of the American Medical Association (JAMA) stated that of 90,000 soldiers who completed the post-deployment health assessment (PDHA) and the post-deployment health reassessment (PDHRA) after redeployment,

20% of Active Component and 42% of Reserve Component Soldiers were identified as needing mental health referral or treatment, most often for PTSD symptoms, depression, or interpersonal conflict..... About half of Soldiers with PTSD symptoms identified on the PDHA showed improvement by the time of the PDHRA, often without treatment. However, more than twice as many Soldiers who did not have PTSD symptoms initially became symptomatic during this same period” (Post Traumatic, 2008, p. 1).

This suggests that Soldiers are more likely to display PTSD symptomology after they began to readjust to daily life several months after their redeployment. Findings from the Mental Health Advisory Team 5 (MHAT-V), reported that multiple deployments and longer rotations have increased the chances of PTSD and other mental health issues in returning military personnel. COL Hoge further reported that,

longer deployments, multiple deployments, greater time away from base camps, and combat intensity all contribute to higher rates of PTSD, depression, and marital problems..... The study showed that with each deployment there is an increased risk; 27% of Soldiers on their third deployment reported serious combat stress or depression symptoms, compared with 19% on their second, and 12% on their first deployment (Post Traumatic, 2008, p1).

The Department of Defense (DOD) has initiated several resources such as Military OneSource, pre/post health assessments, and has increased the behavioral health services that military personnel, veterans and family members can use for mental health resources (Kaplan, 2006). There are several therapeutic approaches used in the treatment of PTSD, which include Psychotherapy, Cognitive Behavioral Treatment (CBT), Family Systems theory, group therapy and psychoeducation. However for the current study, the researcher has chosen to focus on the effectiveness of psychoeducation in the treatment of combat related trauma, a.k.a. PTSD, with military families and veterans. The use of psychoeducation in conjunction with other treatment modalities or as a stand-alone entity also will be examined.

With the increased violence due to the war in Iraq and Afghanistan, many Soldiers are affected by the violence and the trauma associated with conflict. It is important for those who are affected or who may be diagnosed with PTSD to understand the symptomology in order to facilitate healing. This study conducted on

psychoeducation is related to the profession of social work in several ways. PTSD is a prevalent diagnosis and concern for military personnel returning from conflict in the military health system and the Veterans Administration (VA). Social workers are instrumental in the assessment and treatment of PTSD in both military settings and private practice, and thus it becomes important to find a treatment that is useful and effective. Learning and implementing new effective and innovative techniques to treat PTSD will allow social workers and other clinicians to be more productive in facilitating mental health services to military personnel and their dependents.

This study involves in-depth interviews with clinicians who treat PTSD with military personnel and their family members. The study explores the various uses of psychoeducation throughout the treatment process. Psychoeducation is teaching clients about an illness or condition (Baker, 2003). The researcher chose to explore psychoeducation as the method of treatment with PTSD due to the limited body of literature and its adaptability of use with individuals, groups and in a variety of treatment modalities.

Clinicians in private, public and military settings throughout the country were recruited for this study. A snowball sampling method was used for the recruitment of participants. This included word of mouth, placement resources, and referrals by other clinicians. Participants were asked two root questions: Is psychoeducation an appropriate intervention method in the treatment of PTSD? If so, when is it appropriate to use or incorporate psychoeducation in the treatment process with military personnel and/or their family members? Secondly, what have been the outcomes in using psychoeducation as a form of treatment for PTSD with individual military personnel and/or their family

members? How do you measure the effectiveness of this intervention? The following chapters provide insight into these questions.

## CHAPTER II

### REVIEW OF LITERATURE

PTSD has been recognized as a mental disorder in the Diagnostic and Statistical Manual (DSM) since 1980 (Corales, 2005). Since the inception of PTSD, several theories of treatment have been introduced focusing on varied aspects of the biological, social and psychological reasons for the development of PTSD. According to the *Handbook of Post-Traumatic Therapy*, while theories vary, they all had 6 similar assumptions on how trauma affects the individual. Trauma impacts the person's "(1) psychobiological state, (2) changes in learned behavior, (3) changes in cognitive processing, (4) changes in self-structure, (5) changes in interpersonal relationships, and (6) the nature of the stressors experienced within the time-space framework of a culture at a historical moment" (Williams, 1987, p. 15). It is important to recognize that each individual has a unique and diverse symptomology pattern of PTSD (Wilson, Friedman & Lindy, 2001). Therefore, it is necessary to have different treatment theories and interventions available for the clinician's use.

The literature focuses on the use of psychoeducation for the treatment of PTSD in the sample population with little attention paid to race and ethnicity by the authors of published works reviewed. The literature also lacked information regarding diversity in their study samples and its affect on treatment techniques. Often the literature referred to the clients as military personnel, soldiers or veterans in order to group them according to their military status without much else to distinguish them. Other comparison data

focused on the specific diagnosis or disorder of the population with minimal attention to the particular effects that demographics played on the study outcome. There was even less information or attention paid to the race, ethnicity or age of the family members. The researcher of this study is unsure as to why race and ethnicity was not emphasized in the published literature but can conjecture that many did not factor race in as a barrier to the use of psychoeducation.

A large amount of the initial research in the use of psychoeducation in the treatment process pertained to schizophrenia. Many of the studies conducted on schizophrenia found that patients benefited from psychoeducation. More specifically, psychoeducation produced a reduction of relapses, better social functioning, positive effects on well being, and a better understanding and attitudes of family members regarding the illness (Merinder, 2002; Rotondi et al., 2005). Clinicians and mental health providers realized the success of psychoeducation in the treatment of schizophrenia and developed other models incorporating psychoeducation in treating PTSD. This chapter defines terms relevant to PTSD and discusses the use of psychoeducation in family, group and individual therapy.

#### *Definition of Relevant Terms*

*Posttraumatic Stress Disorder (PTSD).* PTSD is considered an anxiety disorder and defined as a “delayed psychological reaction to experiencing an event that is outside the range of usual human experience...events of this type include accidents, natural disasters, military combat, rape and assault” (Baker, 2003, p. 331). The symptomology of PTSD includes but is not limited to anxiety, recurrent and intrusive recollections, distressing dreams, and restricted range of affect, difficulty sleeping, irritability or anger,

and impairment of social and occupational functioning (APA, 2000). PTSD can be a chronic and devastating disorder if treatment is not sought (Creamer & Forbes, 2004).

*Psychoeducation.* According to Hatfield as cited in Allen, (2001), education is designed to “develop long-term, organized bodies of knowledge and generic problem-solving skills that will help the learner solve personal problems, both in the present and in the future” (p.347). Psychoeducation is the “process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment and alternatives (Barker, 2003, p. 347). Psychoeducation’s goal is to offer education and therapeutic strategies to improve the quality of life for the family while decreasing the possibility of relapse for the patient (Solomon, 1996). It also has been described as a “systematic didactic-psychotherapeutic intervention, designed to inform patients and their relatives about the disorder and to promote coping (Lincoln, Wilhelm, & Nestoriuc, 2007, p. 233). By strengthening the coping skills, communication and problem solving abilities of the family, the well-being and adaptability of the individual and family members are expected to improve. Even with limited empirical evidence suggesting the importance of psychoeducation, practical application and experience has proven its effectiveness (Creamer & Forbes, 2004; Lansverk & Kane, 1998).

Psychoeducation can be used to normalize a traumatic experience or memory (Glodich & Allen, 1998; Psychoeducation, 2006). It can be in written form or through verbal communications to aid in the therapeutic approach. Psychoeducation is education used in therapy and includes discussion and application for the edification of the client’s knowledge regarding the diagnosis, treatment options and techniques for coping

(Psychoeducation, 2006; W. P Hornung et al, 1996). It is effective in removing myths associated with the diagnosis, providing statistical data, and in describing the symptomology of the diagnosis and also can be effective in reframing of events.

By reframing posttraumatic symptoms as potentially adaptive, the clinician may counter some of the helplessness, perceived loss of control, and stigmatization that often accompanies flashbacks, activated trauma memories, or psychological numbing. In fact, clients who accept the reframing of flashbacks as trauma processing may even come to welcome some reexperiencing responses as evidence of movement toward recovery (Psychoeducation, 2006, p. 92).

*Stigma.* The characteristic of an individual that is deemed by others as negative (Baker, 2003, p.418). Stigma when referencing mental health refers to the “negative value judgment” (Sansone, Matheson, Gaither & Logan, 2008, p. 1) “prejudice or negative stereotyping” (Corrigan & Penn, 1999, p. 766), associated with the disorder or “an attribute that is deeply discrediting (Gould, 2007, p. 506). According to Greenberg, Langston & Gould, the effects of stigma “can often be felt long after the original problems have disappeared” (Greenber et al, 2007, p 2).

PTSD still has the same stigma associated with its diagnosis for today’s Soldiers and Veterans as the terms shell shock and combat fatigue did for WWI & WWII Soldiers. The stigma associated with receiving mental health services relating to deployment issues is a major obstacle for military personnel. In 2005, a study conducted by the Department of Defense (DOD) stated that at least 16% of returning troops, specifically soldiers and marines, admitted to having severe symptoms of PTSD, depression or other deployment related issues. More than half of them stated that by seeking mental health services, they would be seen as weak or treated differently by their peers (Anderson, 2005). Statistics from the 2007 study reported that between 23-40% of military personnel whose

evaluation showed symptomology for a mental illness did not seek treatment primarily due to the stigma attached for being weak (Post Traumatic, 2008; Creamer a& Forbes, 2004).

*Public stigma vs. Self-stigma of mental health.* Stigma surrounding mental health is prevalent in the military but also in the general society. Public stigma is the “reactions that the general population has to people with mental illness” (Corrigan & Watson, 2002 p. 37). It is society’s perception, and encompasses beliefs and attitudes of individuals with a mental health diagnosis. Individuals with mental illness are portrayed as crazy, irresponsible and unstable in the media. Even the term "mental illness" refers to the condition as a sickness, which implies a negative connotation. They also are seen as needing to be feared or cared for (Corgin & Penn, 1999). Self stigma is “the internalization of how the general public portrays people with mental illness and one’s belief in that portrayal” (Greene-Shortridge, 2007 p. 2). Internalizing the belief that a mental health diagnosis makes you incompetent or unstable affects an individual’s outlooks on their capabilities and self image (Greene-Shortridge, 2007). For military personnel, the perceived stigma of seeking mental health services is exacerbated due to fear of social isolation, perception and blame.

Within a military context, service members experiencing symptoms of PTSD and considering admitting they have a problem to someone else will likely be aware of public beliefs about psychological problems, perhaps anticipating negative consequences from different individuals (e.g., fellow service members, commanders). If soldiers fear social exclusion because they have symptoms of PTSD, they may forgo seeking help due to apprehension about societal stigma. Furthermore, soldiers' perceptions of society holding them accountable for their psychological problems may further inhibit treatment seeking. If the soldier comes to personally endorse the negative beliefs and attributions held by the public, he or she will experience a stronger sense of self-stigma.....Once exposed to a traumatic event and symptoms of PTSD begin occurring, soldiers

may encounter a societal stigma within the military culture. For instance, some military personnel may begin socially distancing themselves from soldiers they perceive as having mental health problems. These individuals may be uncomfortable around soldiers with PTSD and perhaps even blame them for the development of the problem (Greene-Shortridge, 2007 p. 1).

The stigmas associated with PTSD reduces the likelihood that military personnel will acknowledge PTSD symptoms or seek treatment due to fear of isolation, being viewed as weak, being ostracized or jeopardizing one's military career (Friedman, 2006; Gould et al, 2007).

*Effects on family members.* The stigma associated with a mental health diagnosis is not isolated to the individual but also affects their family members. In the article, *Concerns about Career Stigma by Military Parents of Children with Psychiatric Illness*, several studies were presented that proved a correlation between psychiatric disorders and the increased sensitivity and perception of stigma by the family members. The family members involved in the studies had one or more of the following due to the perceived stigma; an increase in suicidal ideations, feelings of discrimination, negative views of themselves as parents, social isolation and avoidance. The article also corroborated the perceived stigma of mental health and the military. Approximately 23-40% participants surveyed were worried about the stigma of seeking help and the impact it would have on their military career (Sansone, Matheson, Gaither & Logan, 2008).

*Early intervention.* Early intervention is defined as the immediate action following onset or diagnosis to ameliorate the effects of a disability; action taken to prevent a possible disabling condition (CIRRIE, 2008). Early intervention is important because it increases the individual's knowledge on the diagnosis or illness (APA, 2004; Fung & Frye, 1998), which can decrease or alleviate stress (Creamer & Forbes, 2004)

and provides information regarding specific treatment models pertinent to their condition (Pratt et. al, 2005). Early intervention is useful to support newly acquired knowledge, coping mechanism and skills (Fung & Frye, 1998).

According to Edwards & McGorry (2002), the rationale for early intervention is early detection, decreased delays of effective treatment and possible delay of onset of the illness. Early intervention, “involves identification of warning signs for individuals at risk for mental health problems and intervening early against factors that put them at further risk for developing mental disorders” (Doyle, 2005, p. 1) in order to reduce long term harm or worsening symptoms (HHD, 2008; Institute of Psychiatry, 2006). Early intervention also can “dramatically improve...immediate and long term health outcomes (Paterson, Jones, Dagg, Scanlon & Raphael, 2001, p. 137).

#### *Psychoeducation and PTSD*

*Family therapy and psychoeducation.* Due to the reduction of inpatient and outpatient services and institutions, the burden of responsibility in the care of mentally ill patients mainly has fallen on the family. This is no exception for military members and veterans diagnosed with PTSD (Sherman, 2003). Many of those diagnosed with PTSD feel a “sense of emotional estrangement” from friends and family members (Mueser & Stanley et al., 2001, p 337). The service member is not alone in his/her feelings of helplessness, worthlessness and isolation; the family also is experiencing similar emotion. PTSD not only affects the individual with the disorder but also affects the family unit that supports the soldier or veteran. The importance of family involvement and support is the key to a service member’s well-being. Most treatments focus on the individual, which can impede treatment success due to alienation of the family (Williams, 1987). In family

therapy, the entire family joins “efforts in order to achieve a better understanding and a better treatment of the disorder” (Bertrando, 2006, p. 13). Research has proven that "patient's outcomes improve when the needs of the family members for information, clinical guidance and support are met" (Dixon et al, 2001, p. 903).

In the article, *Evidence-Based Practices for Services to Families for people with Psychiatric Disabilities*, the author states that the main goals when working with family members of persons with a mental illness is to “achieve the best possible outcome for the patient through collaborative treatment and management and to alleviate the suffering of the family members by supporting them in their efforts to aid in the recovery of their loved ones” (Dixon et al, 2001, p. 904). In most cases the family is the main support system, which includes the mental, physical, emotional and financial care of the individual diagnosed with the illness; and therefore the family has insight and judgment in their dealing with and management of the illness. Research has proven that “patient’s outcomes improve when the needs of the family members for information, clinical guidance and support are met” (Dixon et al, 2001, p. 903). In review of the literature regarding family psychoeducation and schizophrenia, the evidence suggests that family psychoeducation is more effective in relapse prevention and improved quality of life than medication management and individual treatment alone due to the social supports, education and coping skills provided to the individual and the family members (Bertrando, 2006; Fung & Frye, 1999; McFarland et al, 1995).

According to Harkness & Zador, there are three components of family interventions with PTSD, which includes a combination of psychoeducation, disclosure and dialectical dilemma. Psychoeducation involves educating family members on the

illness. Disclosure includes acknowledging the traumatic event. While the disclosure can be specific or generalized, the significance is to share the experience with the family. Dialectic dilemma involves how the family manages the challenge of acknowledgement of the trauma while finding a way to reframe and channel the emotions and energy of the situation. The combination of the three components allows the family to “hear, appreciate and validate” the experience of the service member (2001, p. 351).

Other family therapy models such as trauma workshops, are didactic and educational in nature, and conclude with a discussion period (Allen, 2001). Another model used within the VA is the Support and Family Education (SAFE) Program. This design fosters a supportive learning environment for family members with the goal of providing a more nurturing and supportive home and family environment for the patient. A five-year assessment of the program using a 5-point Likert scale and several qualitative items found that participants gave the program a mean score of 18 out of 20. The participants commented on the usefulness of the information and peer support (Sherman, 2006). Family therapy is useful in involving all members of the family structure in the healing process. The significance of this type of therapy focuses on the collective healing of the entire family, and not just the individual diagnosed with PTSD.

*Group therapy and psychoeducation.* Group therapy is a treatment method used with groups of people who have experienced similar symptoms related to an illness or diagnoses. Group therapy is usually recommended after the treatment of primary symptoms through individual counseling and is widely utilized because it is effective while being cost efficient. The use of psychoeducation in groups is important to ensure that the client has a better understanding of symptoms, triggers and coping strategies.

Group therapy can be designed with different rules, ideas and goals, but all models of group therapy have some similar qualities and expectations. Group therapy allows the person to connect with other individuals sharing similar experiences, which validates and normalizes his/her feelings, and fosters a sense of commonality. Most groups are homogeneous; for example they all share a common trauma (Foy, Schnurr, Weiss, Wattenberg, Glynn, Marmar & Gusman, 2001; Schermer, 2000; Williams, 1987). It allows that person to have a safe haven where he/she can begin to rebuild and regain trust (Allen, 2001; Foy et al., 2001; Schermer, 2000).

Group therapy works under the premise that members take a nonjudgmental approach of other members, are supportive in nature, and share collective responsibility and healing for the common experience (Williams, 1987). This fosters “a psychologically safe, respectable therapeutic environment which permits members to address issues of trust” (Foy et al., 2001, p. 185). The success of a group is dependent upon the realized improvement of the person’s quality of life, symptoms and renewed sense of trust (Schermer, 2000). By incorporating psychoeducation into the group setting, it allows the group members to add personal meaning to the concepts and symptomology of the disorder, reinforcing the subject matter with personal accounts (Allen, 2001).

There are several specific types of group therapy models such as psychodynamic group therapy, cognitive behavior approaches, (cognitive processing group therapy), and supportive group therapies. Psychodynamic and cognitive behavioral group therapy focuses on the effects of the traumatic event in daily life, cognitive functioning and behaviors. This type of therapy can involve vicarious retraumatization and memories for

the client. Supportive group therapy provides support for current everyday issues and it is focused on the here-and-now.

A major study that supports the efficacy of psychoeducation group therapy and trauma involved twenty-nine multiple traumatized women in a 16-week, 3 phased trauma focused psychoeducational group. The group was comprised of all women with a mean age of 41.2. Several participants had comorbid diagnosis, 80% were involved in individual counseling, and 79% were taking prescribed psychotropic medications (Lubin, Lois, Burt & Johnson, 1998).

The therapy procedure included a 90-minute weekly session for 16 weeks. The sessions consisted of three parts; a 15-minute psychoeducational lecture, a 1-hour interactive discussion and a 15-minute educationally focused wrap-up. The model had 3 distinct phases each with a specific focus. Phase I focused on the effects of trauma on the individual's sense of self. Phase II focused on the effects of trauma on interpersonal relationships; and Phase III focused on finding meaning in life in spite of the trauma (Lubin, Lois, Burt & Johnson, 1998). Participants were administered study measures at 1-month intervals during treatment, at termination and at a 6-month follow up. The measures included six different scales that measured symptomology of PTSD, psychiatric symptoms, and consisted of clinician administered and self reported questionnaires.

The study outcome showed a significant reduction in PTSD symptoms (47% reduction from baseline) and proved that group therapy was effective. The study confirmed that group approaches “offer relief from PTSD symptoms in a relatively brief and cost effective manner...suggesting that group therapies with a more structured, psychoeducational format may show efficacy in symptom reduction” (p. 1177).

Gray, Elhai & Freuh (2004) conducted a study of an 8-week group-based program that focused on patient education and PTSD. The study included 17 Veterans and was conducted at a PTSD clinic in a VA hospital. All participants were male; 10 were African Americans and 3 were Caucasian. The mean age was approximately 57. Thirteen served in Vietnam, 3 in WWII and 1 in the Persian Gulf War.

The study had 2 main purposes, 1) to educate participants about PTSD in preparation for potential treatment and, 2) to evaluate patient satisfaction and motivation in complying with treatment regiments. Each session was 1 hour with a specific, independent topic taught consecutively allowing new members to be introduced through the duration of the study. The goal of the intervention was to “systematically enhance patients’ understanding of the etiology of PTSD and the corresponding rationale for treatment” (p. 324). Group topics included a PTSD overview, comorbid psychiatric disorders, psychotherapy, medical issues, family and marriage, anger management, guilt and shame and enhancing quality of life.

The study utilized two scales to measure the satisfaction of the participants’ treatment in the PTSD clinic and the satisfaction of the patient education group. The scales involved self reported measurements using a 5-point Likert scale. The study results showed that all participants were satisfied with the patient education group and the overall quality of care. Participants also were more hopeful, more knowledgeable regarding PTSD treatment techniques, and likely to attend treatment as a direct result of the group (Gray, Elhai & Freuh, 2004). An unintentional but fortunate result of the study was that several participants perceived that their PTSD symptoms had improved because of the educational sessions. The study limitations included the sample size and the

possible lack of anonymity. A significant gain of the study was that it laid the foundation for more expansive and in depth research regarding psychoeducation and PTSD.

*Cognitive Behavioral Treatment (CBT).* Research that compares psychoeducation and schizophrenia shows that incorporating psychoeducation in individual therapy is effective (Landsverk & Kane, 1998). Psychoeducational interventions usually are based on cognitive behavioral models and are cost effective (Auglia, Pascolo-Fabrizi, Bertossi & Bassi, 2007). A study conducted in Italy of 150 schizophrenic patients and their family members suggested that utilizing a psychoeducational model in addition to medication reduced hospitalization rates, increased adherence to the treatment program, and seemed to “improve the individuals’ perception of quality of life, which represents an indirect tool used to reduce self and hetero-stigmatization” (Auglia et al, 2007, p. 12).

A joint effort between the Department of Veterans Affairs (VA) and Department of Defense (DOD), referred to as the Joint Clinical Practice Guidelines for PTSD (JCPG-PTSD), publicized its support of the use of cognitive therapies in the treatment of trauma victims (Russell, Silver, Rogers, and Darnell, 2007). Existing data also states that psychological services are beneficial to military personnel and their family members. There is a wide array of information on CBT due to its popularity in empirical studies (Creamer and Forbes, 2004) and its proven effectiveness (Monson, Rodriguez & Warner, 2005). CBT is focused on cognition (thinking, remembering, reasoning, etc) and the use of positive consequences (Cooper & Lesser, 2005). Incorporating CBT and psychoeducation in individual therapy involves questions and discussion, note taking and a summary of key points discussed in the session. Educating clients also is a common and essential practice in many therapeutic relations (Allen, 2001).

### *Summary*

Psychoeducation has proven to be an effective method in the treatment of schizophrenia and other mental illness including PTSD. A significant portion of the reviewed literature supports findings and justifications for conjoint use of psychoeducation with schizophrenic patients. Some of the reviewed literature focused on psychoeducation and trauma or unspecified mental health illness, but did not specifically relate to PTSD and psychoeducation. The current researcher attempted to explore literature regarding PTSD, trauma, group therapy, family therapy, CBT and treatment models of a similar nature for a comparative analysis, and use the information from the literature review to supplement findings from the current research. The research strongly suggests that psychoeducation can be effective in reducing symptomology, hospitalization and stigma in a person's diagnoses with PTSD while providing support and cost efficient treatment.

CHAPTER III  
METHODOLOGY

*Research Design*

The available literature makes a strong correlation between the effectiveness of psychoeducation and schizophrenia. The researcher attempted to compare existing data from the literature review to conduct a comparative analysis of effective techniques using psychoeducation either as a stand-alone entity or in conjunction with another treatment model. This qualitative, exploratory study using flexible methods was designed to identify how clinicians incorporate psychoeducation in the treatment of PTSD with military personnel and their family members.

Interviews were conducted in a semi structured interview format either telephonically or in person. The questions were open-ended which allowed the participant to provide rich and descriptive narratives of their personal experience, observations and to assess the effectiveness of the treatment as a stand-alone entity or in conjunction with other interventions.

While the study was exploratory, the researcher's assumptions influenced the nature of the questions. The researcher made the assumption that all clinicians incorporate psychoeducation in some aspect of their treatment modality, whether it is formal or informal. Based on the literature review, the researcher also assumed that psychoeducation is useful in the treatment of PTSD but had no opinion on its

effectiveness as a stand-alone entity or in conjunction with other interventions. The field of social work stands to benefit from a study that collected and summarized information on the effectiveness of psychoeducation in the treatment process of PTSD.

### *Sample*

Criteria for participation in this study were licensed clinicians and mental health providers of legal age of consent with a minimal of 5 years experience working with military personnel and family members in the treatment of PTSD. The preference of participants for this study was social workers. Participants were both male and female and work in either the public or private sector. The targeted participants would come from diverse racial and ethnic backgrounds and from public and private settings in order to obtain heterogeneous responses. The intent was to recruit 20 licensed clinicians with an expected attrition rate of 5-8 participants. Participants were recruited using a snowball sampling technique through word of mouth, emails, referrals and contact lists on Military OneSource. Recruitment flyers were also distributed. The researcher targeted the local Veteran Administration Hospital (VA) and local military health systems.

A total of 7 clinicians, 5 social workers and 2 psychologists participated in the study. All clinicians were white and consisted of 6 females and 1 male. The clinician's ages ranged from 32-60 with a mean and median age of 48 years old. The participants' average years of experience working with Veterans and active duty (AD) personnel were 14. Five out of seven clinicians worked in public settings; 2 in a Veteran's Administration hospital, 2 in the Vet Center, 1 in an Army Medical Center and 2 in private practice. All participants worked with Veterans but only 1 worked solely with AD. The distinction between Veterans and AD Soldiers are that Veterans are any service

members that served on AD during combat or peacetime, while AD Soldiers are still in active service.

All participants met the specified licensure and service requirements of 5 years. The 5 social workers had all obtained their licensure of LCSW and the 2 psychologists both have doctorate degrees. The participants had a wide variety of theoretical frameworks they utilized in their therapy. Cognitive Behavioral Therapy (CBT) was the most popular theoretical framework, with 57% of the participants listing it as their clinical orientation. Other frameworks included systems theory, integrative theory, and psychoanalytic or psychodynamic perspective.

All participants worked with individuals and groups, and 86% of the participants also worked with family members. The participants carried a caseload on average of 56 clients with a range of 15 –120 clients per caseload. The average length of time participants worked with their clients ranged from 1 session to 15 years with the average length being 2.37 years. All participants incorporated psychoeducation in some form throughout their treatment methods. Only three of the participants used psychoeducation as a stand-alone treatment technique with an average of 11.9 clients. The majority of the clients using only psychoeducation as a stand-alone entity were case management clients not involved in individual or group sessions.

#### *Data Collection Methods*

Initially this researcher assumed that gathering the sample would be relatively simple, mainly focusing on the clinicians in the VA system, where she had conducted her 2<sup>nd</sup> year internship. The intent was to gather a snowball sample through emails and flyers within the hospital and eventually branch out to those working in the private sector. This

researcher encountered an impasse with the Institutional Review Board (IRB), which was connected to Emory Hospital and Medical School. Unless the project was approved by the IRB, employees in the Atlanta VA system were not allowed to participate in any studies or research projects. The IRB process took an average of 6-8 months for approval. Efforts were made to get an expedited approval but after 2 months of no progress, the recruiting focus was redirected to recruiting clinicians outside of the VA system.

The researcher contacted local counseling centers via telephonic and electronic mail. The researcher also contacted the local Vet Centers clinicians for contacts to their contract clinicians in private practice. Follow up calls were conducted within 1-2 weeks of the initial contact if individuals expressed an interest but had not contacted the researcher. Three of the participants were contacted in person.

Data was collected through in person or telephonic interviews over a two-month period. All interviews were recorded. Participants were sent the demographic questionnaire and informed consent prior to the scheduled interview in order to review and discuss any questions or concerns prior to the interview date. Participants signed the informed consent (Appendix C) and demographic questionnaire (Appendix D), which identified the purpose and risks involved in participating in the study and provided information regarding the participant's experience, theoretical orientation, and client base.

The interviews were comprised of 2 root questions with 10 stem questions (Appendix E). The in-depth interviews focused on the experience and treatment procedures used by the participants. The interview questions were open-ended allowing

a wide variety of descriptive and detailed responses. The interviews lasted between 25 to 60 minutes.

To safeguard participants' confidentiality, demographic questionnaires and signed consent forms were stored separately from the interview notes and responses. All names and identifiable information were not included in the transcribed interviews and the researcher was the only person to transcribe the interviews. The audio recorded interviews were numbered and stored without identifiable information of the participants. All interviews were conducted in a closed space that provided privacy and only the researcher and participant were privy to the conversation.

#### *Data Analysis*

All interviews were conducted in a qualitative research design. The data was transcribed and analyzed manually outlining the major and minor themes as discussed by the participants in the interviews. All responses to a particular question were compared and contrasted and illustrative points and quotes were organized under major themes in search of key words, patterns, commonalities and ideas. The key words and ideas from the data were the bases for the main points discussed and analyzed within the written presentation of this research.

Each recoded interview was transcribed into written form. The transcripts were coded by number and per federal regulations will be maintained for a period of 3 years in a locked and secure environment. Upon termination of the timeframe, the information will either be destroyed or maintained in a secure environment for further study on the subject.

All findings and themes from the data analysis are presented in written form in the subsequent chapters.

### *Limitations of the Study*

Several limitations were evident in this research study as it is a qualitative exploration of a treatment technique for a diagnosis that has little research or discussion available in the literature. The study is not out to prove or disprove findings but to generate information on the usefulness of psychoeducation as a treatment technique for PTSD. Since much of the presented literature is based on using psychoeducation with the schizophrenia, limited empirically tested research and literature is available to compare with the information generated from the interviews in this study.

Another limitation to the study is the narrow focus on military affiliated patients diagnosed with PTSD. The study did not look at all patients diagnosed with PTSD due to trauma or other injuries. Only those involved in military service and with combat related injuries. Since the study excluded patients diagnosed with PTSD outside of the military realm, the findings cannot be generalized to the entire population diagnosed with PTSD.

Gender and race were not equally represented in the study sample. There was only 1 male participant and none of the participants were from a minority race or ethnicity. The sample size was extremely small and focused on clinicians working with military personnel and their family members with PTSD, which also limited the generalized application of the findings to the larger population.

The study looks at the effectiveness of treatment from a clinician's perspective. This limitation does not allow for the perspective and opinions of the actual client to be included in the study material, thus only allowing for one perspective to be analyzed and

dictated in study implications. This is a bias that the researcher is aware of and will note in the research summary.

## CHAPTER IV

### FINDINGS

This exploratory study was designed to determine the effectiveness of psychoeducation in the treatment of PTSD with military personnel and their family members. This chapter presents the findings obtained from telephonic and in-person interviews with 7 participants who are clinicians that use psychoeducation in their treatment methods with military personnel with PTSD. The underlining assumption that influenced the nature of the thesis questions was: psychoeducation is an effective treatment stand-alone method but can be more effective when used in conjunction with another treatment method. The major emphasis throughout this study included, defining psychoeducation, introducing of psychoeducation as a treatment method, using of psychoeducation as a stand-alone entity or in conjunction with another treatment method, and early intervention.

#### *Defining psychoeducation*

Psychoeducation is defined as the “process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment and alternatives (Barker, 2003, p. 347). Each participant was asked to state their definition of psychoeducation. It is important to be aware of each participant’s understanding of psychoeducation in order to properly analyze the data and draw an informed comparison of the data. All of the participant’s

definitions were similar highlighting education of symptoms and defining coping mechanisms as an important part of the definition. The participant's definitions will be explored in this chapter.

Participant 1 defined psychoeducation as, "providing educational materials about the person's symptoms, about PTSD and then instructional material on how to cope with it." This participant has psychoeducational PTSD groups and stated "I rarely work with someone who I don't put in a group because I think that someone with PTSD needs the basic psychoeducation."

Participant 2 had a similar definition of psychoeducation but reiterated that all clients are different and made a point that psychoeducation needed to be generalized.

Definition of the symptoms of posttraumatic stress disorder: what it is? What causes it? How it affects you as time goes on. The other thing that you use in psychoeducation is basic education factors on coping mechanisms. Nothing specific to each client, but something in general as to what works. Every client is different so everyone's going to get different specifics as to what works for them.

Several of the participants agreed that psychoeducation was educating the clients on the symptomology of PTSD but each added specific elements to their definition based upon experience and personal understanding of psychoeducation Participant 3 expanded the definition by using psychoeducation to help the client put "words to feelings and behaviors that they've had for years." Participant 4 stated that psychoeducation involves the client's understanding of the symptoms but also how PTSD is effecting the client's "body and...mind." Participant 5 stated that "psychoeducation is "giving someone information but I also think you have to talk about the information and help provide opportunities, maybe to practice...coping skills...try out what they learned...." Participant 6 reiterated educating the client about the symptomology of the diagnosis, but

also incorporated skill building” such as “anxiety and depression management skills” and “putting [clients] in touch with resources”, while Participant 7 highlighted the importance of including information on medication and stress management in psychoeducation.

To teach what it is that is the disease. So with Posttraumatic Stress Disorder, I talk about, what is Posttraumatic Stress Disorder? What’s the definition? How does it affect the brain? What are the different parts of the brain? How does it work? What are we doing to treat it? Why is medication so important? How long is the patient going to be on medication?..... [S]ometimes we get the doctor to come in and explain that part of it. ....[T]alk about stress manage and how stress plays a role in PTSD.....Answer their questions about the treatment issues, and answer their questions about how long the patients going to be involved in treatment, or the family member’s going to be involved in treatment. And what are their questions about posttraumatic stress disorder and the medication and treatment. What are we doing in treatment? How long does the therapy last? What kinds of treatment are we going to offer this family member?

Several participants’ (1, 2, 5 & 6) definitions were similar to that of Lincoln, Wilhelm, & Nestoriuc (2007) definition of psychoeducation, regarding educating the client but also promoting the use and application of coping skills. The other participants (2, 4 & 7) focused on gaining a better understanding of treatment options and techniques (Barker, 2003; W. P Hornung et al, 1996). Two of the participants described psychoeducational methods they use with their clients and in groups. Both highlighted the importance of talking about the symptomology while also providing the client with an explanation and understanding of their diagnosis. The ultimate goal is for the client to leave with a better understanding of PTSD (Psychoeducation, 2006). Participant 3 stated that,

[I] mostly talk to [them]. I have given them handouts before and of course you know the web is just an amazing tool....But I generally [talk] to them about what [PTSD] is and how it has affected them..... I do still use it throughout therapy, cause you know they, we will talk about something and I will say ‘well you know what we call that, it’s hypervigilance.’ And again it sorta feels like it is a relief to

them that there is actually a name that they are not really crazy because they walk the perimeter of their house every night.....

Participant 5 works in a structured residential program and described how psychoeducation is incorporated in a variety of situations with the program.

I think that in our program and in my one on one work as well, I do a lot of teaching. To me, teaching and providing information is what I think of as psychoeducation in general. So, whether it's sitting with a Veteran one on one and pulling out the DMS IV and going through symptoms of PTSD, like all 17 of them, and talking about...different cultures of symptoms, impact of symptoms on their functioning. Or whether it is doing a group and talking about avoidance, talking about stress inoculations, which is a model of treatment that we use in the program, talking about coping skills, I think all of that falls under the umbrella of psychoeducation.

While their specific definitions varied among all of the participants, all noted that psychoeducation's purpose is to educate the client about their symptoms, coping mechanisms and to have a general understanding of their diagnosis of PTSD.

#### *Introduction to Psychoeducation*

After defining psychoeducation, participants were asked how they were first introduced to psychoeducation. All participants stated they learned about psychoeducation during their work experience, including internships and practicum. Three participants (43%) reported that they were exposed to psychoeducation through field work experience, particularly through their internship and practicum. Participant 1 stated,

During my internship, I guess, in my practicum it was over at the Gainesville Florida VA. I think my supervisors encouraged me to give chapters of books or books to patients that would help them. But formally, when I worked in the PTSD clinical team, the PTC [at] the Tuskegee VA, my supervisor there had designed a 12 week psychoeducational group to precede prolonged exposure. And so that's where I learned it.

Participant 2 explained when and why he first started incorporating psychoeducation into his therapeutic relationships with PTSD clients.

I learned it on my own working with initial clients as they were coming in. They would come in and ask me, ‘what’s wrong with me?’ And so what do you tell them? ‘You know I don’t know.’ Well I had to find out what was really going on. So that’s where you come up with what is the epidemiology of it.

Fewer participants (29%) stated that they initially learned about psychoeducation from literature or in an academic setting.

I certainly heard about [psychoeducation] in an academic setting.... through literature, seminars, and working with it..... Going to workshops and seminars.....Reading seminars, and certainly I learned about it initially at school.

Participant 7 stated that psychoeducation was introduced through “all of the above”, which included academic settings, literature and work experience.

We do a lot of searching through the literature to validate what we are doing. Looking at what’s the newest thing in literature, working with...Emory [University], we have access to actually talking with them and working with them.... When I taught for Florida State, they would call me and say ‘can you co-teach with this professor? We can’t pay you all the money’ but...you work with those professors, who are also keeping up doing [the] research.....Yes, because our professors were telling us that education and psychoeducation,....was really important.... I remember in my Bachelors degree at Florida State, them talking about psychoeducation, but also when I was an undergraduate, working in the field with people who had schizophrenia and those kinds of things.....We were using psychoeducation back then. That was like twenty-five years ago.

All of the participants utilize psychoeducation in some form and first discovered it at various phases of their career. All participants mentioned that regardless of where they first encountered or introduced psychoeducation into their practice, experience was a major factor in effectively and efficiently using psychoeducation as a treatment modality.

#### *Psychoeducation as an appropriate treatment method*

Participants were asked if psychoeducation is an appropriate treatment method for PTSD and if so, when is it appropriate to use or incorporate it into treatment. All of the

participants (100%) stated that psychoeducation was appropriate with 57% specifically stating that they use it early on in the treatment process. This was similar to the findings regarding early intervention, stating that treatment is more effective in the early stages of a diagnosis or illness (Doyle, 2005; Edwards & McGorry, 2002; Fung & Frye, 1998). Participant 5 emphasized the importance of psychoeducation by stating, I've worked as a case manager. I've worked as a psychotherapist. I've gone out and done home visits. I've worked in an office. All kinds of different roles within social work, [but] I have always tried to bring in psycho education (Creamer & Forbes, 2004; Lansverk & Kane, 1998).

Participant 6 expressed that psychoeducation was appropriate especially early on in therapy because it helps to normalize the patient's symptoms and experience (Glodich & Allen, 1998; Psychoeducation, 2006).

I think I find that psychoeducation is essentially important especially early on. Often times because unlike other disorders where people are like "I'm crazy, there is something intrinsically wrong with me," the basis of PTSD, the history of the diagnosis is actually identifying an external cause that is impacting the person's functioning in the world. And although now, later research actually identifies both, more of a diathesis in addition to the external stress. At least it was originally conceptualized as caused by an external stress and I think that that's important to help normalize PTSD with people who come in for combat [trauma]...They are doing what they are normally doing, a bad thing happens and they're not sure why they're still having symptoms. Why they are not able to function. They know they are not depressed, they know they are not anxious, they are not depressed and they don't have a history of whatever it is, but yet something is obviously wrong. So I think educating the veteran or whoever it is about PTSD, the history of it, the symptoms of it, the course of the prognosis what it is, the history of it the course or it, the prognosis, helps normalize it, helps increase the motivation and involvement in treatment.

Participant 1 stated that she incorporated psychoeducation with her clients regardless of the root cause of their trauma. When asked if psychoeducation is appropriate, she stated,

Absolutely, and why I say that?...I work with women who have experience sexually trauma in the military. I've worked with combat vets in the military. I've worked with vets who have been in airplane crashes, in car crashes during their services in the military and have various other kinds of trauma occur to them. And what I see is that because these symptoms sort of occur, the nervous systems resets itself, they're just going on and along in life and they don't even know what a symptom is. So helping them understand what PTSD is and how it occurs; Identify what symptoms are....' Oh this is a symptom? I thought I was just going crazy' or 'I just thought I was more irritable than usual. So this comes from hyperarousal? And tell me how hyperarousal occur.' So I find them very, very hungry for information and I find that giving them information in forms that they can use propels them on to learn. 'Ok, what can I do with this, how do I cope more effectively, How do I turn this symptom around?' And so engaging them cognitively, helping them to understand what's happening physiologically what has happened, what is currently happening, identifying in the moment what's happening and then oh, I have a tool box here, I have a variety of things I could work with.

She goes on to say,

When is it appropriate to use or incorporate [psychoeducation] in the treatment process with military personnel or their families? I say exactly at the beginning and I say that because I followed Judith Herman's' model of treatment and she says the first stage is safety, the second stage is working through the trauma, these are my words, and the third stage is reconnecting to the world. So the very first stage during the period of time when they're needing to build trust and establish a sense of safety within the treatment setting, I believe psychoeducation is highly effective because they don't have to do a lot of talking.... If you bring people into a process group before they've had any psychoeducation and they are just supposed to come in and talk about their problems.... the trauma sorta etches it more strongly into the neuroweb. So that you are simply reinforcing the avoidance and the upset... So, of psychoeducational group, during the 1<sup>st</sup> phase of treatment, enables veterans to become knowledgeable about what their symptoms, knowledgeable about what treatment is effective [and] what their treatment options are.

Participant 3 echoed a similar opinion of psychoeducation's value in the treatment process and also described how she incorporates psychoeducation into her sessions.

That's kind of a hard question because it just happens. Especially early on I think when a Vet first comes in. Of course, PTSD people have heard about it a little bit more than they use to, but I think there is a real relief to them when there's a name given to what's going on with them. And it also helps them lose some of their shame and embarrassment about it. You know, that military persona you know you gotta suck up and it's weak to have problems. And that kind of thing so if they can know that it's a syndrome that happens and is not in their control. In terms of what happens how someone develops PTSD is out of their control. It just happens, so I would say I use it more early on.

Two of the participants (29%) described psychoeducation as an appropriate treatment intervention, but did not specify a specific time to incorporate psychoeducation but one of the participants stated that incorporating psychoeducation varied based on the client's presentation. Participant 4 explains that she does not have a specific period in her treatment plan to incorporate psychoeducation, incorporating psychoeducation when it will be beneficial and received by the client.

I almost always use psycho ed as a piece of what I do. I think it's an important part of people understanding what's going on with them. People come in and they're just different from than how they were. And they often 'think they are going crazy' and they don't know what is going on. And so I think, you know sort of explaining that it's also a biological response is very helpful and so...When they do that and how they do that, it really really depends on the person and it depends on the pacing....The first thing I do is establishing a rapport with someone and establishing a relationship. And if someone comes in and they're really kind of frightened and not necessarily sure that they want to be there ...and they can identify the symptoms. I'll talk to them about it pretty directly, upfront in that way. And then sometimes...I just weave [psychoeducation] in therapy...

Participants in the study agreed with the literature that psychoeducation is an appropriate intervention method in the treatment of PTSD (Allen, 2001; Bertrando, 2006; Gray, Elhai & Freuh, 2004; Psychoeducation, 2006). Participant 7 confirmed her position by stating,

Psychoeducation is very appropriate. I think if you don't do it you are not doing your patients any kind of good treatment because the stress management skills...are extremely important in psycho education...If you're working with

PTSD and you look at any kind of book that teaches PTSD, it teaches about PTSD, it's gonna teach psycho educational things.

*Psychoeducation as a treatment method with individuals and families*

The researcher asked a series of questions regarding psychoeducation in conjunction with another treatment method and as a stand-alone entity. The researcher also inquired if the participants used psychoeducation with all clients, specifically individuals and groups. Lastly, the researcher asked participants if they felt that psychoeducation was more effective in either method or with a particular group. From this research, it was discovered that all the participants incorporated psychoeducation into their treatment with another therapy but that three participants also used it as a stand-alone entity with their clients. The participants who used psychoeducation as a stand-alone entity mainly use it during groups and case management.

Participant 1 stated that she uses psychoeducation in conjunction with other types of treatment. She also mentioned that she does have psychoeducation groups and explained the type of client that would attend those particular groups.

That one is easy. There is a group I'll do, beginning psychoeducational group at the hospital where some women Veterans in the CWT, which is the work therapy program, who can't really get off for any intensive work. Can't take off two times a week and come to individual and come to group treatment. So their social worker, who's in charge of their case, sends them to my group. And so all they receive is my group and that is it. So it is not a choice of this person will only benefit from my group. Bottom line, these women come in and they're homeless and enter into a program and they need treatment and I provide them... I rarely work with someone who I don't put in a group because I think that someone with PTSD needs the basic psychoeducation. So people will start in group and they may go through the groups several times and ask me to put them on a waiting list for individuals. Then they will start working in individual and group and then they just sorta stay with me and move through doing the prolonged exposure and then move to my advanced group which is the reconnect with world group.

Participant 7 also described her experience with incorporating psychoeducation in her therapy.

I incorporate psycho education into every single group that I run... I do psychoeducation stand alone with pretty much every single patient that I work with. Even when I am doing intensive therapy... Actually I probably do two to three sessions of psychoeducation... Because you got to have them get to know you and have them get to trust you and you can use the psychoeducation stuff in that aspect...Yes, I do some of what we call case management and so I use psychoeducation with them and you want to stabilize them. And if you find that you can't do intensive therapy with them, then you are just going to do the psychoeducation/case management...For case management to stabilize them, I probably would run 8 sessions.

In contrast, three of the participants stated that they do not use psychoeducation as a stand-alone entity but two provided very distinct reasons as to why. Participant 2 stated that he never used psychoeducation as a stand-alone entity and went on to say, "Unless that person only comes for one session and then that's all you get to. Ok...then, this is what I see as your problem or this ... is not your problem and we're done." He acknowledged that sometimes his clients will only come for one session, which is the psychoeducational class, and never come back. He stated that would be the one time someone would only receive psychoeducation. Participant 5 attributed not using psychoeducation as a stand-alone entity on her program structure. She works in an inpatient PTSD program. She stated that she does not use psychoeducation, "partly because of the program structure in which I work. It is a component of the treatment that we provide."

All participants agreed that they use psychoeducation during individual and family therapy. Of the responses, 57% felt that using psychoeducation was equally effective with individuals and families, while 14% felt it was more effective with

individuals. Two participants did not specifically answer the question or were unsure how to answer the question. Participant 3 felt that psychoeducation was equally effective, stating such reasons as, “I think both [individuals and families can benefit]. It just depends on what the couple is bringing into the sessions versus the individual. So I don’t know that there is one more beneficial than the other.” Participant 6 stated that psychoeducation, “...normalizes the behavior for whoever has already preconceived notions of what PTSD is. I think it can be equally effective for either the individual or family...”

Participant 5 provided an example of her group members sharing psychoeducation with their family members.

I think a cool thing that happens is that a lot times when the individual receives the psychoeducation they take it home to their family...I had one guy who was very excited to bring home some information to talk about with his adult children. Or once in a while you get someone who really wants to talk to a spouse or significant other about what information on PTSD they’re learning.

Participant 7 discussed why she felt psychoeducation is effective with individuals and families.

Absolutely! I use psychoeducational stuff for family. It’s so so important. If you can get them, family members, in here and do psychoeducation with them, it’s just incredible...I think it’s equally effective [with individuals and family members]. I just think that psychoeducation for people is just...to me, my favorite saying is ‘knowledge is power’. And once you have that information in your brain, you’re going to take it with you your whole life. You can’t un-teach that. And so I always tell my patients, knowledge is power once you’ve got it. And families, they’re the same way, they can’t undo knowing that. So, they’re going to remember that even if they choose to misbehave. Or even if they choose to get angry, they’ve got the stress management technique in their brain. And they’re going to know that and they come back and they say to me, Ms. [X], you know what, ‘I wanted to get angry, I wanted to misbehave but I remember what you taught me’.

Participant 2, felt psychoeducation benefited the individual more than the family member, and based his answer on the fact that psychoeducation allows the individual to start making sense of his diagnosis.

It is more effective with the individual than it is with the family because usually the family, especially the wife, or the husband whatever the case knows that something is wrong and they usually done a little research ahead of time. It is usually the veteran himself that has not gotten into in. So he is the one that benefits the most because now you know it is there and it's something that I know is what's causing all my problems.

*The most effective treatment method incorporating psychoeducation*

The literature and feedback from the participants has determined that psychoeducation is a viable treatment options. Many of the participants stated that they used psychoeducation in conjunction with another model. While the responses varied, 86% stated that they did not feel one type of program or therapy was more effective than another, or that they used a variety of treatment options. The participants also shared which programs and theory orientations they preferred to use and which ones they felt were less effective. Only one participant felt that CBT was more effective than other types of treatment. The participants also expressed their reasoning as to the variety of methods they felt were effective and also expressed their preferred treatment modality. The participants listed several reasons for their treatment preference, which included familiarity, training or specific to a program guide. Their cited treatment modalities included, CBT, EMDR, Prolonged Exposure (PE), psychodynamic therapy and systems theory.

Several of the participants stated that one method was not more effective than the other but listed several rationales for this occurrence. Participant 6 felt that all treatment

modalities are “effective and equally important.” She goes on to say that “true success with a client with PTSD has to have some type of psychoeducation and some sort of skill building and some sort of exposure.” Participant 1 felt that CBT was less effective. She stated that,

I think that CBT is, standing alone is less effective depending on the practitioner. When I see people who come out of programs where that’s all they used, they’re missing the empathic connection.... So in that case I don’t see CBT even though I do CBT in my groups. But people with PTSD have really sharp bullshit antennas. If you don’t know what you are doing they are really quick to pick that up. I don’t see that being particularly effective.

Participant 4 stated,

I don’t think one thing works with [every] person. I think it really depends on where they are in the process. I think it depends on the person, I think it depends on the stage of treatment. I use a lot of different things. Just like Smith [College] teaches you, you start where the client is. For me too, it is a constant and that’s what I do. That’s why I might weave the psycho ed in and out of treatment.

She also stated that she preferred to use psychodynamic therapy and supportive therapy. She explained that, “I always think of psychoanalytic terms in terms of what’s going on with that person and I try to figure out what I think would be most helpful for them in that moment based on that.”

Participant 5 explained that her theory preference is from the program structure she utilizes and feels that psychoeducation works well with all treatment modalities.

We do use full stress inoculation, which is a model based in CBT but also has an exposure component...the cool thing about using that model is that you provide a lot of information in the model, but you also provide a lot of information/psychoeducation about the model. So basically, the Veterans become really aware about the treatment that they’re participating in...Psychoeducation combined with CBT combined with the exposure piece is what we do... In our individual work, our therapists are psychodynamically trained....It is really great with the exposure model and the CBT. Then again I also like to bring it into my individual work too. It is hard to say for me which is more or less effective.... I

guess I can say that I haven't noticed that any treatment modality doesn't work well with psychoeducation.

Participant 7 expressed that regardless of the method, "I think in five years from now..... psychoeducation will be included with all those modalities."

When asked, is there one modality that you feel is more effective with psychoeducation, Participant 3 stated, "In terms of the therapy I use I don't know that any one method is any better than the other." When asked why she preferred to use systems theory as she outlined in her demographic questionnaire, she stated,

I just believe in it....To me, it's really a framework. It's a way to view what is going on in a person's life. Taking into account all aspects, whether its relationships, current relationships, his family of origin, socioeconomic background that he grew up in and where he is now, his church, or lack of church. Just all of that impacts on how he is in the world today. And it certainly impacts, I think that has an impact on how he has managed his PTSD through the years and how he's managing it now. So it's really a framework or a model that just makes sense for me.

Only one participant felt that Cognitive Behavioral Therapy (CBT) was more effective than other treatment modalities (Auglia et al, 2007; Cooper & Lesser, 2005; Russell, Silver, Rogers, and Darnell, 2007). He began by giving his definition of CBT.

You take a person's belief system as it exists and you show them different factors as to how they can change that belief system to make it more appropriate for them. What I use is psychoeducation and then I look at the belief systems and behavioral patterns of each individual and use the CBT for that. It's an individual basis; it's not anything you can put in the book as to step 1, 2, 3, 4, 5.

He goes on to say,

Compared to other treatment, I think it's more effective than other forms of treatment like EMDR, or any other concepts they come with, exposure theory. A lot of people like exposure therapy. The problem you have with exposure therapy, it works extremely well with one trauma. How do you do it when you have someone who has 365 days of different traumas? How do you use it with someone that started out with a traumatic childhood that carries on through into military and where they are retraumatized over and over. Same thing with

EMDR. EMDR works well with one specific trauma that you are dealing with. If there's more traumas in there, you're going to have to go on and on and on and on.

From the responses obtained from this study, psychoeducation is effective with a variety of treatment modalities. Only one participant felt that CBT was the most effective treatment modality when incorporating psychoeducation.

### *Outcomes Using Psychoeducation*

All participants identified themselves as clinicians who use psychoeducation in the treatment of PTSD. This researcher investigated patient outcomes using psychoeducation based upon the participant's testimonials and tried to determine how participants measured the effectiveness of their use of psychoeducation. A commonality amongst participants (100%) was that symptom reduction and a better understanding of PTSD symptoms by the patient, is a major indicator of success with psychoeducation. Participant 5 described the reaction of her client after discovering his symptomology and behavior was a direct correlation to his diagnosis of PTSD. She stated,

I did a group a couple weeks ago in our program on the symptoms of PTSD. We went through the symptoms and talked about how they were actually very adaptive during these experiences of trauma. And we just went through them all as components of PTSD. One of the guys in the group said, 'Wow, I've been clean and sober for about 5 years now, but this is the first day in those 5 years that I realized that I am not crazy because I thought this was all just me'. In terms of outcome, I think when you have moments like that for people to realize that they didn't know what PTSD was or how it really impacted their relationships. It's an anecdote, but to me that's a pretty awesome outcome. So, I think given that we're in a residential program and we see our Veterans a lot over the three months that they're with us, but then not a lot afterwards. It's hard to really provide information on long-term outcomes. But we do see a lot of improvement in terms of just general functioning, willingness to kind of get back out in the world, use coping skills, and get back to work, I mean things like that. A lot of it is sort of experiential I guess, anecdotal and observational.

Several of the participants (71%) did not use formal measures or scales to evaluate the effectiveness of their intervention with psychoeducation. Many used qualitative assessments such as symptom reduction, observations and verbal feedback, to determine the success of their outcome. Participant 4 used the client's observable actions to gauge the success of psychoeducation.

I don't measure it quantitatively. I measure it qualitatively by people's response and if they say it's helpful and literally seeing changes in them...The outcome is that it normalizes things...the body's reaction to an abnormal circumstance. I think it puts people more at ease. I think when they have an understanding their body seems to start to take on like its own thought processes take a lot less effect. So the process is normalizing, eases and causes them to feel less anxious. The outcome is ...it makes people a little less anxious. Measured as you watch their bodies relax and get at ease, what they say, how they respond, if they ask questions and what they report to you.

Participant 3 illustrated how many clinicians, particularly social workers, do not always utilize effective measurement tools. She stated,

That's a good question because you know in general social workers have not been real good about measuring effectiveness. And I remember that being pounded into us at graduate school, about the importance of that. It would be a totally subjective way for me to [gauge]...whether a person's anxiety is reduced because of ..... feedback from the client...If I say something like, 'that's what we call hypervigilance and then they respond back to me with some more questions about it. Or if they go home and look it up on the internet. Or take a [handout] and read it and come back and talk to me the next week about it. To me, the fact that they would talk to me about it more, says that it's meaning something that it's helping.

Two of the seven participants (29%) used written or formal evaluation methods to determine the effectiveness of their treatment. One used a "check-in sheet which is a self-report measure" while the other used questionnaires, comment cards and Clinician-Administered PTSD Scale (CAPS). They mentioned that from the reported data, their clients showed that "nightmares have decreased", patients are enjoying a "better quality of life" and their "family is doing better."

While the participants used several different methods and tools to determine the effectiveness of their treatment outcomes using psychoeducation, the consensus is that incorporating psychoeducation in their treatment modality is an effective intervention method.

### *Early Intervention*

According to the research, early intervention is an effective method in the treatment and/or prevention of PTSD and has been effective in reducing the severity of PTSD (Busko, 2007). Early intervention timeframes vary but has been defined as immediately, within 3 to 10 days to the first few weeks of the trauma (Psychotherapy, 2007). Participants were asked their definition of psychoeducation and if they felt early intervention was effective. The reactions were mixed with several varieties on the definition of early intervention and its timeframe. One of the participants stated that early intervention should be “immediately”, while the others gave varied time frames. Only one participant stated that her lack of experience with early intervention prevented her from answering the question fully.

Two participants stated that early intervention is “education and treatment immediately after the trauma” and it should be “as early as it happens”. Participant 2 goes on to say,

Anytime after that [immediately] is not early...Right as soon as I go out on a mission I get into a firefight and I come back in and fine bam, there is a psychologist, Army, Marine, whatever, right there. ‘Okay, let’s process and find out what happen.’ Anything after that is not early...

The majority of the participants (86%) stated that early intervention was not immediately but a period of time after the trauma. Participant 1 stated that,

Early intervention I believe is like...what they started to do at a 90 day post deployment health reassessment. At that point people are going, 'huhm, my family is telling me there's something wrong. I'm beginning to see that this is out of proportion or there might be something wrong.' So the early intervention to me is a when the Veteran or patient realizes 'ok I do have a problem' and then providing them, 'ok here is what you can do about it.'

Participant 6 stated that,

Unfortunately, I only know what the literature says. I haven't done a lot of crisis intervention, which is where I think that research comes from. And I've heard mixed results of the crisis intervention research in the sense that it often can be useful, but it often, I think the problem is that with a rape victim or a combat Vet comes back from combat immediately. So you say, "oh you went through this PTSD thing", their brain is not able to take in the information. And so I think just providing immediate psychoeducation skills or training, it's just not going to be effective. It just has to be maybe, immediate but it also has to be a little more maintenance...but maybe a couple days, weeks, months later, because we know, just that in terms of what PTSD does in the nature of trauma, and how it affects the brain, you have to wait for some of the psychoautonomic systems and physiological symptoms kind of return relative to base line so that they can process the information and take it in.

Early intervention was also defined as "quick intervention once they have the diagnosis", "providing information after being diagnosed" and "as early as it happens."

Many of the participants felt that early intervention included treatment after an individual has been diagnosed. Another participant stated that, "I believe early intervention in general is critical. I think it's really about being there with somebody."

While the participants did not agree on the timeframe for early intervention, all but one stated that it had positive outcomes with PTSD. One participant did not comment but stated that "providing information after being diagnosed is helpful."

#### *Factors that Effect Treatment Outcomes*

Participants were asked if they felt that race, gender, ethnicity or class affected the treatment outcomes using psychoeducation. An overwhelming number of the

participants (86%) felt that race, gender, ethnicity or class had no effect on treatment outcomes with psychoeducation. Participant 3 stated,

I don't think so...you know certainly those issues, ethnicity and race and all that comes into play just in a therapy session and the therapy relationship. But whether or not it, I can't think that I've used it differently, maybe I have unconsciously used it differently depending on race or that kind of thing but I don't know that I have.

Participant 2 stated that the “symptoms and the epidemiology of PTSD is the same regardless of what your race [or] ethnicity.”

Participant 5 listed educational barriers diagnosis as reasons for psychoeducation not to be effective, as opposed to race or ethnicity.

I guess the safe answer I'd say I don't know. I try to take sociocultural factors into consideration sort of on an as needed basis...particularly around the issues of literacy...I get a lot of Veterans who are like in their 50s and 60s and who have worked with their hands, physical kind of labor through most of their life and don't think of themselves as very smart. And they say I can't understand all that or can you define these words. So I guess I consider it in terms of literacy and ability in that respect. I have not noticed necessarily any other differences.

Participant 6 talked about the effect that support systems have on the outcome of psychoeducation as opposed to race or ethnicity.

I haven't specifically noticed, I do think [the client]...benefits more from CBT skills regardless if they are more verbal or some are more educated people. I think that that does help, for better for worse. But then those people also have a buffer. They are probably less affected by the disorder to begin with. They probably have a better support system because I have not found anything else in terms of ethnicity or class other than education.

Participant 7 stated “yes”, explaining that “I think how you present makes a difference”. She went on to say,

You have to notice whether your patients or your family members understand what you are saying. What I pay attention to is how they're teaching [psychoeducation] because you have to teach at an 8<sup>th</sup> grade level...especially our Vietnam Vets. You have to be careful when you're working with those folks

because they were drafted into the military and they may not have the education. So what you have to do is pay attention to them and their family members and you have to make sure when you give out handouts that they are good handouts but they are simple handouts, in the sense of being easy to understand. So that they can pull them back and look at them.

The participants did not notice that race, gender, ethnicity or class had any bearing on the effectiveness of psychoeducation. Several highlighted educational barriers, which could affect psychoeducation outcomes.

## CHAPTER V

### DISCUSSION

The purpose of this study was to explore whether psychoeducation is an appropriate intervention method in the treatment of PTSD and if used, when is it appropriate. Secondly, the researcher sought an understanding of the outcomes in using psychoeducation as a form of treatment for PTSD with individual military personnel and/or their family member; and how do you measure the effectiveness of this intervention? Findings support the researcher's initial assumption that psychoeducation is an effective treatment method.

#### *Review of the Findings*

In defining psychoeducation, definitions varied among all of the participants. All noted that psychoeducation's purpose is to educate the client about their symptoms, coping mechanisms and have a general understanding of their diagnosis of PTSD. All the participants utilize psychoeducation in some form or another and first discovered it at various phases of their career. All participants mentioned that regardless of where they first encountered or introduced psychoeducation into their practice, experience was a major factor in effectively and efficiently using psychoeducation as a treatment modality. From the research, it was discovered that all the participants incorporated psychoeducation into their treatment with another therapy but also some of the participants used it as a stand-alone entity with their clients. The participants that used

psychoeducation as a stand-alone entity mainly use it during groups and case management. The majority of the participants responded that no one type of program or therapy was more effective than another, or that they used a variety of treatment options. While the participants used several different methods and tools to determine the effectiveness of their treatment outcomes using psychoeducation, the consensus is that incorporating psychoeducation in their treatment modality is an effective intervention method. Participants also were asked about their definition of early intervention and if it was effective. All participants felt that psychoeducation or education after an incident or diagnosis is useful. The participants did not notice that race, gender, ethnicity or class had much bearing on the effectiveness of psychoeducation. Several highlighted educational barriers, which could affect psychoeducation outcomes. The researcher had one major assumption that psychoeducation is an effective stand-alone treatment method but may be more effective when used in conjunction with another treatment method. Findings from this study support existing literature on the relevance and importance of psychoeducation, further emphasizing its applicability and uses. Psychoeducation appears to be a worthwhile method of intervention to be used in the treatment of PTSD and that its usage has positive outcomes on the patient's understanding of the disorder.

#### *Recommendations for Future Research*

This exploratory study looks at the effectiveness of psychoeducation as a treatment method of PTSD with military personnel and their family members from a clinician's perspective. The data gathered can be the basis for a larger scaled study incorporating more participants to develop a generalized consensus of the effectiveness of psychoeducation and PTSD. This research can also be expanded by incorporating

interviews and experiences of actual clients and family members. The study should do more than probe whether psychoeducation is effective, but delineate the specific factors of why psychoeducation is effective and with which treatment methods or population groups.

It is also important to do further research on which treatment modalities are more or less effective with psychoeducation. As more and more of our military members and Soldiers return from war diagnosed with or suffering from PTSD like symptoms, it would be beneficial, financial and educational, to train clinicians on the best practices for the treatment of PTSD.

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APPENDIX A

HUMAN SUBJECTS REVIEW LETTER OF APPROVAL

December 27, 2007

Mary Fisher

Dear Mary,

Your revised materials have been reviewed and you did a fine job. All is now in order and we are glad to give final approval to this very interesting study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain signed consent documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. I hope you get a good response from your recruitment efforts!

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Narviar Calloway, Research Advisor

APPENDIX B

RECRUITMENT FLYER

Attention Counselors & Clinicians

**DO YOU HAVE EXPERIENCE  
WORKING WITH  
POSTTRAUMATIC STRESS  
DISORDER (PTSD)?**

Smith College School of Social Work student seeks clinicians to participate in a study on the use of psychoeducation as a treatment method for PTSD

**This study seeks to evaluate the role and effectiveness of psychoeducation in the treatment of military personnel clients diagnosed with PTSD**

To participate, clinician must have

- Licensure
- 5 years of practice in their discipline/field
- Work with PTSD and military personnel (Active Duty, veterans, Dependents)

Participation includes a 60-120 minute interview with study investigator. There is no financial compensation for participation. However, participation allows you to share your knowledge and experience in the advancement of therapeutic intervention and methods for the treatment of PTSD.

## APPENDIX C

### INFORMED CONSENT

Dear Potential Research Participant,

My name is Mary E Fisher and I am a graduate student at the Smith College School for Social Work in Northampton, Massachusetts. I am conducting a study exploring the use of psychoeducation in the treatment of Posttraumatic Stress Disorder (PTSD) for military personnel and their family members. Your participation is important in understanding the effectiveness of psychoeducation in the treatment of PTSD in conjunction with other treatment modalities or as a stand-alone intervention. This study is being conducted in partial fulfillment of the Masters of Social Work degree at Smith College School for Social Work and for possible presentation and publication.

You are being asked to participate in this study as a clinician directly working with the military personnel diagnosed with PTSD and their family members. You will be asked to participate in an interview conducted via telephone or in person, which should be completed within 1-2 hours. The questions will focus on your use of psychoeducation in treatment, observed results and strengths and/or weaknesses of the treatment.

There will be no financial compensation for your participation in this study. However, your participation allows you to share your knowledge and experience in the advancement of therapeutic intervention and methods for PTSD treatment. Your contribution will be added to the body of literature that supports the treatment of PTSD specific to members of the military and their dependents. Coding and securing methods will be utilized to protect confidentiality.

Your cooperation is completely voluntary and you have the right to withdraw from the study. You can withdraw from the study before, during or after the interview until 15 April 2008, when the report will be compiled. If you decide to withdraw from the study, all data and information collected pertaining to you will be exempt from the study.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

**IF YOU HAVE ANY QUESTIONS OR WISH TO WITHDRAW FORM THE STUDY, PLEASE CONTACT:**

Mary E. Fisher  
Researcher  
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Signature

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Date

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Contact Information

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

*Please provide the following information as part of your participation in the study.*

Participant's name: \_\_\_\_\_

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

Racial Identity: What is your race? \_\_\_\_\_

Ethnic Identity: What is your ethnic background? \_\_\_\_\_

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

Clinical Degree (circle one) MSW      MFT    Psychologist    Psychiatrist    Other: \_\_\_\_\_

Agency Setting: Private practice (    ) Public setting (    )

Name of agency (if applicable): \_\_\_\_\_

Number of years working with Posttraumatic Stress Disorder (PTSD): \_\_\_\_\_

Course work/training related to PTSD: \_\_\_\_\_

Patient Type (circle all that apply)      Military (AD, Veterans) Family      Other:

Theoretical/Clinical Orientation: \_\_\_\_\_

*Please describe your adult client caseload in terms of the past calendar year (2007)*

1.      Approximately how many clients did/do you work with? \_\_\_\_\_
2.      Approximately how many clients did you see with PTSD? \_\_\_\_\_
3.      How many PTSD patients did you work with in individual counseling? \_\_\_\_  
            Family counseling? \_\_\_\_\_
4.      What is the average length of time you worked with patients diagnosed with PTSD?
5.      How many patients use psychoeducation in conjunction other treatment methods?
6.      How many patients use psychoeducation as a stand-alone entity?

## APPENDIX E

### INTERVIEW QUESTIONS

#### Root Questions:

1. Is psychoeducation an appropriate intervention method in the treatment of PTSD? If so, when is it appropriate to use or incorporate psychoeducation in the treatment process with military personnel and/or their family members?
2. What have been the outcomes in using psychoeducation as a form of treatment for PTSD with individual military personnel and/or their family members? How do you measure the effectiveness of this intervention?

#### Stem Questions:

1. You have identified yourself as a clinician who uses psychoeducation in the treatment of Posttraumatic Stress Disorder (PTSD). Please define psychoeducation in your own words.
2. How did you learn about psychoeducation (through literature, experience at the worksite, academic settings etc.)?
3. When were you first exposed to psychoeducation (agency, school, workshop, etc.)?
4. How long have you used psychoeducation as a treatment technique for PTSD?
5. Do you use psychoeducation in conjunction with other treatment alternatives, or as a stand-alone entity?
6. Do you use psychoeducation during individual and/or family sessions? If used in both, is the treatment technique more effective in one over the other?
  - 6a. Please give specific examples?
7. From your personal experience, if psychoeducation is used in conjunction with another treatment method, which method(s) have you found more or less useful in the treatment of PTSD? (i.e. Cognitive Behavioral Treatment, Family therapy, individual counseling etc.)
8. From your personal experience and opinion, has race, gender, ethnicity or class affected the treatment outcomes using psychoeducation?
  - 8a. If yes, can you give examples?

9. According to the research literature, early intervention using psychoeducation is most effective. For this study, early intervention is defined as immediate action following the onset or diagnosis in order to prevent more damage or harm. What is your definition of early intervention? Do you find this to be the case in your experience or practice?
  - 9a. If yes, can you give examples?
10. Is there anything else you would like to share, clarify or expound upon that was discussed earlier in the interview, or excluded?