Wellness Outcomes of Trauma Psychoeducation

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A program evaluation study was conducted to determine if a group psychoeducation course would improve wellness scores in subjects with trauma-related disorders. The sample consisted of 10 men age 20–65 years and 44 women age 20–66 years. Levels of wellness were evaluated using the Wellness Assessment Tool [*International Journal of Psychiatric Nursing Research, 3*(1) (1996), 308–317] that evaluates 10 wellness items in each of the four domains: health, attitudes/behavior, environment/relationship, and spirituality. Paired sample correlations showed statistically significant correlations among 37 of the 50 pairs, ranging from .524 in the health scores to .830 in spirituality. The paired *t* tests also showed significant differences at *P* = .05 in each of the wellness domains. Subjects felt an improvement in overall health, a decrease in interpersonal conflict, a stronger sense of spirituality, and improvement in environmental control and interpersonal relationships.

PART 1 OF this two-part series described the conceptual framework and program components of the mixed-sex group psychoeducational program entitled Become Empowered: Symptom Management for Abuse and Recovery From Trauma (BE SMART) (Moller & Murphy, 2001). This article describes a 3-year program evaluation study of the BE SMART program focusing on wellness outcomes using the Wellness Assessment Test (WAT) originally developed as part of the Three R's Psychiatric Wellness Rehabilitation Program (Moller & Murphy, 1997; Murphy & Moller, 1996).

Traumatic psychological wounds often result in psychiatric disorders such as posttrraumatic stress disorder (PTSD), borderline personality disorder (BPD), dissociative identity disorder (DID), substance abuse, anxiety disorders, mood disorders, eating disorders, and psychotic disorders (Evans & Sullivan, 1995; Goodman et al., 1999; Gunderson & Chu, 1993; Hryvniak & Rosse, 1989; Mazzeo & Espelage, 2002; McLean & Gallop, 2003; Read & Ross, 2003). Psychological trauma can also result in a loss of cognitive functioning (van der Kolk, McFarlane, & Weisaeth, 1996), creating difficulty in relationships, unemployment, and poor parenting skills. Additionally, the presence of trauma has been shown to complicate and exacerbate both emergent and chronic psychiatric symptoms (Ross, 2000). As described in Part 1, a variety of psychiatric treatments have been found to be helpful in promoting recovery from trauma-related disorders. Yet none of the existing research demonstrates interventions associated with recovery from trauma and abuse targeting overall wellness.

BE SMART is currently being implemented in both inpatient and outpatient group settings as well as during one-on-one therapy sessions. The BE SMART group psychoeducational model has been incorporated into the total treatment program at a nurse-managed outpatient psychiatric clinic as part of a therapeutic process identified as trauma reframing therapy (TRT). TRT is based on the

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use of counterintuitive cognitive processes to facilitate attainment of self-directed wholeness (Rice & Moller, 2003). Only anecdotal data are available on the effectiveness of the TRT model.

RESEARCH QUESTIONS

This evaluative study was designed to answer four research questions:

1. Is there a significant difference in WAT scores in subjects with trauma-related disorders before and after completion of the BE SMART psychoeducation program?
2. Is there a significant relationship between the four components of wellness in subjects with trauma-related disorders?
3. Are there significant differences in WAT scores between male and female subjects with trauma-related disorders?
4. Are there significant differences in WAT scores in subjects with trauma-related disorders older than 40 years compared with subjects younger than 40 years?

METHODS

Sample

The evaluation of the BE SMART program was undertaken using a pretest/posttest interrupted time series survey design. The subjects met in classes on Monday evenings from 6:30 to 9:30 p.m. using the 12-session BE SMART curriculum over 12 weeks. Data were collected from all voluntary participants over seven consecutive classes held between 2001 and 2004 at Weeks 2 and 12. All participants, whether they consented to participate in the study, were encouraged to evaluate their own progress using the survey assessment measures as part of the established curriculum. Consistent with the philosophy of empowerment, participants were encouraged to conduct a self-evaluation of their wellness and participate in the evaluation of the course impact on wellness only if they consented to have their responses used to evaluate the program. All classes were taught by one advanced practice psychiatric nurse and a psychiatric nurse practitioner graduate student.

The convenience sample consisted of subjects who voluntarily attended a 12-session, 36-hour course between 2001 and 2004. Class participants were recruited with flyers distributed throughout mental health clinics, hospitals, and outpatient settings in the Inland Northwest. The flyers offered a chance to participate in a 12-week course focusing on recovery from trauma based on principles of wellness and to participate in an evaluation of the course. All subjects who participated in the evaluation of the program were required to meet the following inclusion criteria:

1. at least 18 years;
2. can read and write English;
3. be actively involved in outpatient psychiatric treatment and have the approval of their primary provider to participate regardless of the primary psychiatric treatment model;
4. attend 9 of the 12 weeks of the course;
5. attend Weeks 2 and 12 when self-assessments wellness were conducted;
6. voluntarily consent to complete the questionnaires; and
7. voluntarily consent and submit their responses to be used for evaluation of the program.

Wellness Measures

The participant levels of wellness were evaluated using the WAT (Murphy & Moller, 1996). The WAT evaluates 10 components in each of the four wellness domains of health, attitudes/behavior, environment/interpersonal relationships, and spirituality. The WAT (Table 1) is a patient self-rating that evaluates attainment of wellness tasks on a percentage of time basis using the following scale: 1 = 0–25%; 2 = 26–50%; 3 = 51–75%; 4 = 76–100%. An individual can receive a subscale score ranging from a low of 10 to a high of 40 and a total scale score between 40 and 160.

Murphy and Moller (1995) report that the WAT was developed as a subset of the overall Moller–Murphy Symptom Management Assessment Tool, an integral component of the Three R's Psychiatric Rehabilitation Wellness Program (Moller & Murphy, 1997; Murphy & Moller, 1996). The tool was validated during focus groups consisting of 178 clients and 125 family members over a period of 3 years as part of a community psychoeducation course (Moller & Murphy, 1997). The reliability of the WAT was established using responses from individuals with chronic mental illnesses (N = 96) including schizophrenia, bipolar disorder, and major depression. Internal consistency of the