The BE SMART Trauma Reframing Psychoeducation Program

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Despite the human capacity to survive and adapt, traumatic experiences can cause alterations in health, attitudes and behaviors, environmental and interpersonal functioning, and spiritual balance such that the memory of an event or a set of events taints all other experiences. The BE SMART (Become Empowered: Symptom Management for Abuse and Recovery from Trauma) group psychoeducation program is a 12-week course designed for both men and women to learn wellness coping principles in recovering from the aftermaths of trauma and abuse. The course is based on the Murphy–Moller Wellness Model [Murphy, M. F., & Moller, M. D. (1996). *The Three R's Program: A Wellness Approach to Rehabilitation of Neurobiological Disorders. The International Journal of Psychiatric Nursing Research*, 3(1), 308–317] and the Trauma Reframing Therapy [Rice, M. J., & Moller, M. D. (2003). *Wellness Outcomes of Trauma Psychoeducation.* Podium presentation at the 2003 Meeting of the American Psychiatric Nurses Association. Atlanta, Georgia. October].
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DESPITE THE HUMAN capacity to survive and adapt, traumatic experiences can cause alterations in health, attitudes and behaviors, environmental and interpersonal functioning, and spiritual balance such that the memory of an event or a set of events taints all other experiences. Unresolved trauma can generate feelings of helplessness, hopelessness, and entrapment. When the emotional devastation created by traumatic wounds is not healed, psychiatric disabilities such as posttraumatic stress disorder (PTSD), borderline personality disorder, dissociative identity disorder (DID), substance abuse, anxiety disorders, mood disorders, eating disorders, and psychotic disorders can develop (Evans & Sullivan, 1995; Goodman et al., 1999; Gunderson & Chu, 1993; Hryvniak & Rosse, 1989; Mazzeo & Espelage, 2002; McLean & Gallop, 2003; Read & Ross, 2003). These disorders can be collectively referred to as trauma-related disorders.

Consequences of unresolved trauma may result in a negative impact on adult cognitive functioning (van der Kolk, McFarlane, & Weisaeth, 1996), creating a myriad of problems, including difficulty with relationships, inability to sustain employment, and problems in parenting. The accompanying physiological changes (Bonne et al., 2001; Bremner, 1999; Damasio, 1999; Sapolsky, 2002) contribute to medical comorbidity and affect the ability to complete activities of daily living (Famularo, Fenton, Kinscherff, & Augustyn, 1996; Heitkemper et al., 2001). In addition, the presence of trauma has been shown to complicate and exacerbate both emergent and chronic psychiatric symptoms (den Herder & Redner, 1991; Ross, 2000).

Psychotherapeutic treatments such as exposure therapy (Foa & Kozak, 1986; Paunovic, 2003), cognitive–behavioral therapy (Bisson, Shepherd, Joy, Probert, & Newcombe, 2004; Harvey, Bryant, & Tarrier, 2003), group therapy (Barlow, 2001; Morgan & Cummings, 1999; Wolfsdorf & Zlotnick, 2001), eye movement desensitization repatterning (Smith, 2003; Wilson, Becker, &

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Tinker, 1997), and dialectical behavioral therapy (Lanius & Tuhan, 2003) have been investigated and found to be helpful in promoting various levels of recovery from selected target symptoms of trauma-related disorders. None of the existing research demonstrates therapeutic interventions related to recovery from trauma and abuse with a targeted effect on levels of wellness.

DEVELOPMENT OF THE BE SMART TRAUMA RECOVERY PROGRAM

A psychoeducational model specific to coping with the aftermaths of trauma and abuse was developed in recognition of the role of bio-psycho-social-spiritual processes in promoting recovery and subsequent health outcomes. In 1999, a pilot group psychoeducational group program based on the Three R's Psychiatric Wellness Rehabilitation Program (Moller & Murphy, 1997; Murphy & Moller, 1996) was conducted in two independent nurse-managed outpatient clinics. The goal of the pilot program was to develop a curriculum that would specifically address interventions to promote wellness for those living with the aftermaths of trauma and abuse. The original sample involved 16 women, 10 in one site and 6 in another, ranging in age from 21 to 48 years. The pilot curriculum, initially scheduled to be developed within 8 biweekly sessions, actually took 18 months to be developed. The final 12-session curriculum and participant workbook was finished in 2001. The course was named Become Empowered: Symptom Management for Abuse and Recovery from Trauma and is referred to as BE SMART (Moller & Murphy, 2001). Males with trauma-related disorders were invited to participate upon completion of the workbook and with recommendations from women who knew men who were also victims. Similar to the findings of Nicholas and Forrester (1999), the inclusion of men helped diffuse generalized resentments by the women as they realized that men could suffer similar kinds of abuse that they do (Nicholas & Forrester, 1999). The term "ordinary heroes" was coined by one participant to describe efforts to maintain wellness, practice symptom management, and prevent relapse.

BE SMART is currently being implemented in both inpatient and outpatient group settings as well as during one-on-one therapy sessions and has been incorporated into the overall treatment program as part of a therapeutic process identified as Trauma Reframing Therapy (TRT). The TRT is based on the use of counterintuitive cognitive processes to facilitate attainment of self-directed wholeness (Rice & Moller, 2003). A facilitator training program model of the TRT and the BE SMART process was developed and initiated in 2002.

THE TRT

The term "cognitive processes" refers to the information processing systems (IPSs) that develop as individuals mature and learn how to succeed in the world. IPSs result from complex interactions between genetics and the environment, resulting in neural pathways that can short circuit. The neurochemistry of fear creates brain damage in structures vital for emotional processing such as the amygdala and hippocampus (Damasio, 1999; van der Kolk, 1996). In normal situations, these IPSs inform a person that the world is safe and that success in life will occur and desired life goals will be achieved if specified instructions given by adults are followed. IPSs operate differently in persons with trauma-related experiences.

Trauma-based IPSs are shaped as a result of struggling to stay alive and survive potentially life-threatening experiences. With few exceptions, individuals with PTSD, DID, and personality disorders develop their IPSs based on the intuitive need to survive. Their cognitive processes are formed on the belief that life is based on survival of the fittest. As a consequence, individuals with trauma-associated disorders experience the world in a *me* view as opposed to a *we* view.

Individuals with a *me* view see all life events having negative direct consequences on them and have a limited ability to establish safe boundaries

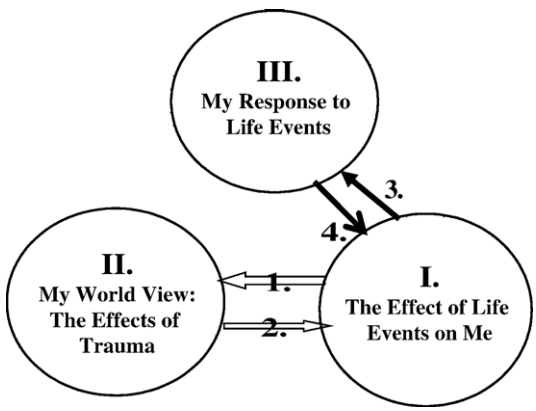

Fig 1. The PTSD view of the world—*Me*.

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