ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/352131560

Don't ask. Don't tell --- Reactions of clinicians and clients towards Trauma Intervention.

Article *in* American Journal of Psychiatric Rehabilitation · May 2021

CITATION
1

READS
140

7 authors, including:

Weili Lu
Rutgers, The State University of New Jersey
60 PUBLICATIONS **1,327** CITATIONS
SEE PROFILE

William Waynor
Rutgers, The State University of New Jersey
27 PUBLICATIONS **140** CITATIONS
SEE PROFILE

Carolyn Bazan
Rutgers, The State University of New Jersey
11 PUBLICATIONS **13** CITATIONS
SEE PROFILE

Giovanna Giacobbe
Rutgers, The State University of New Jersey
13 PUBLICATIONS **54** CITATIONS
SEE PROFILE

Some of the authors of this publication are also working on these related projects:

The Role of Hope and Self-efficacy in Predicting Career Oriented Activities for Persons with Serious Mental Illness in Assertive Community Treatment View project

Career development of people with serious mental illness View project

All content following this page was uploaded by Carolyn Bazan on 07 September 2021.

The user has requested enhancement of the downloaded file.

Don't Ask, Don't Tell---Reactions of Clinicians and Clients towards Trauma Interventions

Lue Ann Libera[1]

Weili Lu[1]

William Waynor[1]

Philip Yanos[2]

Carolyn Bazan[1]

Giovanna Giacobbe[1]

Amy Balazse[1]

[1]Rutgers University

[2]John Jay College, City University of New York

Abstract

Individuals with mental health support needs have increased rates of posttraumatic stress disorder (PTSD). Yet, the implementation of PTSD treatment interventions in psychiatric rehabilitation settings continues to lag. The present article is a report of an innovative way to reduce barriers in providing trauma-informed care and considers the ways in which administrators, clinicians, and clients respond to addressing trauma in psychiatric rehabilitation settings by discussing their contrasting reactions during and after the implementation of group CBT treatment for PTSD. Multiple benefits including realization, relief, reflection, and re-learning were reported by clients who received structured PTSD treatment. Findings suggest benefits for administrators, clinicians, and clients when PTSD treatment is implemented.

Keywords: *PTSD, psychiatric rehabilitation, trauma, serious mental illness, trauma counseling*

Don't Ask, Don't Tell---Reactions of Clinicians and Clients towards Trauma Interventions

Introduction

Research consistently supports that the majority of individuals using psychiatric rehabilitation services has a history of traumatic experiences (Mihelicova et al., 2018; Grubaugh et al., 2011). Trauma and its consequences are frequently overlooked by clinicians who work with individuals with mental health support needs (Lutton & Swank, 2018). Rates of exposure to complex traumas, traumas which are interpersonal and prolonged in nature such as ongoing sexual abuse during childhood, are particularly high among people managing mental health conditions (Giorouo et al., 2018; Hyland et al., 2017). Cumulative childhood trauma has been found to be correlated to an increased rate of mental health disorders, poorer health, and functional impairments (Copeland, et al., 2018). Trauma causes physiological vicissitudes in the brain and can alter its neurochemistry (Gianfrancesco et al., 2019, Kaye, 2020). Individuals with a history of severe childhood trauma are more vulnerable to experiencing psychosis, delusions, auditory hallucinations, dissociations, and suicidality (Bailey et al., 2018; Popovic et al., 2019; Zheng, et al. 2018). Further, of the individuals who have experienced trauma, a large proportion likely meet the criteria for posttraumatic stress disorder (PTSD) (Dondaville et al., 2019; Minsky et al. 2015). Estimates of the *current* prevalence of PTSD among people with mental health support needs range from 29 and 43%, considerably higher than the general population *lifetime* prevalence of 8-12% (Grubaugh et al., 2011; Nishith et al., 2019).

Symptoms and difficulty with coping experienced by people who utilize psychiatric rehabilitation services often involve numerous variables, some of which overlap with and are similar to criteria common to PTSD. While determining a definitive diagnosis of mental health conditions may lack an objectivity due to consistently emerging scientific evidence, recognizing

the experience of trauma and providing appropriate treatment warrant examination of assessment measures and refinement of sufficient interventions. There is a wide range of possible reactions to having experienced a traumatic event, and symptoms of PTSD may manifest in many forms. For example, in addition to general feelings of anxiety or fear, symptoms may also include numbness, anhedonia, and anger (American Psychiatric Association, 2013; Lu et al., 2017a). Furthermore, symptoms of PTSD may appear much later than the period immediately following trauma (i.e. 20 years later on average) (Lu et al., 2013) and frequently reoccur when the person is faced with ongoing life and environmental stressors; as a result, the person's coping mechanisms may be ineffective during such exacerbation. The phenomenon is very similar to, and may be easily confused with, the cycle which may frequently occur for individuals during the course of managing psychiatric conditions and episodes of acute symptoms (Pratt et al., 2014), but may have a different origin and, hence, requires a different intervention approach. Further, negative alterations in cognition (e.g. post-traumatic cognitions such as "people can't be trusted") which are now considered to be a hallmark of PTSD may interfere with the attainment of rehabilitation goals to increase social engagement or engagement in work activity. Moreover, Complex PTSD develops as a result of having exposure to multiple traumatic events or prolonged traumatic events. These tend to be of an interpersonal nature, and are common among people who experience partner abuse as well as childhood abuse (Coventry et al., 2020; Palic et al., 2016). Complex PTSD can also occur as a result of being involved in a situation from which it is difficult or impossible to escape (Coventry, 2020). Being involved in complex traumatic events can lead to having more psychopathological symptoms than is typical for PTSD (Knefel & Lugel-Schuster, 2013). Complex PTSD includes three symptom clusters of PTSD (re-experiencing, avoidance, and arousal or hypervigilance), as well as three additional clusters,

which include affective dysregulation, negative self-concept, and disturbances in relationships (Karatzias et al., 2017). Complex PTSD is associated with less educational attainment and increased likelihood of living alone, and increased odds of co-occuring depression and social phobia, compared to PTSD alone (Perkonigg et al, 2016). In all those scenarios described, lack of appropriate intervention may be an issue which interferes with successful rehabilitation (Meltzer et al., 2012). As an example, if lack of willingness to engage in social activity is erroneously attributed to "negative symptoms," rather than to post-traumatic cognitions, an intervention such as a medication change might be used, rather than a trauma-informed intervention such as psychotherapy to address maladaptive cognitions. Thus, traumatic reactions may be inadvertently overlooked, and effective mental health support may not be offered.

Many front-line practitioners lack knowledge about the myriad of variables involved in the overall development of psychiatric conditions, including those variables related to PTSD. It has been shown that trauma is not regularly or explicitly indicated in medical documentation (Cusack et al., 2006), thus, it is difficult to ascertain through the recorded histories of mental health service users whether traumatic events have, in fact, occurred. Furthermore, there is typically a lack of understanding of the link between traumatic events in a person's life and the development of PTSD as well as mental illnesses such as schizophrenia, bipolar disorders, or major depressive disorders. Although it is often not readily shared by the survivor and not evident in medical records, trauma may be suspected by clinicians as a potentially adverse variable contributing to the development of mental illness (Frueh et al., 2006). However, despite beliefs about the potential positive impact of cognitive-based interventions, practitioners are often reluctant to discuss symptoms related to trauma, either because they fear "triggering"

adverse reactions through such discussion, or because they lack the necessary skills to confidently and competently assist people in facing and coping with symptoms related to traumatic events (Frueh et al., 2006).

As the provision of evidence-based behavioral health services becomes more prevalent, there is growing support for the use of cognitive and behavioral therapy (CBT) techniques to effectively help people with mental health support needs who have also experienced trauma (Mueser et al., 2008; Mueser et al., 2015). CBT interventions teach people in recovery the skills needed to manage the thoughts and feelings related to traumatic experiences and to recover meaning and purpose in their lives (Mueser et al., 2008; 2015; Lu et al., 2012; Lu et al., 2017b). Although more research is required, even intensive treatments (potentially not preferred by many undergoing treatment for trauma), such as exposure-based interventions and techniques of eye movement desensitization and reprocessing, have been found to be practical and useful in reducing PTSD symptoms for people diagnosed with psychiatric conditions (de Bont et al., 2013; Grubaugh et al., 2016). Furthermore, the influence of treatment is neither characterized by adverse effects or distress, increased psychiatric symptoms, nor negative impact on social functioning (de Bont et al., 2013; Grubaugh et al., 2016; Sin et al., 2017). In essence, not addressing trauma will represent a disservice to people and may lead to continued or increased experience of symptoms and problems with functioning.

In contrast to practitioner hesitation and reluctance, the words of people served contradict the faulty notions of inexperienced clinician described above. People who utilize psychiatric services wish to be treated as a whole person by the mental health system, and a truly holistic approach involves the acknowledgement of the experience of trauma itself. People in recovery may be willing and/or feel prepared to raise the subject with helpers as a means of catharsis and a

way to begin to understand the reasons for their difficulty forming satisfying, lasting relationships and maintaining productive, meaningful lives (Frueh et al., 2005; Fisher, 2017).

A conceptual barrier confronting the psychiatric rehabilitation field exists which makes routine screening and treatment of PTSD less likely; because practitioners believe the process of screening program participants for trauma may cause distress and potentially lead to "decompensation" (Cusack et al., 2006), they fear conducting such evaluations. Often, practitioners' fear of triggering a crisis by addressing issues related to trauma leads to ignoring those critical issues. Unfortunately, avoidance of trauma related issues becomes an obstacle to the recovery process for the large percentage of people living with mental health support needs who have co-occurring PTSD (Mcneil & Galoski, 2015).

The present article considers the ways in which administrators, clinicians, and clients respond to addressing trauma in psychiatric rehabilitation settings by discussing the contrasting reactions of administrators, clinicians, and clients who underwent the implementation of group CBT treatment for PTSD. The authors attempt to discriminate between the avenues which clinicians could take to raise the topic of trauma and ascertain those which clients find most helpful. The purpose of the article is to identify an optimum approach to increasing clinician comfort with discussing trauma and PTSD with people who use psychiatric services.

Method

The study protocol, consent, and all study-related materials were reviewed and approved by the university Institutional Review Board. Study participants were people with mental health support needs (schizophrenia, major depression, bipolar disorder, etc.) at 10 Supported Employment (SE) programs. The study sites were located in urban, suburban, and rural communities in three northeastern states. Additionally, the SE programs were all part of larger

mental health agencies which provided an array of services including: supportive housing, partial care, medication management, substance abuse counseling, peer support, assertive community treatment, and other case management programs. In order to facilitate referrals for the randomized controlled trial comparing a 12-week group cognitive behavioral treatment (CBT) for PTSD program with treatment as usual (TAU) in supported employment programs operated in three Northeastern states (Lu et al., unpublished manuscript), trauma history and PTSD screening were implemented at these sites. Participants were screened for PTSD for the CBT for PTSD randomized controlled trial. Trauma informed interventions were introduced through a series of activities: 1) SE program and study staff were trained to conduct PTSD screening and coordinated with researchers to choose dates for PTSD screenings at their respective programs. SE staff then notified the program clients of the opportunity to be screened for PTSD and the dates when the study staff would conduct the screenings at the agency. Agency staff posted flyers in the office as well as made personal calls to clients informing them of the day of the screening (note that the invitation to participate was open to all clients at the recruitment sites). Individuals who were interested came to the SE program on the day of the screening and met with study personnel who explained the screening process. If the individual agreed, study personnel and SE staff conducted a comprehensive screening of trauma exposure and PTSD symptoms. Participants who agreed then completed a permission to contact form, Authorization of Release of Protected Health Information form, and a consent form to have the results of the screening provided to the research team. Additionally, an eligibility checklist was filled out. Gender was recorded as noted by the interviewers. Participants were paid $10 for completing the screening.

2) Upon the completion of the trauma screening, participants were then asked if they were willing to have their screening data provided to the research team for possible participation in a treatment study of cognitive behavioral therapy (CBT) for PTSD. Participants indicated whether they would be interested in being contacted by the research team if they met preliminary eligibility criteria for the study. For the randomized controlled trial, potentially eligible and interested clients were contacted by a team member, who described the study and obtained informed consent. Once consent was obtained, the completion of a baseline interview would confirm the diagnosis of PTSD using structured clinical interviews via the Clinician Administered PTSD Scale (CAPS-5; Weathers et al, 2013; 2018). Participants were paid $30 for the completion of the baseline interview.

Participants

Five hundred thirty-six persons receiving SE services participated in screening and produced usable screening assessments. Usable screening assessments were characterized by having more than half of data points recorded. Participants were closely split by gender. African Americans comprised 46% of the participants' racial identity. In addition, those who participated in the screening were, on average, in their late 40s (M= 47.23, SD= 12.91). On the Eligibility Checklist, participants answered yes or no to having a diagnosis of mental health disorder and were then prompted to write-in their diagnosis. Diagnoses for this study were based on self-report. One hundred and ninety-four (36.2%) participants reported their psychiatric diagnosis(es) on the Eligibility Checklist. The most common self-reported diagnoses were Depressive Disorders (30.9%), Bipolar Disorders (31.4%), and Schizophrenia / Schizoaffective Disorder (23.2%). Other commonly reported disorders include generalized anxiety disorder, obsessive compulsive disorder, personality disorders and adjustment disorders. In addition, only 6.2%

(n=33) of participants reported having a diagnosis of PTSD. Of those 536 participants, 132 participants completed the baseline interview and met the criteria for PTSD using CAPS-5. These 132 participants were typically in their late 40s (M = 45.97, SD = 11.94), were mostly females (n=81; 61.4%), and were nearly evenly split between African-American (42.4%, n = 56) and white (43.9%, n = 58) racial groups.

Measures

PTSD Screening: An abbreviated 16-item version of the *Traumatic Life Events Questionnaire* (TLEQ) (Kubany et al., 2000) was used to screen lifetime trauma history for all participants. For each event on the scale, the participant indicated whether they had ever experienced it over their lifetime in a binary (yes/no) format (e.g. "Has anyone threatened to kill you or seriously hurt you?"). The TLEQ asks about the experience of traumatic events using wording that corresponds with the DSM-IV criterion A for PTSD. This version of the TLEQ was used to screen for trauma exposure in previous studies with persons using community mental health support programs (Mueser et al., 2008).

The *PTSD checklist for DSM-5* (PCL-5) was used to assess the severity of the participant's symptoms. The PCL-5 is a 20-item self-report measure which assesses the 20 DSM-5 symptoms of PTSD (Weathers et al., 2013). This assessment can be used to screen individuals for PTSD and to make a provisional PTSD diagnosis. The wording of the PCL-5 items reflects both changes to existing symptoms and the addition of new symptoms indicated in the DSM-5. The self-report rating scale is 0-4 for each symptom, reflecting descriptors of the following: "Not at all," "A little bit," Moderately," "Quite a bit," and "Extremely" on a 5-point scale. The PCL-5 was administered without Criterion A since trauma exposure was measured previously by TLEQ. A total symptom severity score (range - 0-80) can be obtained by summing the scores for

each of the 20 items. Preliminary work suggests that a PCL-5 cut-off of 33 indicates probable PTSD.

Participants who scored greater than 33 on PCL-5 and were willing to participate in the intervention study were approached for a full baseline interview. Inclusion criteria to participate in the trauma intervention study were the following: 1) age >= 18; 2) currently receiving SE services within the past 24 months; 3) history of treatment for mental illness; 4) current diagnosis of PTSD; 5) no current diagnosis of alcohol or drug dependence as described in the medical record; 6) no hospitalization or suicide attempt in the past 2 months; and 7) willingness to provide informed consent to participate in the study. The Clinician Administered PTSD Scale for DSM-5 (Weathers et al., 2018; CAPS-5) is the gold standard in PTSD assessment, and was administered to assess PTSD diagnosis and severity of PTSD symptoms. The CAPS-5 is a 30-item structured interview which corresponds to the DSM-5 criteria for PTSD. In various clinical studies, Clinician Administered PTSD Interviews have been used to make diagnostic impressions of persons who manage psychiatric symptoms and conditions (Mueser et al., 1998; Mueser et al., 2008; Mueser et al., 2014). Depression was assessed with the Beck Depression Inventory-II (BDI-II; Beck et al., 1988) and general psychiatry symptoms with the Expanded Brief Psychiatric Rating Scale (BPRS; Lukoff et al., 1986). Several aspects of social functioning, including activities of daily life, participation in work, social activity, and family contact, as well as subjective life satisfaction, were assessed with the Brief Quality of Life Interview (QOLI; Lehman et al., 1995). Employment history and employment activities were also collected.

Treatment programs

All study participants continued to utilize the psychiatric services with which they had already been involved. Study participants were randomly assigned to either the group CBT or the TAU program.

CBT program

There is evidence that the integrated cognitive-behavioral treatment model (I-CBT) has been effective in addressing co-occurring PTSD among people who are living with severe mental illnesses (Mueser et al., 2008; Mueser et al., 2015). The I-CBT program is based on cognitive models of PTSD which acknowledge that individuals who have experienced trauma base their perceptions of the world on their life experiences and on their difficulties with coping, resulting in cognitive distortions. Those distortions typically include heightened arousal, distressing emotions, and disbelief in one's sense of self-efficacy and abilities. While SE programs are designed to address both vocational and clinical services in tandem (Wolff et al., 2004), many of the teams are inadequately prepared to meet the unique needs of peers who have experienced trauma yet who have not received treatment for their history and present symptoms of trauma. However, current available versions of I-CBT for PTSD are aimed primarily towards individual psychotherapy and are difficult to implement in SE settings. Furthermore, I-CBT does not target the impact of trauma and PTSD symptoms on employment functioning. Therefore, to address the needs of those people who have been unable to successfully make use of evidence-based SE services, the authors developed a specific version of the I-CBT intervention which could be implemented in group format specifically for the population described.

The I-CBT for PTSD intervention covers five learning and skill components aimed to improve PTSD symptoms and employment outcome: 1) Personal work recovery; 2) Education about PTSD and its relation to employment and recovery; 3) Breathing retraining (a behavioral

anxiety reduction skill); 4) Cognitive restructuring (a cognitive approach which emphasizes the link between cognitions, feelings, and behavior, particularly in employment situations); and 5) Coping skills for persistent PTSD symptoms such as the experience of intrusive thoughts, avoidance of work-related responsibilities and tasks, and difficulty managing irritability / anger as well as problematic interpersonal situations in the work setting. Those components, which are central to effective PTSD interventions (Keene, 2009), are included in the I-CBT manual.

Measures were taken to ensure to ensure coordination of services so that the intervention met the needs of group participants. In order to facilitate consistent communication between I-CBT group leaders and SE program staff, the groups were conducted at the SE program sites. I-CBT group facilitators and SE staff met monthly for 90 minutes to review members' progress in their SE program and in the PTSD treatment. Groups were held weekly for a duration of 12 weeks and included four modules, consisting of three sessions each. Teaching methods and materials (handouts, worksheets) are designed to be practical and useful for folks managing more severe symptoms, such as psychotic symptoms, cognitive deficits, and higher levels of stress vulnerability. Following each training session, facilitators collaborated with members to develop homework assignments designed to practice breathing retraining and cognitive restructuring skills.

Module I, titled Overview of Trauma and Employment, covers psychoeducation, breathing re-training / relaxation skills, and the development of goals for recovery specifically for the life domain of work. Session leaders regularly followed up with members about their attempts to find employment. Module II, titled Trauma and Dreams for Tomorrow, addresses the impact of trauma on one's negative expectations of work. The module provides training in cognitive restructuring skills to examine and challenge erroneous beliefs which lead to

distressing thoughts, emotions, and, ultimately, actions. Module III, titled Trauma and Work-Related Self-Efficacy, emphasizes trauma-related beliefs related to the experience of being damaged, defeated, and currently unable to find and/or maintain employment. The module discusses the influence of trauma on the individual's identity, self-esteem, and ability to work. Module IV, titled Trauma and Social Relations at Work, addresses the impact of trauma on interpersonal relationships at work, such as isolation and possible issues with authority.

Cognitive restructuring, first introduced during Module II and continued through Module IV, is taught as a self-management skill for dealing with negative feelings through the articulation of specific thoughts which underlie the distressing feeling followed by objectively evaluating the evidence which supports or refutes those thoughts. People learn to initially use cognitive restructuring to cope with any distressing feelings, and as their skills develop, they shift to address trauma-related thoughts and beliefs which underlie PTSD symptoms. Participants are taught how to modify inaccurate thoughts (e.g. "I am responsible for my sexual abuse.") which are not supported by the evidence. If, indeed, there is some evidence to validate the thought, then members learn to develop 'action plans' to address situations in which the distressing thoughts are deemed to be accurate (e.g. "My new boyfriend is becoming abusive and I am at risk of getting hurt.") so that they could make changes, such as reaching out to and using support people and services.

Data Analysis

Reports and observations were collected from administrators, therapists, and clients concerning their reactions towards trauma screening and intervention.

Data was entered and cleaned using SPSS 26. Missing data was handled using list-wise deletion for the TLEQ questionnaires. For PCL-5, only two participants had completed fewer

than half of the PCL-5 items, and 473 (88.6%) had complete data on the PCL-5. Missing data on PCL-5 was handled through mean imputation. Data was also analyzed on the sample who was screened and the sample who participated in the randomized controlled trial (n=536; 132 respectively).

Results

Administrators' Experiences

Although the administrators and staff members of many programs involved in our study were receptive to the concept of the research, others remained cautious. Many administrators expressed the concern that once clients began talking about their trauma or upon completion of the intervention, clients would "decompensate", and crisis intervention or hospitalizations would be required. The research team provided education about trauma-informed care and assured administrators that clients typically already live with the memories of trauma and often experience daily symptoms of PTSD. Researchers emphasized that when practitioners engage clients in talking about their trauma, they then validate the client's experiences as opposed to the traditional approach of practitioner avoidance of trauma history which inadvertently leaves clients feeling invalidated. Despite persisting reservations regarding client safety, administrators agreed to collaborate on the project with the caveat that they needed to set aside a timeslot every week during team meetings to discuss the progress of clients who were receiving group CBT for PTSD. Administrators welcomed that which they subsequently observed, specifically that clients did not "decompensate" and, furthermore, no hospitalization were required. Administrators were even surprised to determine that many clients began reporting a reduction in the frequency or severity of their symptoms and that people became more engaged in their recovery goals. Administrators offered support during the execution of the research by keeping abreast of

clients' progress throughout the duration of the study. Some administrators, in fact, required notification via email before and after members of the study team met with clients for PTSD assessments. There were no resulting adverse events reported in relation to PTSD assessments throughout the study. The administrators eventually communicated with the research team and coordinated client care. As is part of research protocol for clients managing psychiatric conditions, the research team assured regular communication with the clinical team of the site, particularly about whether a client was found to be suicidal or homicidal.

Clinicians' Experiences: Variation Among Settings

To start, the authors attempted to recruit participants by preparing line staff of identified programs to screen and refer potential candidates. These clinicians were also invited to attend one-hour training sessions of the trauma screening process. They were provided with handouts, screening tools, and step-by-step guidelines on how to score the screening results and how to refer clients, and they were provided a standard script to use when introducing screening, which was previously used in a large community mental health center where more than 3,000 participants were screened (Lu et al., 2013). This screening was recommended to be conducted during either the second intake session for new clients or regular sessions for clients who were already in treatment. If clients experienced grossly psychotic symptoms or suicidality, the screening was deferred until a time when the person was more clinically stable. The following script was used to introduce clients to the screening and information about PTSD:

"It is very common for people to have experienced some very stressful and upsetting events. Even if these events happened a long time ago, they can still affect how a person thinks and feels, and how a person reacts to other people and situations many years later. People who have experienced a traumatic event, repeated traumatic events, or certain kinds of stress over a

long period of time often have different mental health treatment needs than people who have not experienced trauma or chronic stress. Because of this, it can be helpful to you if your treatment providers are aware of your past experiences of trauma and chronic stress, and the way in which these may be still affecting you now. We would like you to try to answer the following questions. We want to see if any of these things, problems or complaints has happened to you. If you are not sure of an answer to a question, please make your best guess. If you have any questions, I would be happy to talk with you about them."

Clients were asked to complete both the Trauma History Screening (TLEQ) and the PCL-5, based on the most upsetting event on the TLEQ. Scores at or above 33 on PCL-5 indicated probable diagnosis of PTSD.

Clinicians were also invited to attend the iCBT sessions (only one clinician was allowed in each session in order to achieve integration of services). There were 14 clinicians altogether across sites who interacted with the study team. Three identified as African American and the rest identified as Caucasian. Seven clinicians were below the age of 40 and seven were over the age of 40. Two clinicians identified as male and the remaining 12 identified as female. Three clinicians were licensed in social work (21.4%), two were certified rehabilitation counselors (14.3%), three were certified psychiatric rehabilitation practioners (21.4%) and one was a licensed professional counselor (7.1%). In addition, two clinicans reported obtaining a Bacherlor's degree (21.4%) and nine reported obtaining a Master's degree (64.3%) as their highest level of education. The level of education of two clinicians was unknown (14.3%).

The authors faced the reluctance of some providers to endorse the eventual delivery of the clinical intervention to particular people and to even approve of the process of screening potential subjects from their programs. For example, practitioners became rather dismayed after

some people who had been screened later mentioned the extreme difficulty they had with discussing traumatic events. Some of those who had completed the screening process subsequently raised the issue with their individual therapists. Those therapists strongly recommended that, because of the risk of increase in symptoms and/or "decompensation", potential subjects should not be asked to participate at all in the study. Additional education and clarification as well as support for the program staff were required on our part in order for them to understand that people who have endured trauma do regularly experience symptoms, such as feeling "triggered" to re-experience the event(s) and the associated distressing feelings and thoughts, and that those symptoms must be addressed and managed.

Clinicians' Experiences: Providing the Intervention

The authors (LL, GG, CB, BS, AB, WW) facilitated separate series of the Integrated Cognitive Behavioral Therapy (i-cbt) group intervention. Members of the groups reported the value and helpfulness of the strategies which were practiced; to protect anonymity, variations of their statements are provided below in quotation marks. Although reflection on particular traumatic memories and examination of one's experience with thoughts and feelings were not easy processes, many expressed relief with being able to discuss their situations, even if not in full detail. They shared their appreciation for the psychoeducational component ("This information is better than my individual therapy") and their feelings of pride and capability to utilize coping skills of stress relief, cognitive restructuring, and problem-solving ("At first I thought, yeah right, I won't use the techniques, but after a relapse of symptoms like auditory hallucinations and feeling bad about myself, I found myself going through the five steps in my head.").

Clients' Experiences: Receiving Group CBT Treatment for PTSD

With regard to trauma screening, it appeard that most clients were able to tolerate the process when trauma screening was introduced in a structured fashion. No adverse events were filed with the IRB and this may be related to the fact that those who did not want to participate in the study were not screened. This may have resulted in a self-selection bias. There were a few cases in which clients became emotionally upset and needed to speak with a counselor after screening. In those cases, proper arrangements were made with a trusted case manager or counselor. No clients were hospitalized and no crises were reported. Group CBT for PTSD appears to be therapeutic for persons with mental health support needs. Group members reported benefits of realization, relief, reflection, and re-learning during the group CBT process. Members of the group intervention made numerous strides in their functioning in various areas and marked improvements to their overall quality of life. They expressed appreciation for the opportunity to learn new material and receive support. The areas in which the group members derived most benefit may be seen in Table 1. Members reported experiencing realization of insight, relief through sharing, reflection on their automatic thoughts and distortions thereof, and re-learning various coping strategies in relation to stress management and problem solving skills.

However, at times, participants experienced more difficulty with the material learned in group. To illustrate, the authors taught members about the specifics of trauma, subsequent problems, and the idea that their issues represented bona fide experiences of trauma which warranted attention. The latter point raised feelings of sadness for some members and anger for others. Many people did not deem themselves worthy of a determination assigned most often by both professionals and society in general to people in the military who "deserve" the recognition because of their experiences faced in combat ("I got angry at the doctor who tried to tell me I

have PTSD. I thought I wasn't worthy of the diagnosis because I didn't go through *real* trauma like soldiers in the war did.").

Additional content provided in the intervention required that members conduct a good deal of reflection about their thoughts and feelings and that they examine themselves and regularly practice techniques for "homework." Thus, although members were not expected to share the details of the traumatic events which they personally experienced, they were taught to identify their thoughts and feelings and to acknowledge that some of those thoughts and feelings have been problematic for them ("I tried doing my homework in Dunkin Donuts, but thinking about it made me literally cry tears in front of everyone. It was easier to take my time and do it at home."). Some members in particular reported uneasiness and doubt about themselves and the effects of their thoughts and feelings on their behavior. Despite education that thoughts and feelings are based on one's life experiences (i.e. thoughts inevitably develop through no fault of their own), some people in group had difficulty grasping the concept that particular beliefs, although naturally automatic, may be erroneous and, therefore, have detrimental influence on behavior. Others were saddened and frustrated by the fact that their usual style of thinking was at times ineffective ("I feel like I can't trust anyone at a job. They find things out, and I'm always eventually let go." and "I don't tell anyone about my mental illness. If I require an accommodation, I explain to people who don't need to know the details that I have a physical condition.").

Certain members of the group were unable to tolerate some of the material presented. As noted above, members were skeptical that they may have distorted their perception of stressful situations and their interpretation of subsequent reactions. Simply reviewing and attempting to recognize common symptoms of PTSD, such as fear, sadness, shame, and anger, proved to be

difficult for some, and they expressed firm conviction in their automatic beliefs which had served as a type of defense for them when experiencing those symptoms ("I avoid talking to or making friends with anyone other than people at program. Why should I trust anyone else? Avoiding them and their stigma has worked for me so far.").

As an example, a group member who had sustained emotional and physical abuse from her parent thought that, as a matter of course, it must be true that she was stupid and incapable of pursuing her dreams. She felt safest when not interacting with others who cannot be trusted with absolute certainty, yet she was devastatingly frightened of being alone. She faced numerous barriers in trying to build a life apart from family, such as attempting to hold a job. However, she protected herself with the idea that even when situations appear to proceed smoothly, they will eventually result in disaster, thus, the risk of making decisions and taking action initially seemed rather insurmountable to her. It was important for the group facilitator to present information in a structured, concrete format. With patience and time, that member of the group was able to open up and share more of her thoughts and feelings. Again, the structure of the group was such that members were reminded that the sessions should not be considered "psychotherapy" and that they were not expected to reveal private information and conduct a great deal of personal "work." Instead, an agenda was followed which included practical strategies for examining one's thoughts and feelings and recognizing the impact of such perceptions on behaviors. The member in question began to tentatively disclose experiences in which she found herself severely distressed, and she slowly dismantled such a situation in order to recognize her automatic, "normal" feelings yet subjective, questionable thoughts. For her, the process of developing ways to problem-solve and to take action was significant. She needed to take small steps in order to evaluate factual evidence about her situation, attempt to modify her

thinking, and willingly accept feedback from others about her strengths and resilience. The patience, non-judgement, and strong communication skills of the clinician are significant to the above processes for people using such services.

Another example involves a member who found goal-setting very stressful. She reported that developing goals and achieving them had been strictly enforced by her father when she was raised, and failure to reach goals resulted in abuse. She was aware of her desire as an adult to be able to go out and become involved in activities outside her home on a more frequent basis, and she wanted to increase her comfort in doing so. However, because of the fear instilled by her parent, she was at first unable to articulate the steps which could help her reach her objective. The ability of the facilitator to confidently discuss the situation and also effectively involve peer input in the process is quite obviously necessary in that scenario.

Those members of the group who were most cautious about using strategies to revise or change their thinking were also less clear from the start about their employment goals and less comfortable overall with future coworkers' possible attitudes of stigma or unrealistic concerns about psychiatric conditions. The members also questioned whether symptoms experienced were due to PTSD or the course of managing their mental health. However, those members demonstrated resilience despite their lack of recent experience with work or their focus on previous attempts which they had deemed in their eyes as failures. The participants required supportive recognition of their accurate thoughts which had led them to take some type of pertinent action.

Case Examples and Discussion

John is a 35-year-old African American male living in a large city in the mid-Atlantic region of the U.S., who attended the I-CBT for PTSD in SE group. John was diagnosed with

Bipolar Disorder and Borderline Personality Disorder. His first hospitalization occurred at age 14 and he had been hospitalized multiple times; the most recent hospitalization was three years prior to the start of the group. He had a long history of physical, sexual, and psychological abuse. At baseline, John reported his status as being an unemployed college student who wanted to work but feared employment. John was initially resistant to participating in the program. He held strong beliefs about his cognitive distortions related to work and trusting others and was resistant to considering them as cognitive distortions, refused to engage in breathing exercises, and wanted to talk to his counselor at all hours of the day / night. He also did not want to participate in group, was increasingly dysregulated, and a couple times said he wanted to drop out of the intervention. John and his counselor had a long talk together about his participation (or lack thereof), and, after a difficult conversation which addressed his accountability, he changed his mind and completely reversed his level of participation. John then actively participated in group, completed homework, and began to examine his cognitive distortions along with regularly using his breathing exercises to self-regulate. John's PTSD symptoms included moderate intrusive memories, severe distressing dreams, moderate cued psychological distress, severe cued physiological distress, moderate avoidance of memories, thoughts or feelings, moderate avoidance of external reminders, severe inability to recall important aspect of event, severe negative beliefs or expectations, mild distorted cognitions leading to blame, moderate persistent negative emotional state, mild irritable behavior and angry outbursts, moderate hypervigilance, and severe sleep disturbance (i.e. he experienced increased frequency of nightmares). His anxiety posed a challenge when working on group projects, as well as prevented him from taking the lead or asking questions in class at school. At one year follow up, he noted that he gained employment as a healthcare provider. Furthermore, he reported that he was able to overcome his

anxiety at both work and during his personal time by receiving support from-coworkers. He commented on how the practice and use of cognitive remediation led to more personal responsibility for handling his own thoughts and feelings and gave him more control over them. He was not taking medication at one-year follow-up. At Baseline, his PCL-5 was 36. During treatment his PTSD Checklist (PCL-5; with a cutoff score of 33 for probable PTSD) scores were 36, 40, 56, 4, and 12, at sessions 1, 4, 7, 10, and 12, respectively. At one-year follow-up after completion of the program, he no long met criteria for probable PTSD, as he had a score of 20 on PCL-5. His Beck Depression Inventory (BDI; with a score of 0-13 considered as "minimal depression," 14-19 as "mild depression," 20-28 "moderate depression," and 29-63 as "severe depression") scores were 8, 11, 20, 2, 3 at sessions 1, 4, 7, 10, and 12, respectively. At one-year follow-up after completion of the program, his BDI score was 2.

Steve is a 44-year-old white male living in a suburban city in the mid-Atlantic region of the U.S., who attended 12 sessions of the I-CBT for PTSD in SE group. Steve was diagnosed with Major Depressive Disorder and Pedophillic Disorder. He was referred to SE from a psychiatric hospital after being hospitalized for 11 years. Steve's reported his index trauma as physical abuse from his mother's ex-boyfriend which consisted of weekly beatings from age 4-17 years old. Before treatment, Steve's PTSD symptoms included: severe recurrent distressing dreams, severe dissociative reactions, moderate intense, prolonged psychological distress to internal or external cues, mild cued physiological reactions, moderate avoidance of internal reminders, severe avoidance of external reminders, mild inability to recall important aspects of events, moderate persistent/exaggerated negative beliefs, severe persistent negative emotional state, severe feelings of detachment, moderate persistent inability to experience positive emotions, mild irritable behavior/angry outbursts, severe hypervigilance, moderate exaggerated

startle response, and severe sleep disturbance. Steve was very excited to join the group and learn more about his symptoms of PTSD. During the group, he connected with others very easily and provided positive support to his peers. The skills learned in the I-CBT group particularly helped him challenge negative thoughts which he experienced while working at the local supermarket. Steve continuously tried to work on his recovery by staying committed to the group. At baseline, his PCL-5 was 59. During treatment his PTSD Checklist (PCL-5; with a cutoff score of 33 for probable PTSD) scores were 59, 47, 45, 25, and 25 at sessions 1, 4, 7, 10, and 12, respectively. At one-year follow-up after completion of the program, he no long met criteria for probable PTSD, as he had a score of 28 on PCL-5. His Beck Depression Inventory (BDI; with a score of 0-13 considered as "minimal depression," 14-19 as "mild depression," 20-28 "moderate depression," and 29-63 as "severe depression") scores were 29, 18, 11, 4, and 4 at sessions 1, 4, 7, 10, and 12, respectively. At one-year follow-up after completion of the program, his BDI score was quite low (4).

Discussion

The hesitation of community mental health center clinicians and administrators to discuss traumatic experiences which clients who are managing psychiatric conditions frequently experience may unintentionally be communicated to the clients who are using those services. Clients who experience trauma may feel unable to address the traumatic events which they had endured and the impact of that trauma on their daily functioning. When practitioners lack the confidence to remain present and supportive, they risk losing the opportunity for the client to experience relief and additional benefits (e.g. increased awareness) of simply sharing such instances (Newman & Kaloupek, 2004). Some providers, in fact, acknowledge the need for the development of trust and rapport necessary to discussing trauma (Frueh et al., 2006). Relevant

content may be developed and disseminated via training sessions about appropriate clinician attitudes, knowledge, and skills; such preparation could positively influence the comfort and confidence of providers in competently using trauma informed practices (Williams, & Smith, 2017; Wilson, & Nochajski, 2016).

While research shows that as many as two thirds of specialists have been found to evaluate trauma exposure and symptoms as well as make referrals for individuals diagnosed with PTSD, many clinicians do not utilize valid screening assessments (Young et al., 2005). Additionally, in a study of the provision of evidence-based treatment specifically appropriate for veterans with PTSD, 87% of practitioners failed to assign individuals to appropriate care after intake, citing various reasons such as referring clientele instead to alternate PTSD treatments, placing priority on other clinical issues, inability to engage the veterans, and even client misunderstanding and negative beliefs about treatment (Lu et al., 2016). Clearly, clinicians must be adequately trained to not only recognize traumatic reactions experienced by clients, but also accurately assess the severity of the impact on the functioning of individuals and the safety and well-being of those with continued exposure to trauma (e.g. ongoing domestic violence) (Frueh, 2012).

Group CBT for PTSD appears to provide therapeutic value for persons who are living with mental helath support needs and co-occuring PTSD. Multiple benefits including realization, relief, reflection, and re-learning were reported by clients who received structured group CBT for PTSD. Some clinicians reported that particular techniques may have been especially helpful, such as specific techniques for anger management, or techniques to ground oneself when experiencing a flashback or dissociation. On the other hand, additional interventions may be useful as adjunctive services. One client reported that she needed DBT in addition to CBT.

Another client who suffered the loss of her son due to drug overdose would have benefited from additional grief counseling due to her complicated grief symptoms and profound depression. Some group members reported to the group facilitator (GB) that they had looked forward to the groups and had built trust among each other; they stated that they would have preferred that the groups continue beyond 12 weeks. Agencies may benefit from implementing such groups at their agencies.

Our study is unique in that it provided group CBT intervention for PTSD, addressing the functional goal of employment. The research expands on previous work by Mueser et al (2015) by translating individual therapy into group format and linking functional impairment to PTSD treatment. Trauma diagnosis has been found to be predictive of less sustained employment among people living with and managing serious psychiatric conditions (Russinova et al., 2018). This study aims to address the consequenses of trauma in the domain of employment. The limitations of this study include a lack of systematic data collection of what clinicians and clients see as barriers to implementation.

Implications for Practice

The findings from the present study indicate that the introduction of group CBT treatment for PTSD in community mental health centers is not without its challenges. Inadequate trauma screening procedures or trauma assessments not only limit opportunities to engage clients in identifying trauma histories but also limit the supports available to access trauma treatment. Moreover,the lack of practitioner knowledge about best practices for trauma informed care or the treatment of trauma within the public mental health service sector contributes to the client's persistence of unmitigated traumatic stress, over pathologizing of trauma responses as mental health conditions, as well as impacts functional implications in role attainment. A group trauma

intervention may not suffice to meet all of the multifaceted needs of clients with trauma histories; they may be best served with additional complimentary treatments such as DBT or grief counseling. Lastly, when attempting to process their distressing event as a trauma which has profoundly impacted their wellness, self perception, and ways they view the world or others, clients may encounter great difficulty and a significant struggle.

Many clients who use psychiatric rehabilitation services may, indeed, experience distress when addressing trauma-related symptoms. However, there exists a disconnect between the ways in which clinicians expect clients to react to a trauma-focused intervention (e.g. concerns about "triggering") and the manner through which clients actually respond (e.g. feeling that the focus on trauma validates their experience). Our reported findings suggest that when persons using mental health services, administrators, clinicians, and clinical researchers work together, an optimal outcome may be obtained in providing trauma treatment to those who need it.

Authors' Notes

This research was supported by NIDILRR Field Initiated Grant # HHS-Administration for Community Living number 90IF0074. We wish to thank the following individuals for their assistance with this project: Carol Gao, Audra Schulman, Gabrielle Crisafulli, Crystal Socha, Arlene Campbell, Maria Lambarski, Alexis Pugh, Christina Fidanza, Lindsay Little, Laurie Vite, Jordan Horowitz, Anneke Habersaat, Susan Jagoditch, and Alicia McNeil.

Disclosure of Conflict of Interest

Disclosures: None for any authors

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Craine, L. S., Henson, C. E., Colliver, J. A., & MacLean, D. G. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital & community psychiatry*, *39*(3), 300–304. https://doi.org/10.1176/ps.39.3.300

Cusack K. J., Grubaugh A. L., Knapp R. G. & Frueh B. C. (2006). Unrecognized trauma and PTSD among public mental health consumers with chronic and severe mental illness. *Community Mental Health Journal, 42*(5), 487-500. https://doi.org/10.1007/s10597-006-9049-4

de Bont, P. A., van Minnen, A., & de Jongh, A. (2013). Treating PTSD in patients with psychosis: a within-group controlled feasibility study examining the efficacy and safety of evidence-based PE and EMDR protocols. *Behavior Therapy*, *44*(4), 717–730. https://doi.org/10.1016/j.beth.2013.07.002

Dondanville, K., Young-McCaughan, S., Mintz, J., Lapiz-Bluhm, D., Pruiksma, K., Yarvis, J., Peterson, A., Resick, P., Wachen, J., & , . (2019). Testing a variable-length cognitive processing therapy intervention for posttraumatic stress disorder in active duty military: design and methodology of a clinical trialhttp://dx.doi.org.proxy.libraries.rutgers.edu/10.1016/j.conctc.2019.100381

Fisher, D. (2017). *Heartbeats of Hope*: *The Empowerment Way to Recover Your Life*. National Empowerment Center.

Frueh, B. C., Grubaugh, A. L., Cusack, K. J., & Elhai, J. D. (2009). Disseminating evidence-based practices for adults with PTSD and severe mental illness in public-sector mental

health agencies. *Behavior Modification*, *33*(1), 66–81. https://doi.org/10.1177/0145445508322619

Frueh, B. C., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., & Wells, C. (2006). Clinicians' perspectives on cognitive-behavioral treatment for PTSD among persons with severe mental illness. *Psychiatric Services (Washington, D.C.)*, *57*(7), 1027–1031. https://doi.org/10.1176/ps.2006.57.7.1027

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., Yim, E., Robins, C. S., Monnier, J., & Hiers, T. G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric services (Washington, D.C.)*, *56*(9), 1123–1133. https://doi.org/10.1176/appi.ps.56.9.1123

Giourou, E., Skokou, M., Andrew, S. P., Alexopoulou, K., Gourzis, P., & Jelastopulu, E. (2018). Complex posttraumatic stress disorder: The need to consolidate a distinct clinical syndrome or to reevaluate features of psychiatric disorders following interpersonal trauma?. *World journal of psychiatry*, *8*(1), 12–19. https://doi.org/10.5498/wjp.v8.i1.12

Gottlieb, J. D., Mueser, K. T., Rosenberg, S. D., Xie, H., & Wolfe, R. S. (2011). Psychotic depression, posttraumatic stress disorder, and engagement in cognitive-behavioral therapy within an outpatient sample of adults with serious mental illness. *Comprehensive Psychiatry*, *52*(1), 41–49. https://doi.org/10.1016/j.comppsych.2010.04.012

Grubaugh, A. L., Clapp, J. D., Frueh, B. C., Tuerk, P. W., Knapp, R. G., & Egede, L. E. (2016). Open trial of exposure therapy for PTSD among patients with severe and persistent mental illness. *Behaviour Research and Therapy, 78,* 1–12. https://doi.org/10.1016/j.brat.2015.12.006

Grubaugh, A. L., Zinzow, H. M., Paul, L., Egede, L. E., & Frueh, B. C. (2011). Trauma exposure

and posttraumatic stress disorder in adults with severe mental illness: a critical review. Clinical psychology review, 31(6), 883–899. https://doi.org/10.1016/j.cpr.2011.04.003

Howgego, I. M., Owen, C., Meldrum, L., Yellowlees, P., Dark, F., & Parslow, R. (2005). Posttraumatic stress disorder: an exploratory study examining rates of trauma and PTSD and its effect on client outcomes in community mental health. *BMC Psychiatry*, *5*, 21. https://doi.org/10.1186/1471-244X-5-21

Lu, W., Mueser, K. T., Rosenberg, S. D., Yanos, P. & Mahnoud, N (2017a). Post-Traumatic reactions to psychosis: A qualitative analysis. Frontiers in Psychiatry, 8, 129.

Lu, W., Waynor, W. R., Yanos, P. T., Stone, B., Giocobbe, G., Reily, A., & Bazan, C. (2017b). The hidden barrier to employment: Untreated and undiagnosed Post Traumatic Stress Disorder. *Journal of Rehabilitation*, *83*(2), 11-16.

Lu, M. W., Plagge, J. M., Marsiglio, M. C., & Dobscha, S. K. (2016). Clinician documentation on receipt of trauma-focused evidence-based psychotherapies in a VA PTSD clinic. *The Journal of Behavioral Health Services & Research*, *43*(1), 71–87. https://doi.org/10.1007/s11414-013-9372-9

Lu, W., Yanos, P. T., Silverstein, S., Mueser, K., Rosenberg, S. D., Gottlieb, J. D., Duva, S. M., Kularatne, T., Dove-Williams, S., Paterno, D., Hawthorne, D., & Giocobbe, G. (2013). Public mental health clients with severe mental illness and probable Post Traumatic Stress Disorder: Trauma exposure and symptom severity. *Journal of Trauma Stress*, *26*(2). https://doi.org/10.1002/jts.21791

Macias, C., DeCarlo, L., Wang, Q., Frey, J., & Barreira, P. (2001). Work interest as a predictor

of competitive employment: Policy implications for psychiatric rehabilitation. *Administration and Policy in Mental Health*, *28*(4), 279–297. https://doi.org/10.1023/A:1011185513720

Marcello, S. C., Hilton-Lerro, K., & Mueser, K. T. (2009). Cognitive behavioral therapy for Posttraumatic Stress Disorder in persons with psychotic disorders. *Clinical Case Studies*, *8*(6), 438–453. https://doi.org/10.1177/1534650109355188

Meltzer, E. C., Averbuch, T., Samet, J. H., Saitz, R., Jabbar, K., Lloyd-Travaglini, C., & Liebschutz, J. M. (2012). Discrepancy in diagnosis and treatment of post-traumatic stress disorder (PTSD): treatment for the wrong reason. *The Journal of Behavioral Health Services & Research*, *39*(2), 190–201. https://doi.org/10.1007/s11414-011-9263-x

McNeill, G. & Galovsky, T. (2015). Coping styles among individuals with severe mental illness and comorbid PTSD. *Community Mental Health Journal*, *51*(6), 663–673. https://doi.org/10.1007/s10597-015-9887-z

Mihelicova, B., Brown, M., & Shuman, V. (2018). Trauma-informed care for individuals with serious mental illness: An avenue for community psychology's involvement in community mental health. *American Journal of Community Psychology*, *61*(1-2), 141–152. https://doi.org/10.1002/ajcp.12217

Minsky, S. K., Lu, W., Silverstein, S. M., Gara, M., Gottlieb, J. D., & Mueser, K. T. (2015). Service use and self-Reported Symptoms Among Persons With Positive PTSD Screens and Serious Mental Illness. Psychiatric services (Washington, D.C.), 66(8), 845–850. https://doi.org/10.1176/appi.ps.201400192

Mueser, K. T., Gottlieb, J. D., Xie, H., Lu, W., Yanos, P. T., Rosenberg, S. D., Silverstein, S. M.,

Duva, S. M., Minsky, S., Wolfe, R. S., & McHugo, G. J. (2015). Evaluation of cognitive restructuring for post-traumatic stress disorder in people with severe mental illness. *The British Journal of Psychiatry:The Journal of Mental Science*, *206*(6), 501–508. https://doi.org/10.1192/bjp.bp.114.147926

Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., Hamblen, J. L., Rosenberg, H. J., McHugo, G. J., & Wolfe, R. (2008). A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, *76*(2), 259–271. https://doi.org/10.1037/0022-006X.76.2.259

Mueser, K. T., Salyers, M. P., Rosenberg, S. D., Goodman, L. A., Essock, S. M., Osher, F. C., Swartz, M. S., Butterfield, M. I., & 5 Site Health and Risk Study Research Committee (2004b). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: demographic, clinical, and health correlates. *Schizophrenia Bulletin*, *30*(1), 45–57. https://doi.org/10.1093/oxfordjournals.schbul.a007067

Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., Auciello, P., & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, *66*(3), 493–499. https://doi.org/10.1037/0022-006X.66.3.493

Newman, E., & Kaloupek, D. G. (2004). The risks and benefits of participating in trauma-focused research studies. *Journal of Traumatic Stress*, *17*(5), 383–394. https://doi.org/10.1023/B:JOTS.0000048951.02568.3a

Nishith, M., Meuser, K., Morse, G., & Schumacher, U. (2019). Alcohol expectancies in persons

with severe mental illness and posttraumatic stress disorder. *Cogent Medicine*, *6*(1). https://doi.org/10.1080/2331205X.2019.1635805

Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2014). *Psychiatric Rehabilitation*. San Diego, CA: Academic Press.

Seal, K. H., Bertenthal, D., Maguen, S., Gima, K., Chu, A., & Marmar, C. R. (2008). Getting beyond "Don't ask; don't tell": an evaluation of US Veterans Administration postdeployment mental health screening of veterans returning from Iraq and Afghanistan. *American journal of public health*, *98*(4), 714–720. https://doi.org/10.2105/AJPH.2007.115519

Sin, J., Spain, D., Furuta, M., Murrells, T., & Norman, I. (2017). Psychological interventions for post-traumatic stress disorder (PTSD) in people with severe mental illness. *The Cochrane Database of Systematic Reviews*, *1*(1), CD011464. https://doi.org/10.1002/14651858.CD011464.pub2

Switzer, G. E., Dew, M. A., Thompson, K., Goycoolea, J. M., Derricott, T., & Mullins, S. D. (1999). Posttraumatic stress disorder and service utilization among urban mental health center clients. *Journal of Traumatic Stress, 12*, 25–39. https://doi.org/10.1023/A:1024738114428

Williams, T. M., & Smith, G. P. (2017). Does training change practice? A survey of clinicians and managers one year after training in trauma-informed care. *Journal of Mental Health Training, Education & Practice, 12*(3), 188-198.

Wilson, B., & Nochajski, T. (2016). Evaluating the impact of trauma-informed care (TIC) perspective in social work curriculum. *Social Work Education*, *35*(5), 589–602. https://doi.org/10.1080/02615479.2016.1164840

Wolff, N., Frueh, B. C., Shi, J., & Schumann, B. E. (2012). Effectiveness of cognitive-behavioral trauma treatment for incarcerated women with mental illnesses and substance abuse disorders. *Journal of anxiety disorders*, *26*(7), 703–710. https://doi.org/10.1016/j.janxdis.2012.06.001

Young, H. E., Rosen, C. S., & Finney, J. W. (2005). A survey of PTSD screening and referral practices in VA addiction treatment programs. *Journal of Substance Abuse Treatment*, *28*(4), 313–319. https://doi.org/10.1016/j.jsat.2005.02.006

Table 1. Demographic/ Clinical Characteristics

	Study 1 (N=536)		Study 2 (N=132)	
	N	%	N	%
Gender				
Male	288	53.7	51	38.6
Female	248	46.3	81	61.4
Race/ Ethnicity				
African American	248	46.3	56	42.4
White (non-Hispanic)	187	34.9	58	43.9
Hispanic	38	7.1	8	6.1
Other	26	4.9	10	7.6
Missing	37	6.9	0	0
Primary Psychiatric Diagnosis				
Schizophrenia/ Schizoaffective	92	27.5	28	21.2
Depressive Disorders	114	34.1	55	41.7
Bipolar Disorders	92	27.5	38	28.8
Other	36	10.8	11	8.3
	M	SD	M	SD
Age	47.23	12.91	45.97	11.94
BAI			23.44	12.33
BDI			27.03	12.11
CAPS-5			37.21	10.25
PCL-5	36.44	21.31	48.84	14.76
BPRS			47.3	8.53

Table 2. Demographics of Clinicans

Characteristic		N	%
Age	>40	7	50
	<40	7	50
Gender			
	Male	2	14.3
	Female	12	85.7
Racial-ethnicity			
	White	11	78.6
	African American	3	21.4
	Asian	0	0
	Hispanic	0	0
	Other	0	0
Licensure			
	Social Worker	3	21.4
	Certified Rehabilitation Counselor	2	14.3
	Certified Psychiatric Rehabilitation Practioner	3	21.4
	Professional Counselor	1	7.14
Highest Degree			
	Bachelor's	3	21.4
	Master's	9	64.3
	Doctorate	0	0
	Missing	2	14.3

Table 3. Descriptions of group process provided by clients receiving group CBT for PTSD

Realization	* Some examination of events was required
	* Process was arduous yet eye-opening
Relief	* Ability to share, release, vent, help
	* Application of illuminating material
Reflection	* Exploration of experiences and emotions
	* Recognition of automatic thoughts/distortions
Re-learn	* Reduce stress

* Identify feelings
* Alter thinking
* Change behaviors
* Develop strategies
* Resolve problems

View publication stats