

BRIEF REPORT

Online Group-Based Internal Family Systems Treatment for Posttraumatic Stress Disorder: Feasibility and Acceptability of the Program for Alleviating and Resolving Trauma and Stress

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Objective: Demand for trauma-focused therapy continues to increase, especially in community mental health care settings where group treatment models can be cost-effective and increase access to care. The Internal Family Systems (IFS) model for posttraumatic stress disorder (PTSD) may offer an effective therapeutic approach. The purpose of this proof-of-concept study was to evaluate the feasibility and acceptability of a novel, trauma-focused, group-based treatment approach and investigate potential mechanisms of action. **Method:** Study participants completed the Program for Alleviating and Resolving Trauma and Stress (PARTS), an online-delivered program including 16 weeks of 90-min IFS-based groups with eight 50-min individual IFS counseling sessions. Participants completed assessments including clinician-administered and self-report measures of PTSD, common comorbid conditions (e.g., complex PTSD [disturbances in self-organization], depression, anxiety, and suicidality), and potential mechanisms (e.g., decentering, self-compassion, and emotion regulation). **Results:** Most participants ($n = 11/15$; 73%) attended 12+ group sessions, with 92% (12/13 responders) reporting they would recommend PARTS to a friend. All respondents reported the program was helpful (13/13; 100%). PTSD symptom severity was reduced from baseline to Weeks 16 ($d = -0.7$, $p = .005$) and 24 ($d = -0.9$, $p < .001$). A clinically meaningful response (i.e., 10+ point reduction on the Clinician-Administered PTSD Scale for *Diagnostic and Statistical Manual of Mental Disorders* [5th ed.]) was demonstrated in 53% of participants (8/15) by Week 24. Decentering, self-compassion, and emotion regulation all improved ($p < .05$). **Conclusions:** PARTS was feasible and acceptable as a group-based, online intervention in an urban, public community health care system. While PARTS showed promise in reducing overall PTSD symptom severity, well-controlled efficacy research is needed.

Clinical Impact Statement

This proof-of-concept study examined the feasibility and acceptability of an online trauma-focused treatment utilizing the Internal Family Systems Therapy (IFS) approach for individuals with posttraumatic stress disorder (PTSD). Treatment included 16 weekly groups and eight biweekly individual counseling sessions. Results demonstrated that this treatment approach was feasible and acceptable among participants in a public health care system. Clinically significant reductions in PTSD total symptom severity were seen over the course of treatment and at follow-up. These preliminary findings suggest that an online IFS group-based approach to PTSD treatment may be an efficient way to deliver PTSD treatment, compelling further empirical study.

Keywords: posttraumatic stress disorder, group, psychotherapy, emotion regulation, complex posttraumatic stress disorder

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continued

While several evidence-based treatment options for posttraumatic stress disorder (PTSD) are currently available, PTSD in the community is often accompanied by complex trauma and/or psychiatric comorbidities (Coventry et al., 2020). Hence, more feasible and effective treatments are needed for the multifaceted and varied presentations of PTSD (Roberts et al., 2015). Current research suggests that single-component treatments for PTSD symptomology do not target these comorbidities and that many effective interventions have thus far been impractical for implementation (Coventry et al., 2020).

The Internal Family Systems (IFS) model targets the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) PTSD symptomatology, while also addressing disturbances in self-organization (DSO), a hallmark of *International Classification of Diseases, 11th Revision* Complex PTSD (Shevlin et al., 2018), and common comorbidities (e.g., depression, anxiety; for an explanation of the IFS treatment model and potential key mechanisms of action, see Supplemental Materials). While research on IFS is limited, it is widely utilized, with 12,000+ fully trained clinicians by the end of 2022 (IFS Institute, personal communication), and evidence of its clinical effect is emerging (Hodgdon et al., 2022; Shadick et al., 2013). For instance, a recent pilot study examining IFS for PTSD symptoms reported significant reductions in PTSD, depressive, and disrupted self-perception symptoms following 16 weekly, 90-min individual sessions (Hodgdon et al., 2022). While patients seemed to like the 90-min individual sessions, it would have been impractical to implement for a community mental health care system with limited clinician availability for individual therapy (Hodgdon et al., 2022) because it required 288 clinician hours for treating 12 persons. The need for resource-efficient interventions may be especially salient for community mental health care systems with limited resources and high demand. The present study paired a group-based model of IFS for PTSD with limited individual counseling, which may benefit both patients seeking treatment and health care systems seeking cost-effective solutions. Program for Alleviating and Resolving Trauma and Stress (PARTS) provides care to more patients for less cost with minimal clinician time (i.e., 104 clinician hours to treat 12 persons).

The present study was conducted in an ethnically and socioeconomically diverse community health care system in the Metro Boston area. This proof-of-concept, single-arm Stage 1 behavioral therapy study (Rounsaville et al., 2001) examined the acceptability and feasibility of the PARTS, an online group-based, IFS approach, while also investigating the effects on clinical symptoms (e.g., PTSD, DSO, depression, and anxiety) and on three potential mechanisms (i.e., decentering, self-compassion, and emotion regulation).

Method

Participants

We recruited adults aged 18–70 years by clinician referral. Of the 26 patients referred, five did not pass the prescreen call. After

informed consent, six were not allocated to the program due to withdrawal at screening ($n = 3$) or not meeting inclusion criteria, including insufficient level of PTSD symptom severity ($n = 2$) and indication of mania/hypomania, acute suicidality, and current severe depression ($n = 1$; see Supplemental Material for details). Participants ($N = 15$) were assigned to the intervention (see Supplemental Figure 1). The study was approved by the Cambridge Health Alliance Institutional Review Board (CHA-IRB-1158/09/20), and outcomes were registered a priori (NCT04713501).

Procedure

The PARTS intervention is an integrated IFS group-based approach delivered online via videoconference, including 16 weekly, 90-min IFS-based groups with eight twice-monthly, 50-min individual IFS counseling sessions. Group and individual sessions were provided as insurance billable, online outpatient psychiatry visits by a Cambridge Health Alliance clinician who had completed IFS Level 2 Training. Outcome measures included in analyses were collected at three time points: baseline, Week 16, and Week 24 (see Supplemental Figure 2). Participants completed a baseline survey for sociodemographic variables (e.g., gender, race, income, and education). Program retention and session attendance were recorded to assess feasibility (Najavits, 2015). The primary acceptability item was a priori defined as “I would recommend this program to a friend,” at Week 16 using a 5-point Likert scale, with responses of *mildly agree* to *strongly agree* indicating acceptability (Reichheld, 2003). Adverse event (AE) reports were collected biweekly and postintervention.

We utilized several measures to assess PTSD and other mental health symptoms: Life Events Checklist Version–5 (Weathers et al., 2013) to identify lifetime traumatic events; Clinician-Administered PTSD Scale (CAPS-5; Weathers et al., 2018), administered by a trained interviewer, to assess PTSD *DSM-5* diagnosis and symptoms; PTSD Checklist for *DSM-5* (PCL-5; Blevins et al., 2015) to measure PTSD symptom severity over the past month; International Trauma Questionnaire (ITQ; Cloitre et al., 2018) to assess DSO; and modules from the Computer Adaptive Testing for Mental Health interview (CAT-MH; Achtyes et al., 2015) to screen for PTSD (CAT-PTSD; Brenner et al., 2021), mania/hypomania (CAT-MANIA), depression (CAT-DI), anxiety (CAT-ANX), and suicide risk (CAT-SS; Gibbons et al., 2017). Mechanisms were assessed with the Experiences Questionnaire–Decentering (EQ-D; Fresco et al., 2007) to measure decentering; Self-Compassion Scale–Short Form (SCS-SF; Raes et al., 2011) to measure self-compassion; and Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) to assess emotion regulation difficulties.

We used univariate statistics to summarize baseline demographics and main feasibility and acceptability outcome measures. We conducted a repeated measures analysis using linear mixed-effects models with fixed parameters for primary (16 weeks) and secondary endpoints (24 weeks) and participant-specific random

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Table 1*Primary Outcome: Clinician-Administered PTSD Scale for DSM-5, Mixed-Effects Analysis*

Outcome	Baseline	Week 16	Week 24	Differences over time baseline to Week 16		Differences over time baseline to Week 24	
	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	β (<i>SE</i>)	<i>d</i>	β (<i>SE</i>)	<i>d</i>
CAPS-5 total severity	28.0 (2.8)	19.9 (3.0)	16.7 (3.3)	-8.1 (2.9)**	-0.7	-11.3 (3.2)***	-0.9
Criterion B (Intrusion)	6.6 (0.8)	3.3 (0.9)	3.1 (1.0)	-3.3 (1.0)**	-0.9	-3.5 (1.1)**	-1.0
Criterion C (Avoidance)	3.5 (0.4)	2.1 (0.5)	1.2 (0.6)	-1.5 (0.6)*	-0.7	-2.3 (0.7)**	-1.2
Criterion D (Mood/Cognition)	11.0 (1.4)	8.1 (1.5)	7.0 (1.7)	-2.9 (1.5)*	-0.5	-4.0 (1.6)*	-0.7
Criterion E (Arousal/Reactivity)	6.9 (0.9)	6.4 (1.0)	5.1 (1.1)	-0.5 (0.8)	-0.1	-1.7 (0.9)	-0.5

Note. These are the criteria of PTSD (<https://www.ncbi.nlm.nih.gov/books/NBK525126/table/ch2.tab1/>). *N* = 15. Total severity (range 0–80); Intrusion (range 0–20); Avoidance (range 0–8); Mood/Cognition (range 0–28); Arousal/Reactivity (range 0–24). PTSD = posttraumatic stress disorder; CAPS-5 = Clinician-Administered PTSD Scale for DSM-5; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.); *SE* = standard error.

* $p < .05$. ** $p < .01$. *** $p < .001$.

intercepts. We calculated standardized effect sizes expressed as Cohen's *d*. We conducted similar analyses to assess exploratory mechanisms. We conducted sensitivity analyses with nonparametric Wilcoxon-ranked sums and mixed-effects generalized linear models with negative binomial distributions and log links when distributions were nonnormal, skewed, or overdispersed (see [Supplemental Materials](#)). Clinically meaningful response was defined as a reduction of 10 points in the CAPS-5 by Week 24 (O'Neil et al., 2019), and reliable change index was defined as a reduction of 15 points in the PCL-5 by Week 24 (Marx et al., 2022). We conducted independent *t* tests and Fisher's exact tests to examine attrition bias and to determine potential differences in baseline mental health and demographic variables associated with intervention withdrawal, completion of Week 16 outcomes, or Week 24 follow-up assessments. To prevent bias during analysis, an external statistical consultant (TBC) monitored the analysis plan, STATA 17 syntax, and results.

Results

Sample Characteristics

Participants (*N* = 15) were 86.7% (*n* = 13) female with a median age of 33 years (range = 29–49). Approximately 60% (*n* = 9) of participants identified as White, 20.0% (*n* = 3) identified as Black/African American, and 20% (*n* = 3) identified as Hispanic. Among traumatic experiences reported, 35% (*n* = 7) reported childhood physical or sexual abuse, and 25% (*n* = 5) reported intimate partner violence (see [Supplemental Table 1](#)).

Feasibility, Acceptability, and Outcomes

Participants (*N* = 15) allocated to PARTS attended a mean of 12.1 (*SD* = 3.9) of 16 sessions, with 80% (*n* = 12) attending 8+ sessions, and 73% (*n* = 11) attending 12+ sessions. By Week 16, 73% (*n* = 11) were still enrolled in the group; several (*n* = 4) withdrew for various reasons, that is, group was overwhelming (*n* = 2), difficulty engaging in group (*n* = 1), scheduling conflict (*n* = 1). Acceptability results demonstrated that 92% of responders (12/13) would recommend the program to a friend and 100% of responders (13/13) found the program helpful. Three adverse events were possibly to probably related to the intervention and were the result of

increased PTSD symptoms during one of the first four sessions of group; these symptoms were transient and expected, and all three participants continued the intervention following the adverse event (see [Supplemental Table 3](#)).

Mixed models analysis revealed reductions over time both in CAPS-5 PTSD symptom total severity (Week 16: $d = -0.7$, $p = .005$; Week 24: $d = -0.9$, $p < .001$; [Table 1](#)) and in self-reported PTSD symptom severity using CAT-PTSD ($d = -1.2$, $p < .001$; $d = -1.2$, $p < .001$, respectively) and PCL-5 ($d = -1.0$, $p < .001$; $d = -1.2$, $p < .001$, respectively; [Table 2](#)). A clinically meaningful response on CAPS-5 was demonstrated in 53% (8/15) by Week 24, and a reliable change index on PCL-5 was reached by 53% (8/15) by Week 24. PARTS was also associated with significant decreases in anxiety (CAT-ANX), depression (CAT-DI), suicide risk (CAT-SS), self-reported DSO (ITQ-DSO), emotional dysregulation (DERS), and increased decentering (EQ-D) and self-compassion (SCS-SF) at Weeks 16 and 24 ([Table 2](#)).

Discussion

This proof-of-concept study suggests that PARTS is a feasible and acceptable intervention for patients with PTSD in a community mental health care setting. The program exhibited feasibility with retention rates on par or better than other evidence-based, trauma-focused treatments for PTSD (Najavits, 2015). High levels of acceptability suggest participants felt it was helpful for PTSD. PARTS shows promise as a novel intervention for addressing PTSD, complex PTSD, depression, anxiety, and suicide risk. PARTS demonstrated symptom reductions similar to past studies of individual IFS therapy for PTSD and common comorbidities (Hodgdon et al., 2022). However, delivery in a group-based format used fewer resources (i.e., a 64% reduction in clinician time from the individual IFS PTSD model).

The present study also identified preliminary evidence for three theoretically relevant mechanisms for PTSD symptom reduction using the IFS-based therapeutic approach. We identified decentering as a mechanism, as IFS may allow participants to decenter from the cognitive and emotional aspects of experience through a process called "unblending" (see [Supplemental Material](#)). This approach differs from standard mindfulness-based interventions and cognitive behavioral therapy, which focus on changing one's relationship to thought content (e.g., "thoughts are not facts"; Boggs et al., 2014).

Table 2*PTSD Measures, Mental Health Outcomes, and Exploratory Mechanisms, Mixed-Effects Analysis*

Outcome	Baseline	Week 16	Week 24	Differences over time baseline to Week 16		Differences over time baseline to Week 24	
	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	β (<i>SE</i>)	<i>d</i>	β (<i>SE</i>)	<i>d</i>
PCL-5	42.6 (4.0)	24.9 (4.3)	21.0 (4.5)	−17.7 (3.7)***	−1.0	−21.6 (4.0)***	−1.2
CAT-PTSD	62.1 (3.7)	42.4 (4.1)	41.6 (4.9)	−19.7 (4.7)***	−1.2	−20.5 (5.4)***	−1.2
CAT-ANX	64.6 (4.7)	42.0 (4.9)	42.9 (5.6)	−22.6 (4.3)***	−1.1	−21.7 (5.0)***	−1.1
CAT-DI	61.6 (4.7)	52.0 (4.9)	47.9 (5.5)	−9.6 (4.2)*	−0.5	−13.7 (4.8)**	−0.7
CAT-SS	49.8 (4.2)	36.9 (4.4)	34.5 (4.9)	−12.9 (3.5)***	−0.8	−15.3 (4.0)***	−0.9
ITQ-DSO	15.4 (1.4)	8.7 (1.5)	7.5 (1.6)	−6.7 (1.4)***	−1.1	−7.9 (1.5)***	−1.3
EQ-D	31.0 (1.7)	35.5 (1.8)	36.4 (1.8)	4.5 (1.4)**	0.6	5.4 (1.5)***	0.8
SCS-SF	2.2 (0.2)	2.9 (0.2)	3.0 (0.2)	0.7 (0.2)***	0.9	0.8 (0.2)***	1.0
DERS	106.7 (6.1)	86.9 (6.5)	85.4 (6.8)	−19.9 (5.3)***	−0.8	−21.4 (5.6)***	−0.8

Note. *N* = 15. PTSD = posttraumatic stress disorder; *SE* = standard error; PCL-5 = PTSD Checklist for *DSM-5* (range 0–80); *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.); CAT-PTSD = Computer Adaptive Test–PTSD (range 0–100); CAT-ANX = Computer Adaptive Test–Anxiety (range 0–100); CAT-DI = Computer Adaptive Test–Depression (range 0–100); CAT-SS = Computerized Adaptive Test–Suicide Scale (range 0–100); ITQ-DSO = The International Trauma Questionnaire–Disturbances of Self-Organization (range 0–24); EQ-D = Experiences Questionnaire–Decentering (range 11–55); SCS-SF = Self-Compassion Scale–Short Form (range 1–5); DERS = Difficulty in Emotion Regulation Scale (range 36–180).

* *p* < .05. ** *p* < .01. *** *p* < .001.

and challenging distorted thoughts (Beck, 2020), respectively. In contrast, IFS directly addresses the mind's tendency to self-identify with current thoughts/feelings/urges that may otherwise make disengagement more difficult, by framing this content as coming from a "part." As IFS encourages relationship-building between the "Self" and "parts," individuals can "be with" the experience while fostering meta-awareness (i.e., decentering) and reducing the potential for internal conflict between competing, self-identified thought patterns. Our findings also suggest that self-compassion may be a potential mechanism of symptom reduction. The IFS conceptualization of the "Self," which approaches all "parts" with acceptance and compassion, appears to increase self-compassion through different processes than other compassion-based interventions (Neff & Germer, 2013). Finally, the process of identifying "parts" may help with emotion differentiation (Barrett et al., 2001) while mitigating tension between "parts," thereby reducing difficulties in emotion regulation (Powers et al., 2015; Schuman-Olivier et al., 2020).

The present study had several limitations. First, results may not be generalizable due to the small sample size (*n* = 15) and limited gender diversity. While racial diversity was in line with national census data (Jones et al., 2021), Black participants completed fewer Week 24 follow-ups. Future studies would benefit from diverse study teams and attention to Black participant engagement.

Without a controlled design, nonspecific group effects (Newton-John & Geddes, 2008), placebo-/expectation-related effects, regression to the mean, and/or demand characteristics may have had an impact unrelated to the intervention's theoretical approach (Enck & Zipfel, 2019). This single-arm proof-of-concept study had a small sample with some binomial and overdispersed distributions. While sensitivity analysis either confirmed the original analysis results or showed larger changes than the original linear mixed-effects models, findings represent preliminary estimations; they do not definitively infer causality and should be interpreted with caution (Zhang et al., 2013).

Due to the promising results of this research, a robust randomized control trial using an attention and time-matched comparison may provide insight into the "real-world efficacy" of PARTS on PTSD

symptoms and comorbid symptoms, and mechanisms of changes in PTSD symptomatology. Future research is needed to investigate both the effects of PARTS on dissociation and the additional specific mechanisms of action of the group in a group-based IFS intervention format.

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