Psychoeducation

Although much attention is paid in the treatment literature to the cognitive and emotional processing of traumatic memories, psychoeducation is also an important aspect of trauma therapy (Allen, 1991; Flack, Litz, & Keane, 1998; Friedman, 2000a; Najavits, 2002). Many survivors of interpersonal violence were victimized in the context of overwhelming emotion, narrowed or dissociated attention, and, in some cases, a relatively early stage of cognitive development; all of which may have reduced the accuracy and coherence of the survivor’s understanding of these traumatic events. In addition, interpersonal violence frequently involves a more powerful figure who justifies his or her aggression by distorting objective reality—for example, by blaming victimization on the victim. These fragmented, incomplete, or inaccurate explanations of traumatic events are often carried by the survivor into adulthood, with predictable negative results.

Therapists can assist in this area by providing, when indicated, accurate information on the nature of trauma and its effects, and by working with the survivor to integrate this new information and its implications into his or her overall perspective. Although often presented relatively early in treatment (for example, Talbot et al., 1998), psychoeducational activities are helpful throughout the therapy process. For example, as the client addresses traumatic material later in treatment, he or she may gain from additional information that normalizes or provides a new perspective on traumatic memory.

Although psychoeducation is usually provided during ongoing individual treatment, it also can occur in the context of separate, clinician-led support
groups, wherein a small number of people with similar trauma histories compare stories, give each other advice, and discuss interpersonal violence and its effects. An advantage of group interventions is that the survivor can learn from the similar experiences of others; a process that may be more powerful and enduring than when similar material is delivered solely by the therapist. On the other hand, by their very nature, support groups may be less efficient than face-to-face psychotherapy for the client’s own processing, integration, and personal application of whatever he or she learns from such information.

**Handouts**

Whether it occurs in individual therapy or in a guided support group, psychoeducation sometimes includes the use of printed handouts. These materials typically present easily understood information on topics such as the prevalence and impacts of interpersonal violence, common myths about victimization, and social resources available to the survivor.

The therapist should keep at least four issues in mind when deciding what (if any) written material to make available and how it should be used:

1. **The quality of the materials.** Some handouts contain misinformation, may advocate religious or social perspectives that may indirectly blame, proselytize, or exclude, or may be written at a level that is not easily understood by the survivor.

2. **The language of the materials.** For example, a person whose primary language is Spanish may gain little from a pamphlet written in English.

3. **The cultural appropriateness of the information or depictions.** For example, materials may reflect more middle-class concerns, or visual depictions may be limited to Caucasian figures.

4. **The risk of insufficient cognitive-emotional integration.** Merely offering educational materials is not the same as providing effective psychoeducation, especially if the materials are distributed without sufficient discussion or application to the client’s own history or current situation.

Most important, handouts should be considered tools in the psychoeducation process, not stand-alone sources of information. The public health literature, for example, suggests that didactic material alone may not be especially effective in changing the beliefs or behaviors of victimized individuals (Becker, Rankin, & Rickel, 1998; Briere, 2003). Instead, the clinician should ensure that the information is as personally relevant to the survivor as possible, so
that whatever is contained in the handout or media is directly applicable to his or her life, and thus has greater implicit meaning.

Client-oriented brochures and information sheets can be obtained from a number of organizations, either via the Web or by requesting materials by mail. At the time of this writing, three Web sites that include especially useful consumer information are:

International Society for Traumatic Stress Studies
http://www.istss.org/resources/index.htm

Office for Victims of Crime (U.S. Department of Justice)
http://www.ojp.usdoj.gov/ovc/help/welcome.html

David Baldwin’s Trauma Pages
http://www.trauma-pages.com/pg4.htm

Books

Clinicians may also refer clients to readily available books that are “survivor-friendly,” such as Judith Herman’s *Trauma and Recovery* (1992a). Although obviously limited to individuals with adequate reading skills, such books allow clients to “read up” on traumas similar to their own. Other books are specifically written for the survivor or interested layperson (one of the best being Jon Allen’s [2005] *Coping With Trauma*) and contain advice as well as information. Some may be too emotionally activating for some survivors with unresolved posttraumatic difficulties, however—at least those individuals early in their recovery or treatment process. Other books may contain erroneous information or suggest self-help strategies that are not, in fact, helpful. For these reasons, we recommend that the clinician personally read any book before recommending it to a client; not only to make sure that it is appropriate to the client’s needs and is factually accurate, but to gauge its potential to activate significant posttraumatic distress in those unprepared for such emotional exposure.

Verbal Information During Therapy

Although written psychoeducational materials can be helpful, more typically information is provided verbally by the clinician during the ongoing process of psychotherapy. Because the educational process is directly imbedded in the
therapeutic context, it is often more directly relevant to the client’s experience, and thus more easily integrated into his or her ongoing understanding. (Briere, 2003) Additionally, psychoeducation provided in this manner allows the therapist to more easily monitor the client’s responses to the material and to clear up any misunderstandings that might be present. As noted at the end of this chapter, however, over- or misapplication of psychoeducation during treatment can also impede therapy progress; as with many aspects of good therapy, the issue is often the correct balance of content versus process and sufficient attunement to the client’s clinical response.

**General Focus**

Whether through written or verbal means, clinicians in the trauma field often focus on several major topics during psychoeducation. These include:

- **The prevalence of the trauma.** Data on the prevalence of interpersonal violence tends to contradict the common belief that the client was specifically selected by the perpetrator by virtue of weakness, badness, or unconscious provocation, or that the client is virtually alone in having experienced the trauma. For example, knowing that approximately 1 in 5 women in the general population have been raped at some point in their lives, or that 20 percent of men have been sexually abused as children, may be a meaningful antidote to the survivor’s fear that he or she alone has experienced such events and that something specific to him or her caused the event to occur.

- **Common myths associated with the trauma.** As noted at various points in this book, interpersonal violence often occurs within a broader social context that, to some extent, blames victims for their experiences and/or supports perpetrators for their behaviors. For example, rape victims are often believed to have been seductive or otherwise to have “asked for” their victimization (Burt, 1980); domestic violence may be justified as appropriate and rightful dominance of wives by husbands (Walker, 1984); and it may be assumed that individuals, in general, frequently lie about having been abused or assaulted in the service of manipulation or retribution. When the client subscribes to these myths, he or she is more likely to, in fact, blame himself or herself for the victimization or explain away the trauma as something not worthy of treatment (Resick & Schnicke, 1993). For this reason, it can be helpful to discuss “rape myths” or “common myths about wife battering” in a way that makes it clear that such beliefs are not accurate.

- **The usual reasons why perpetrators engage in interpersonal violence.** This may include describing the often compulsive, multivictim nature of many perpetrator behaviors, and the psychology driving the perpetrator’s actions—including the offender’s frequent need for power and dominance in the face of insecurity and feelings of inadequacy. Such information can reduce the client’s self-focused
explanations for the assault and increase his or her awareness of the perpetra-
tor’s dysfunctional or malignant characteristics. This shift in attribution
may make self-blame appear less logical to the survivor. In addition, knowledge
that the client was “one of many” for the perpetrator may further decrease
his or her tendency to take personal responsibility for what was done to him
or her.

- **Typical immediate responses to trauma.** Among other victim reactions to
adverse events, this may include peritraumatic dissociation (for example, “spac-
ing out,” out of body experiences, or experiencing time distortion at the time of
the trauma), occasional sexual responses associated with sexual traumas (as
opposed to, in many cases, positive psychological feelings), relief at not being
injured or killed when others have been, and “Stockholm effects,” wherein the
victim becomes attached or somehow bonded with the perpetrator. Because
these are all relatively normal responses to trauma, despite their apparent neg-
ative qualities, the client may eventually experience relief, as well as decreased
guilt and self-blame, upon receiving and integrating such information.

- **The lasting posttraumatic responses to victimization.** Information on the com-
monness and logical nature of posttraumatic stress symptoms (for example,
flashbacks, numbing, or hyperarousal responses) and other trauma-related res-
ponses (for example, substance abuse, panic attacks, or intimacy fears)—as
described in Chapter 2—are an important part of most good trauma therapy.
As the client comes to understand that posttraumatic symptoms are normal (in
the sense that such symptoms are logical and relatively common) responses to
abnormal or toxic circumstances, he or she is less likely to experience himself or
herself as damaged or mentally ill and may feel less out of control. Similarly, it
is almost always preferable to view oneself as suffering from a well-understood
cluster of typical responses to traumatic events (for example, posttraumatic
stress disorder [PTSD]) than it is to see oneself as besieged by a variety of
bizarre, unrelated symptoms. In addition, psychoeducation may prepare the
client for symptoms that arise in the future. By describing symptoms before they
occur, the clinician can provide a sense of predictability. This, in itself, may
significantly reduce posttrauma anxiety. And successfully predicting potential
symptoms enhances the overall credibility of the therapist especially in terms
of his or her nonpathologizing analysis of what symptoms mean and do not
mean.

- **Reframing symptoms as trauma processing.** Psychoeducation can involve refram-
ing certain posttraumatic symptoms more positively, even as evidence that
recovery is occurring. This is a somewhat more active process than the normal-
ization of symptoms described earlier. Not all symptoms can be reframed, of
course, nor should they be. Depression, panic attacks, suicidality, or psychosis,
for example, are generally what they appear to be: evidence of psychological
disturbance of some form or another. On the other hand, as described in
Chapter 8, posttraumatic reliving symptoms are often signs of attempted psy-
chological processing (even when unsuccessful), and posttraumatic avoidance is
frequently an adaptive attempt to reduce the overwhelming aspects of reactivated
distress. 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.

- **Safety plans.** Women who are at risk for ongoing domestic violence may need to learn about “safety plans” that other women have used successfully in similar circumstances. Typically, this involves developing a detailed strategy for exiting the home (for example, prepacked suitcases, escape routes) and finding a new, safer, environment, whether it be a friend’s home or a local women’s shelter (Jordan, Nietzel, Walker, & Logan, 2004). Other clients may benefit from concrete information on how to access medical or social services, a child protection worker, or police assistance (Briere & Jordan, 2004). The goal of such interventions is to increase the power of victims to ensure their own safety, and thus to decrease not only the likelihood of continued victimization, but also some of the helplessness often associated with exposure to chronic interpersonal violence.

**Constraints**

Despite its generally salutary effect, psychoeducation can backfire if not carefully adapted for the individual client, or if the conclusions that the client draws from the information are not monitored. For example, while information on the commonness of interpersonal violence may reduce the client’s sense of being the only one who has been victimized, it may also reinforce the client’s overestimation of the amount of danger in the interpersonal environment, leading to increased fear and avoidance of others. Similarly, too much focus on perpetrator dynamics may reinforce the client’s need to excuse his or her perpetrator, and information on standard posttraumatic reactions may inadvertently cause the client to feel disordered or dysfunctional or to take on a trauma “sick-role.”

Ultimately, psychoeducation should not occur in a vacuum. Information is often helpful, and may be antidotal to distorted beliefs and maladaptive responses, but it must occur in the context of ongoing therapeutic discussion and evaluation (Najavits, 2002). Specifically, the clinician should attend carefully to how clients integrate new information into their worldviews and how they apply such information in their daily lives. Simply teaching (let alone lecturing) clients about what to do or not do, or suggesting how they should think about trauma and its effects, is rarely helpful in and of itself (Neuner, Schauer, Klaschik, Karunakara, & Ebert, 2004). Instead, psychoeducation is most useful when it is integrated into the ongoing therapeutic process.
Suggested Reading


