

POST-TRAUMATIC STRESS DISORDER AND TREATMENT

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Abstract

Post-traumatic stress disorder (PTSD) symptoms have been estimated to affect about 8 to 9% of the world population. Research has shown that PTSD occurs in 25% of persons who have been exposed to a traumatic stressor. It has occurred in 35-92% of those who have experienced rape, 65% of those who have endured a nonsexual assault, and 30% of Vietnam veterans. In 1980, the definition of PTSD was created and counsellors were at a loss of how to treat this disorder. Presently, treatment for this disorder is still being developed. This paper conducts a literature review on therapies for PTSD and available studies of their effectiveness. Most psychotherapies for PTSD focus on the reprocessing of traumatic memory, through cognitive or exposure strategies. These treatments include various cognitive behavioural therapies such as exposure therapy, eye movement desensitization and reprocessing (EMDR), psychoanalytic, as well as multimodal combinations of therapies. Research has shown that some of these interventions have produced favourable results in providing relief of symptoms to victims of PTSD. The current discussion found that therapies such as cognitive and exposure have been successful in decreasing symptoms of PTSD; certain therapies were found to be more successful than others with clients who suffered from specific trauma-inducing events.

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Post-Traumatic Stress Disorder and Treatment

Traumatic incidents can occur in any context, at any given time, and numerous individuals in society are vulnerable to their adverse psychological effects. For the past few decades, researchers and other professionals have examined and studied the outcomes of experiencing a traumatic event. This examination has led researchers to search for various treatments in hopes of decreasing, or even alleviating symptoms of trauma (Pasillas, & Follette, 2008). Although some research has found that many individuals will recover from the traumatic event, other persons may experience adverse effects and may be left with life-long symptoms of trauma (Pasillas, & Follette). Although there are different sequelae to trauma, the focus of this paper will be on the symptoms described in post-traumatic stress disorder.

Prevalence of Post-Traumatic Stress Disorder

In the late eighties, post-traumatic stress disorder (PTSD) symptoms were estimated to affect about 8 to 9% of the world population (Wolfe, 1989); however, this number has been steadily increasing. Research has shown that PTSD occurs in 25% of persons who have been exposed to a traumatic stressor (Greene, 1994). It has occurred in 35-92% of those who have experienced rape, 65% of those who have endured a nonsexual assault, and 30% of Vietnam veterans (Figley, 1995; Greene).

Experiences of trauma have long been correlated with continuing stress and anxiety; however, despite these findings, trauma and PTSD did not emerge as an identifiable psychiatric condition until the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). Since PTSD has become recognized as a psychiatric disorder, numerous treatments have been

developed for the PTSD condition and acknowledgment of trauma symptoms has improved (Danovitch, 2006).

Incidents such as 9/11 have resulted in PTSD becoming a more frequently prevailing disorder in society. Some clinical studies have found that an estimated 75% of individuals will endure traumatic circumstances that may result in the potential for PTSD (Danovitch, 2006); furthermore, 25 - 33% of these individuals may experience the consequence of PTSD and its symptoms (Danovitch). Therefore, these numbers reflect an alarming need for mental health professionals to examine this psychiatric condition in order to produce effective treatment interventions for victims of PTSD.

In Search of PTSD Treatment

In 1980, the definition of PTSD was created in concordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), generating difficulty for counselors. The acknowledgment that trauma survivors portrayed a distinctive variety of responses called for remedies that were not yet in existence at the time. The search for appropriate and effective treatment interventions continued to be a significant concern in more recent counseling practice (McFarlane & Yehuda, 2000). Although various interventions have provided a framework for professionals in the study of trauma, current applications have yet to produce results that can provide relief from all trauma symptoms (McFarlane & Yehuda) in the PTSD framework.

Treatment Modalities

Most psychotherapies for PTSD focus on the reprocessing of traumatic memory, through cognitive or exposure strategies (Danovitch, 2006; Foa, 2000, 1999). These treatments have included various cognitive behavioural therapies such as exposure

therapy, eye movement desensitization and reprocessing (EMDR), psychoanalytic, as well as a multimodal combination of therapies (Foa). Research has shown that some of these interventions have produced favourable results in providing relief of some symptoms to victims of PTSD. However, a goal for researchers is to determine specific interventions that result in a decrease or alleviation of all PTSD symptoms (Bradley, Greene, Russ, Dutra, & Westen, 2005). Furthermore, although there exists a vast array of interventions for trauma, establishing which PTSD treatments provide the most favourable outcomes and for which individuals, remain a focus for present research (Ford & Kidd, 1998).

PTSD and Comorbidity

PTSD has often been found to occur in conjunction with other psychiatric disorders such as depression and anxiety (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Ouimette, 2000); furthermore, substance abuse is also frequently associated with trauma symptoms (Kessler et al.). PTSD has been said to occur as a result of continual exposure to trauma cues (Brewin, Andrews, & Valentine, 2000). Findings from one clinical study that examined trauma and comorbidity revealed that individuals who presently have PTSD, describe more stress incidents preceding their experience resulting in their diagnosis of PTSD (Brewin et al.). This signals the importance of examining past histories of individuals who have endured trauma (Inaba & Cohen, 2004; Ouimette, 2000). The complex dynamic of the difficult events that individuals experience, as well as the psychological consequences of these events, results in complexities for professionals in treating PTSD.

A Need for Effective Treatments

PTSD can often be comorbid with mental health and addiction issues (Inaba & Cohen, 2004). Furthermore, diverse trauma populations may require individually-tailored treatments in order to be effective. Lastly, gender is also an issue with women more often being the victims of trauma at earlier ages (Clark et al., 2005). The age at which a traumatic incident occurs also appears to have an impact on the experienced outcome of the trauma (Schumacher, Coffey, & Stasiewicz, 2006), and resulting PTSD symptoms. Therefore, taking into account some of the factors that have a bearing on PTSD treatment outcomes, the aim of this project is to examine and discuss treatment options for various types of trauma victims in order to uncover successful therapies for individuals who have experienced PTSD.

Chapter I: Theoretical Foundations

Trauma

Various forms of trauma exist; individuals can experience psychological trauma in situations of war, violence, childhood abuse and sexual assault. The consequence of trauma may affect cognitive and physical functioning (Flannery & Everly, 2000). Not all individuals that have experienced a traumatic event manifest PTSD symptoms; there may be other cognitive, physical sequelae such as muscle tension or headaches or psychosomatic problems, or psychological sequelae such as loss of trust and low self-worth (Flannery & Everly). Many individuals may also experience symptoms similar to PTSD but not be diagnosed due to variations in its presentation in accordance with the varying traumatic stressors (Herman, 1997).

PTSD and Symptoms

PTSD is characterized by re-experiencing of the traumatic event, avoidance of reminders of the event, and hyperarousal symptoms that continue for more than 1 month proceeding a traumatic incident (Diagnostic and Statistical Manual of Mental Disorders; 4th ed., text rev. [DSM-IV-TR]; American Psychiatric Association, 2000). Recent research has postulated that about 1 in 9 women and 1 in 20 men have experienced an event that has resulted in the surfacing of PTSD symptoms (Kessler et al., 1995). Therefore, these approximations can suggest that about 11 million women and 5 million men in the United States have experienced, or are currently experiencing PTSD as a result of suffering a trauma.

Researchers have reported that PTSD victims may experience increased physiological arousal as well as a continual re-living of their trauma through visions and memories

(Danckwerts & Leathem, 2003). Disturbing visions may interrupt regular functioning resulting in uncharacteristic behaviour from the affected individual for an undetermined period of time. Furthermore, this constant and irregular stimulation on the mind may result in the restructuring of various features in the brain as well as potentially producing adverse effects on memory processes, affective functions, and symptoms which may impinge on the individual's ability to perform further mental operations (Danckwerts & Leathem; Yehuda, 2002).

Prolonged PTSD

Researchers have commented that a lack of education and information about PTSD and trauma may result in prolonged PTSD when an individual experiences PTSD in the long-term (Klein, Caspi, & Gil, 2003). Prolonged PTSD may result in an individual's sense of self becoming completely unidentifiable because symptoms have overtaken their ability to think and act as they normally do (Klein et al., 2003). The result of the trauma may cause a person to question themselves and who they have become. The individual may further be distressed by the idea that they have degenerated into a completely different person encompassing uncharacteristic thoughts and behaviors. This is also true of repeated trauma, where these symptoms may be exacerbated and result in complex forms of PTSD (Herman, 1997).

As a further consequence of experiencing a trauma, the affected person may now view the world as dangerous and everyone around them may be perceived as questionable or harmful. Their worldview becomes disrupted (Herman, 1997). This unfavorable outcome may generate incongruence within the individual because their transformed thoughts and feelings could feel alien to them (Klein et al., 2003).

Complexities with the PTSD Diagnosis

A problem for researchers in diagnosing persons with PTSD is that the assessment process often remains incomplete. The trauma that was the alleged cause of PTSD may not be the sole cause of this disorder; other causes for symptoms may, or may not be revealed dependent on if the assessment process is brief and more thorough. In contrast, other disorders may result from trauma in which trauma is no longer viewed as the root cause and consequently, it is left untreated. Furthermore, PTSD can be the result of the experience of multiple traumas (Klein et al., 2003; Shear, 2002). Traumatic incidents may result in uncharacteristic thoughts from the affected individual. The individual may believe that their own life, or another's is endangered. This distress may lead to a common feeling of helplessness in combination with a strong component of terror. There are numerous incidents that may result in the presence of PTSD (Danckwerts & Leathem, 2003). Trauma populations are discussed in a further section.

Chapter II: Procedures

This project conducts a literature review to examine PTSD, and the treatment modalities for this disorder. The goal of the project was to examine and describe forms of treatment for various types of trauma resulting in PTSD and taking into account diverse individual characteristics. A literature review was conducted and the end result was a discussion of trauma, PTSD and treatment options. The following project defines and discusses PTSD and its prevalence in our world today. Furthermore, trauma-inducing events in the research literature are identified such as war, disaster, abuse (physical, sexual, emotional) and violence. PTSD that is comorbid with others disorders and addiction is also discussed. Further sections discuss PTSD and the need to have effective therapies for this disorder. Lastly, multimodal therapies are also examined.

Approach to the Literature Review

I utilized quantitative and qualitative studies from the PsycINFO database within Ebsco Host that were published on or after the year 2004, as well as books that were published in relation to trauma and PTSD. Key words that were initially searched for were trauma, post-traumatic stress disorder, war veterans, cognitive therapy, exposure therapy, sexual assault, disaster and childhood abuse. Extending the search were key words encompassing treatment and therapy in relation to trauma and PTSD, comorbidity and addiction. All of these above words were used to create the end result of the literature review about trauma and treatment. Literature reviews about trauma and PTSD were also utilized to aid in synthesizing information. Lastly, I searched using these words but included multimodal and trauma in order to review studies that examined a combination of therapies for trauma. Innovative therapies that were mentioned in research were also

included in this literature review to highlight unique treatment methods and their utility in regards to specific trauma-induced events.

Chapter III: PTSD-Inducing Events and Comorbidity

Various incidents can result in the experience of trauma or PTSD affecting different populations. Trauma populations that have been extensively researched involve military personnel and war veterans, victims of sexual and/or physical abuse, and refugees. These forms of trauma are discussed below.

Military Personnel and War Veterans

Recent research suggests that military employees are at risk for acquiring PTSD (Danckwerts & Leathem, 2003). The Veterans Affairs health care system has deemed PTSD as one of their greatest challenges; persons within the field of counseling, psychology and research concur with this statement (Bell & Nye, 2007).

Research has examined combat exposure and has found it to have a strong association with the development of PTSD (Fontana & Rosenheck, 1993). Furthermore, researchers have postulated that numerous reasons exist for the occurrence of PTSD within the war veteran population. One cause of trauma may be the continual violent experiences involved in the participation of war, as well as witnessing acts of violence and brutality (Fontana & Rosenheck). However, further contributing reasons for the development of PTSD may also involve war veteran's failed attempts to reintegrate themselves back into society when they returned from the war, as well as the absence of psychiatric support upon return from combat (Appy, 1993). Lastly, the absence of social support processes could have resulted in further adverse psychological effects for veterans (Appy; Grossman, 1995).

Researchers have found that 15% of military veterans returning from Vietnam experienced symptoms, and met criteria for PTSD; 30% of these victims endured a

prolonged result of this disorder and suffered symptoms long-term (Kulka et al., 1990). In relation to prolonged PTSD in civilian members of society, The National Comorbidity Survey found that 33% diagnosed with PTSD met criteria for experiencing this disorder over the course of their entire lifetime (Kessler et al., 1995).

Complexities with Treatment

Studies of war veterans and PTSD have focused largely on middle-aged and younger adults and have been generalized to older populations. Therefore, older adults who have suffered a trauma have not been adequately examined (Sheikh and Cassidy, 2000). Older adults may encompass numerous physical difficulties as well as cognitive impairments which may result in lack of success with certain treatments (Flint, 2004).

Women and Violence

Recent research has found that women may be more vulnerable to the symptoms of PTSD; and further findings have shown a higher susceptibility for PTSD for individuals who have been diagnosed with a previous disorder such as depression (Shear, 2002). Researchers further discuss domestic violence and women, and postulate that the presence of PTSD is increased if a woman decides to depart from her partner (Enns & Campbell, 1997). These findings are supported by research that has found that approximately 45-60% of battered women fit the diagnostic criteria for PTSD (Enns & Campbell).

Prevalence of PTSD in Women

PTSD is becoming a larger problem in the United States; research has found that women that have experienced a rape or sexual assault have a 50% probability of acquiring this disorder (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992).

Translated into actual numbers, 12 million women may develop PTSD as a result of some form of sexual assault (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1991),

Researchers document that the United States outlines PTSD as most frequently occurring in victims of rape (Resnick et al.).

The term “rape” has been included in the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders under Section V61.1 titled, “Sexual Abuse of Adult” (*DSM-III-R*; American Psychiatric Association, 1987); this section can be utilized when the concentration in therapy is sexual abuse or rape. Criteria for PTSD can be encompassed within the category which discusses events “outside the range of usual human experience,” that would be anticipated to have the consequence of distress with nearly everyone who experiences this form of event. As a result of the rape victims’ symptoms following the attack, it is necessary to examine interventions for victims of sexual assault who have been diagnosed with PTSD (Rothbaum, Astin, & Marsteller, 2005).

Researchers examined a sample of female college students and determined that 24-54% of women have experienced a form of sexual assault; furthermore, of these women, 13-23% had endured a full rape (Koss, Gidycz, & Wisniewski, 1987). Researchers also established that 57% of women who had suffered a sexual assault were diagnosed with prolonged PTSD. Lastly, these researchers also found that of this sample, approximately 17% of these women continued to experience PTSD for an average of 17 years after their traumatic incident (Kilpatrick, Saunders, Veronen, Best, & Von, 1987). This study was conducted almost 20 years ago and therefore, it is possible that these findings are under-representative of today’s statistics. In another study, women who reported sexual and/or

physical abuse were examined and results found that the women that had been sexually abused had the greatest risk of developing PTSD (Pelcovitz, Roth, Newman, van der Kolk, & Mandel, 1997). This study further found that women who had been sexually as well as physically assaulted had the greatest risk of developing PTSD.

Rape crisis agencies have often been a source for research samples regarding rape and PTSD. In a recent study, researchers established that 94% of sufferers of recent rape met criteria for PTSD (Rothbaum et al., 1992). This highlights that the brief time period immediately after a rape can translate into high susceptibility to the symptoms of PTSD. A longitudinal study found that PTSD symptoms did decrease as time went on in most victims, with 65% of rape sufferers still enduring this disorder 4 weeks after the incident; this number declined to 47% of victims still experiencing symptoms 12 weeks after the trauma (Rothbaum et al). As a result of the high prevalence of sexual assault reported in current statistics, women should be screened regularly for the presence of this form of trauma at their doctor's office (Rothbaum et al., 1992).

An important study sought to examine a sample of female assault victims. Results found that although these victims displayed a decrease in trauma symptoms during the 3 months following the assault, one-third of victims still met criteria for PTSD after the 3-month period. This study is aligned with past research that has found similar findings (Riggs, Rothbaum, & Foa, 1995; Rothbaum et al., 1992). This research can exemplify that effective therapies are needed to decrease PTSD symptoms for sexual assault victims.

Refugees

In our world, refugees flee their countries in order to avoid the treacherous conditions that they may be enduring at home as a result of war and persecution. An estimated 19 million refugees have been known to exist across the world with approximately half of them being children (United Nations High Commissioner for Refugees, 2005). Children who have fled their countries to seek refuge elsewhere may have experienced and/or witnessed horrific crimes such as murder or torture. Furthermore, they may have been immersed in the middle of a military conflict. These experiences may have resulted in the presence of trauma leading to PTSD symptoms (Rousseau, 1995).

Domestic Violence and Children

PTSD has recently been examined in children in relation to witnessing domestic disputes within the home. Researchers have postulated that children's presence in the occurrence of violence could be a forecaster for PTSD symptoms (Margolin & Gordis, 2000). The American Psychiatry Association has recognized this focus and has included in the recent versions of the DSM any event which, "may result in causing death, injury, or threaten the physical integrity of the child or a loved one" as a PTSD precursor (American Psychiatric Association, 1994).

Currently, numerous homes experience the threat of domestic violence; this event may cause prolonged distress on the children who witness these incidents between family members (Margolin & Gordis, 2000). Numbers from recent studies suggest that 30% of American families will observe violence in the home (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). The General Social Survey on Victimization (1999) in Canada revealed that 37% of women and men who reported they were physically abused

by a spouse also stated that their children had witnessed this violence act. Furthermore, research also points to children being the direct victims of violence. Statistics reveal that 5-10% of children experience serious physical punishment on a regular basis (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998).

The issues that come with the factor of domestic violence are pronounced and complex. Children may observe violence in the home but may not be the direct targets; therefore, they may not be receiving social support for this witnessing of violence because no signs of abuse visibly exist. The end result may be a failure of clinicians to implement appropriate treatment strategies; a further consequence could be a misunderstanding of the cause of a child's difficulties (Fantuzzo, Mohr, & Noone, 2000). For example, clinicians may attribute a child's problems to other factors such as school-related difficulties. Terr (1991) found that children may experience four forms of symptoms after experiencing a trauma. These four symptoms consist of repeated memories of the trauma, engaging in repetitive behaviours, experiencing fears that are associated with the trauma and lastly, altered attitudes about others.

Violence has long been correlated with PTSD in children. Research has established that domestic violence often transpires along with child abuse in the home. Statistics show that an estimated 40% of homes with domestic violence also experience child abuse (Appel & Holden, 1998). An important point to highlight is that the violence that a child suffers may be the result of becoming involved in a domestic dispute between parents (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). Lastly, children who experience violence in the home may not only be enduring physical abuse, but they may also be experiencing emotional consequences as a result of experiencing or observing hostility

(Toth & Cicchetti, 2006). Therefore, the assessment of children for experiencing violence should also include an evaluation of the occurrence of other trauma exposures.

Research has examined the relationship between childhood trauma and symptom complexity reported later on in adulthood (Briere, Kaltman, & Green, 2008). Researchers have found that there is a positive relationship between number of traumas experienced in childhood, and symptom complexity later on in adulthood. This research confirms previous research which states that the occurrence of multiple trauma in childhood can result in a variety of symptoms later on in life (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

PTSD and Comorbidity

Research has established that a strong relationship exists between PTSD and the comorbid presence of other mentally-debilitating disorders (Dansky Roitzsch, Brady, & Saladin, 1995). Recent findings have shown that 20-60% of persons who meet criteria for PTSD also experience depression (Kessler et al., 1995) or a substance use disorder (Dansky et al; Fullilove, Fullilove, Smith, & Winkler, 1993). Briere (1997) states that suicidality and substance abuse are common among persons who are experiencing PTSD; these comorbid conditions may result from depression, low self-esteem or a feeling of hopelessness. Symptoms of suicide have been found in combat veterans (Adams, Barton, Mitchell, Moore, & Einagel, 1998) and victims of sexual and/or physical assault (Ullman & Brecklin, 2002). This large comorbidity rate highlights the complexities associated with providing treatment to PTSD sufferers. Individuals experiencing co-occurring symptoms from other disorders with PTSD may require multidimensional treatment

options. Researchers have found that there is a positive relationship between number of traumas experienced, and symptom complexity (Briere et al., 2008).

Predictive Factors

Research has found that a person's upbringing may be a large contributor to the presence of psychiatric disorders later on in life (Bebbington et al., 2004). Debilitating disorders such as schizophrenia and bi-polar disorder may be the end result of past physical or sexual abuse (Bebbington et al.). Furthermore, the aspect of prior traumatic experiences may result in a heightened response to traumatic incidents in the future; therefore, PTSD may be acquired more easily after repeated exposure to trauma.

Statistics have found that 29-48% of persons with a serious mental illness also experience symptoms of PTSD (Bebbington et al.). In comparison, the presence of PTSD in the general population is about 3.5%, with the rates being higher for prolonged PTSD at 7-12% for lifetime prevalence (Breslau, Davis, Andreski, & Peterson, 1991).

Complexities of Comorbidity

Other debilitating factors may also occur concurrently in persons who suffer from mental illness as well as PTSD. Individuals with co-occurring disorders with PTSD undergo more hospitalizations as well as a decrease in functioning in comparison to other persons who suffer strictly from PTSD (Mueser, Essock, Haines, Wolfe, & Xie, 2004); these compounding factors may negatively contribute to treatment efforts by professionals and result in the PTSD victim lacking trust with their therapist (Mueser, Rosenberg, Goodman, & Trumbetta, 2002). A positive outcome of researchers examining the comorbidity of PTSD with other psychiatric disorders is the current implementation

of standard screening of trauma victims to assess for comorbidity at mental health facilities (Cusack, Frueh, & Brady, 2004).

A final issue with persons who suffer from mental illness is that they bring numerous complexities for professionals during the treatment process. Clinical signs of suicidal behavior as well as other psychological thoughts and actions may be difficult for practitioners to modify in treatment (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). Lastly, the debilitating symptoms that victims of mental illness can endure may lead to long-term disability resulting in these individuals facing poverty, as well as a lack of social support from the community (Waghorn, Chant, White, & Whiteford, 2004). These factors can highlight the need for adequate and efficient intervention programs for persons who are experiencing comorbidity of PTSD with other mental illness.

A recent clinical study examined the mental illness prevalence over 30 years among persons who had participated in a longitudinal study who had been diagnosed with PTSD (Ouimette, Moos, & Finney, 2003). Research has found that the more disorders that a person is suffering from, the more likely it is that they will seek out help (Ouimette et al.). The 1037 participants were originally from the Dunedin Multidisciplinary Health and Development Study; this study was longitudinal and examined the health and behavior of children born between 1972 and 1973 (Ouimette et al.). This research design allowed researchers to examine the mental health histories of clients who had been diagnosed with PTSD between the ages of 26 and 32. (Ouimette et al.). Researchers found that 93% of persons in the sample had been diagnosed with another mental illness between the ages of 11 and 21 and over 60% had met criteria for another mental illness by age 16 (Ouimette et al.). This research confirms previous research which states that the occurrence of

multiple trauma earlier in life can result in a variety of symptoms later on in life (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

PTSD and Addiction

Trauma and PTSD have long been correlated with addiction; the underpinnings of this research began with veterans of war who were first diagnosed with PTSD; these individuals were also experiencing alcohol abuse and dependency (Cross & Ashley, 2007). Medical professionals who treated these individuals also noticed a large number of PTSD clients were also drawing on alcohol to perhaps self-medicate their symptoms of PTSD. The observation that many victims of trauma also experience a substance use disorder is gaining prominence today (Cross & Ashley). Findings have shown that 20-60% of persons who meet criteria for PTSD also experience a substance use disorder (Dansky et al., 1993; Fullilove et al., 1993).

Researchers have established that a large percentage of persons who may encompass both trauma symptoms and addiction issues may have been physically or sexually abused as children (Inaba & Cohen, 2004); these numbers indicate about 50% of adults researched had violent pasts. Further research in this study found that about 75% of women examined who presented with a substance use disorder reported a sexually-abusive or violent history (Inaba & Cohen; Resnick et al., 1991).

PTSD and Past Exposure to Trauma

As stated above, some studies have taken a further step in examining addiction and studied the correlation between substance use disorder and past exposure to traumatic events; they have uncovered some correlations. Some researchers have found that drug use (as opposed to alcohol) has a strong association with past exposure to violence

(Kilpatrick, Saunders, & Best, 1987). More specifically, studies have revealed that persons who have a history of substance abuse report more past traumas than persons who do not have such a history (Kilpatrick et al.). Furthermore, the individuals who are abusing substances also present with more diagnoses of PTSD (Cottler, Compton, & Mager, 1992). Lastly, when hospital samples were examined, researchers have found that of the persons who are there in relation to a substance disorder, 40% of these persons have also been diagnosed with PTSD (Dansky, Roitzsch, Brady, & Saladin 1997; Resnick et al., 1991).

An interesting finding is that cocaine users specifically have reported the most past exposure to traumatic events (Cottler et al., 1992). Furthermore, these users report events that most strongly meet criteria for a PTSD experience (such as a violent situation), as well as symptoms meeting criteria for PTSD in comparison to non-users of cocaine (Cottler et al.). Lastly, Kirkpatrick (1990) in her study of women and substances found that women who specifically used cocaine in comparison to other drugs had a higher past probability of having been sexually or physically assaulted.

An important study which is aligned with the above research used a sample of 105 female drug users to examine trauma histories (Fullilove et al., 1993). Of the 105 participants, 104 reported at least 1 trauma in their lifetime. Furthermore, 59% of participants reported symptoms that met diagnostic criteria for PTSD; almost all of the women who reported symptoms of PTSD stated that they had endured a violent trauma (Fullilove et al.). This study concluded that women who have addiction issues have an increased likelihood of encompassing a past of violent trauma; therefore putting them at higher risk for acquiring PTSD.

PTSD and Alcohol

A strong correlation has been uncovered between PTSD and alcohol abuse. Studies that have examined war veterans have found that of the veterans diagnosed with PTSD, more than half of them exhibited signs of alcohol abuse (Bremner, Southwick, Darnell, & Charney, 1996). A further finding is that female victims of PTSD have also reported using alcohol to self-medicate and mask symptoms of PTSD (Epstein, Saunders, Kilpatrick, & Resnick, 1998). These findings suggest a strong correlation for women with both PTSD and alcohol abuse and dependency.

Some research has revealed that women are about twice as likely than men to display both PTSD and substance use disorder (Najavits, Weiss, & Shaw 1997). However, researchers noted that because women report a higher occurrence of past exposure to violent and sexually-abusive situations in comparison to men, this finding may lead to an increased rate of comorbidity of PTSD with substance use disorder (Clark et al., 2005).

A recent study examined the correlation between PTSD and alcohol dependence (Schumacher et al., 2006). Researchers postulated that aligned with developmental theory, the earlier that a trauma occurred, the more pronounced is the PTSD as well as the alcohol dependence (Kubany, Haynes, & Leisen, 2000). Forty-two adults participated in the study with a large percentage of them being women; these individuals were diagnosed with PTSD as well as alcohol dependence. A further requirement of the study was the reported trauma must have been experienced before the age of 18; it was established that 86% of the participants stated that they endured a trauma prior to the age of 13 and almost 75% stated that they had become intoxicated at the age of 13 or older. The outcomes of the study confirmed prior predictions that degree of PTSD as well as alcohol

dependence were correlated with earlier age of trauma; the earlier that the trauma had occurred for participants the more severe the PTSD symptoms as well as alcohol use (Schumaker et al).

A recent study examined treatment in regards to PTSD onset with war veterans diagnosed with substance use disorder. Researchers studied whether providing treatment to victims within the first two years predicted less alcohol dependence 5 years later (Ouimette et al., 2003). Three follow-up assessments occurred at 1, 3 and 5 years after treatment. Researchers found that PTSD needed to be treated early in order for persons to adopt coping mechanisms to promote recovery; otherwise the end result may be more frequent use of alcohol. Therefore, having treatment within the first 2 years after diagnosis did predict alcohol behaviours 5 years later (Ouimette et al.). These results state that PTSD treatment specifically, may be the key in alleviating substance use disorder later on as well as PTSD. A final finding was the participant's motivation level was not associated with less alcohol dependence 2 or 5 years later (Ouimette et al., 2000).

Resilience and PTSD

An important point to highlight is that numerous persons may endure distressful incidents in their lives but not all of them will display PTSD symptoms (Keane, Weathers, & Foa, 2000). Research has found that there are other elements that play a role in the occurrence of PTSD symptoms within individuals. The predisposition to PTSD may include biological traits, experiencing prior traumas before the present incident occurred, and the existence of mental illness (McNally, Bryant & Ehlers, 2003).

PTSD and Culture

Culture can be viewed as an important factor in the treatment of trauma and PTSD. Persons from Westernized cultures may cope with the symptoms of PTSD in a way that is different from persons from other cultures. Therefore, a need exists for researchers to examine characteristics that differentiate cultures in regards to PTSD and its symptoms. A recent study sought to determine differences in PTSD symptom severity between Hispanic, Non-Hispanic Black and Caucasian police officers (Pole, Best, Metzler, & Marmar, 2005). This study utilized data from Pole et al.'s (2001) examination of PTSD among police officers from varying ethnicities and found that the Hispanic officers tended to over-report their trauma symptoms (Pole et al., 2001).

Past research on war veterans has found that Hispanic Americans may be more greatly affected by traumatic events; Kulka et al. (1990) found that degrees of PTSD were almost twice as high in Hispanic veterans in comparison to the Caucasian veterans. The current study's research found results contradictory to past findings (Pole et al., 2005). Consequently, it was found that Hispanic officers had a tendency to underreport their trauma symptoms (Pole et al.). This finding may indicate that the Hispanic group's number of symptoms may exceed what they actually state.

A further finding in the Pole et al. (2005) study was that the Hispanic officers were more likely to engage in a self-blaming coping style as well as be more hopeful about a symptom decrease. Researchers stated that this form of coping may have led these officers to engage in rumination (an aspect of PTSD) and therefore, result in more severe symptoms of PTSD. A final finding was that the Hispanic officers gained less social support following their trauma, which could have resulted in higher degrees of PTSD

(Pole et al.). A possible reason for this finding was that the Hispanic officers may have had trouble admitting that they were experiencing symptoms and may have also not wanted to burden others with the symptoms that they were experiencing. Researchers commented that a goal for future research could involve identifying challenges that this ethnic group may have in obtaining support from others (Pole et al.). This above research points to the idea that cross-cultural research is needed in order to determine diverse client characteristics before establishing effective interventions for PTSD.

One study sought to determine cultural differences in battered women coping with trauma (Adriance, 1999). Participants consisted of mostly European-American and African-American women. Researchers found that results did not reveal large differences in coping style between the two groups. However, results did uncover a negative relationship between attitudes about wife assault and an introversive coping style (Adriance). Furthermore, women who perceived others around them as having negative attitudes towards abuse victims displayed more trauma symptoms. Therefore, this study can highlight the necessity to remember that trauma may manifest differently in everyone and produce different coping styles independent of culture (Adriance).

Chapter IV: Counselling Interventions For Trauma

This chapter discusses current interventions for decreasing PTSD symptoms. Primary therapies consist of cognitive therapy utilizing exposure techniques, cognitive restructuring, and eye movement desensitization reprocessing. Also, innovative therapies such as anxiety management and emotional intelligence training have been recently introduced. The discussed treatments can be viewed as effective when utilized separately, or as a multimodal method (Foa et al., 1999).

Assessment of PTSD

There are multiple factors that are important to look at in an assessment of PTSD. The trauma-inducing event, age at which the event was experienced, and subsequent and multiple trauma events are all variables that need to be examined. Research has found that the trauma-inducing event can play a part in determining the onset of PTSD (Heptinstall, Sethna, & Taylor, 2004). It has been postulated that severe experiences such as homicide or brutal assault may more likely lead to symptoms of PTSD (Heptinstall et al.). Furthermore, an individual's involvement in a traumatic incident, such as witnessing as opposed to directly undergoing the incident, may also be a key determinant in the outcome of PTSD symptoms (Quirk & Casco, 1994).

Nader (2007) discusses the variables related to assessing trauma in individuals from other cultures. Important variables to bear in mind are an individual's ethnicity, and their traumatic stressors. Other potential cultural differences that should also be remembered are presentation of emotional expression, reporting practices, the individual's interpretation of symptoms and behaviours, and gender differences (Nader).

Past/Multiple Trauma and Individual Characteristics

Researchers have also postulated that situations that render a person helpless and without understanding of what occurred as a result of the traumatic event, may more easily produce PTSD symptoms (Quirk & Casco, 1994). Another factor to consider is each individual's thoughts and cognitions in regards to the traumatic event. Some individuals may be more vulnerable to experiencing symptoms of PTSD as a result of past trauma or individual characteristics (Quirk & Casco).

A recent study sought to determine predictors that allow military personnel to seek treatment as a result of experiencing PTSD symptoms (Fikretoglu, Brunet, & Schmitz, 2006). Five-hundred and nine personnel met criteria for PTSD and were included in the study. Researchers found that the form of trauma-inducing event played a large role in determining if a person would request treatment for trauma; furthermore, the number of traumatic experiences a person had throughout their life also predicted treatment-seeking. Researchers found that treatment was sought out by persons who had endured more traumatic episodes perhaps because their degree of PTSD was more pronounced as a result of compounded distress (Ozer, Best, Lipsey, & Weiss, 2003).

A further point that emerged from the above study is that the severity of PTSD and the form of trauma-induced event may not be correlated. For example, one individual may experience a severe trauma such as murder but may not present with a high degree of PTSD symptoms (Fikretglu et al., 2006). Alternatively, another person may experience a less severe trauma but may be presenting with a more complex diagnosis of PTSD. A final finding in this study was the female victims were less likely to seek treatment. Furthermore, in relation to socioeconomic status, persons in the lower pay brackets as

well as persons who were married were more likely to seek treatment. This last point can highlight the idea that social support may contribute to the likelihood to seek help (Fikretglu et al.). This factor can relate to the idea that women who feel supported by others may display less symptoms of PTSD (Adriance, 1999).

The aforementioned forms of trauma can have implications for the assessment process. A PTSD victim may have presented symptoms as a result of a recent trauma, but other traumas may have previously existed which could have complicated the final outcome of PTSD within the victim. Recent research has shown that of the persons that report physical and sexual abuse, approximately half of them had previously experienced a violent incident (Kilpatrick, 1990).

History-Taking

The assessment process when interviewing a trauma victim should be extensive and detailed in regards to past exposure. This factor can highlight the idea of individuality among trauma victims; every person who has suffered a trauma may require different treatment methods because the combination of their situation, past history and circumstances can be completely diverse from another victim. Trauma often isn't assessed at all when the client is presenting with comorbid disorders and/or disorders resulting from the trauma where the trauma is forgotten (Quirk & Casco, 1994). Lastly, an examination of the client's current coping mechanisms including methods that they may be utilizing to receive relief from symptoms, such as social support or substance-using, may be beneficial in identifying treatment needs (Amstadter, McCart, & Ruggiero, 2007).

Assessment Tools

A further area to consider is the utilization of specific assessment tools before beginning the treatment process. Symptoms may need to be specifically reported by the PTSD sufferer in order to produce a treatment method that can result in positive outcomes. Therefore, utilizing an assessment tool that contains item scales must be carefully considered. Differences exist in assessment tools and their features such as a scale that may provide a victim with a yes or no response option (for example, the Structured Clinical Interview for DSM–IV PTSD), and a scale that may utilize a Likert format (PTSD Checklist) and therefore, may ask the client to rate their symptoms from mild to strong (Amstadter et al., 2007). These different forms may offer information pertinent to different therapeutic approaches.

This latter form of assessment may result in a more detailed understanding of the client's symptoms, as well as the severity of these symptoms. The end result may allow clients to be more responsive to treatment because their specific and most severe symptoms are being targeted. Furthermore, the Likert scale format can allow practitioners to have a more specified understanding of how treatment is affecting which symptoms, as well as the severity of symptoms for trauma victims (Amstadter et al., 2007).

Counselling Interventions

Main therapies for PTSD treatment consist of cognitive therapy encompassing exposure techniques, cognitive restructuring and eye movement desensitization reprocessing. Also, innovative therapies such as anxiety management and emotional intelligence training have been introduced for PTSD. Researchers suggest that based on current studies, there exists only a few treatment modalities that have been empirically

supported in providing a decrease in PTSD symptoms (Yule, 1999). These main therapies are outlined below.

Exposure Therapy

Avoidance of reminders of the traumatic event can be a common behavioural and cognitive characteristic that PTSD victims engage in. However, this coping method can be viewed as short-lived because cues and triggers of the trauma are present in the victims' daily life (Yule, 1999). Researchers postulate that avoidance of the trauma occurs because the traumatic event may signify fear, sadness or other negative feelings for the trauma survivor. Therefore, researchers believe that allowing the person to be re-exposed to the event continuously may result in the trauma losing impact as well as the negative effect that it originally had which caused PTSD symptoms (Yule).

Studies that utilize exposure techniques reveal that this form of therapy is effective in reducing trauma symptoms. Research has shown that individuals who have suffered physical and/or sexual assaults (Foa et al., 1999) and war veterans (Schnurr, Friedman, & Engel, 2007) have benefited from symptom reduction in exposure therapy. However, other research results for exposure techniques have found that individual characteristics of clients such as aggression may be correlated with negative outcomes in treatment (Foa et al., 1995). Furthermore, some studies suggest that the exposure method may increase pre-existing trauma symptoms (Foa et al.).

Continual exposure may result in the traumatic event losing all meaning and becoming a manageable event for the victim over time. Exposure therapy has its roots in the treatment of anxiety and has gradually transferred over to the treatment of PTSD (Yule, 1999). Exposure, now more commonly known as prolonged exposure, involves the

continual habituation of the victim to the trauma that resulted in PTSD symptoms (Yule). The goal of therapy is to gradually decrease physiological arousal so that the affected person is able to manage viewing the event without experiencing prior increased symptoms (Yule).

One aspect to remember specifically with PTSD sufferers is that exposure to the real life situation may not be possible (such as with war veterans) or psychologically suitable; therefore, imaginal exposure consisting of the client visualizing the trauma may be beneficial in treatment for those groups where this treatment is useful. The client can recall the event and describe it to the counsellor as if it was actually occurring. This procedure can also take place at home once the client is somewhat less reactive in recalling and describing the event. The goal of this technique is to allow the client to understand which features of the incident are causing the most distress (Yule, 1999).

The client's anxiety levels can be measured when describing various scenes of the trauma in order to determine their physiological state. An important aspect to maintain is that the client may have developed further factors along with PTSD symptoms that may be drastically altering their daily lives and routines (Yule, 1999). For example, agoraphobia may have resulted because the client no longer feels the world is safe; therefore, they may choose to be confined to their home. In this circumstance, the use of real-life exposure may be beneficial for the victim in progressing them back to their regular routine. Therefore, prolonged exposure may allow the victim to gradually be faced with cues to the event and eventually confront their trauma (Yule).

Outcome studies. Outcome studies that examine the use of exposure techniques indicate that this form of therapy is effective in reducing trauma symptoms. Research has

shown that individuals who have suffered physical and/or sexual assaults have benefited from prolonged exposure (Foa et al., 1999). Specific symptoms of trauma have also been examined in relation to exposure therapy; depression and anxiety have shown decreases after completion of this form of treatment (Foa et al.).

Although there exists numerous studies that highlight the positive outcomes of exposure techniques on trauma victims, some recent research discusses the idea that this method may increase trauma symptoms as a result of confrontation with the event, whether it be imaginal or real-life (in-vivo) (Foa et al., 1999). A further point is that in the past, exposure techniques have been associated with higher drop-out rates in community samples; however, this finding has been discredited by various researchers who have examined existing research and state that drop-out rates for this form of therapy are similar to other therapies in the treatment of trauma (Van Etten & Taylor, 1998).

Client characteristics. Characteristics of clients have recently been correlated with negative outcomes in treatment. Clients who suffer from symptoms of extreme anger have been viewed to be more difficult to treat with exposure therapy because this emotion may override all others during exposure; the fear that may need to be expressed when imagining the traumatic event may not emerge (Foa et al., 1995). Researchers have postulated that instructing clients to focus on the exposure treatment and to try to avoid any anger cues may result in more positive outcomes (Clark et al., 2005).

Exposure therapy may not be appropriate to utilize with certain older adults because of heightened arousal that may lead to physical problems such as cardiac arrest (Shapiro, 1995). A recent study involved two treatment groups; for the first group, researchers utilized a multimodal approach on war veterans who had been diagnosed with PTSD; this

method encompassed exposure and cognitive therapy along with psychoeducation. The second group encompassed person-centered therapy and did not involve a focus on the experienced trauma (Schnurr, Freidman, & Foy, 2003). Treatment lasted for approximately 7 weeks and researchers did not observe either treatment condition to be superior to the other.

Clients with addiction issues for self-medicating to decrease trauma symptoms may be in danger of engaging in these unhealthy methods to cope during the course of exposure techniques. Researchers state that having a client become clean for a substantial period of time (3 months or more) may allow the effects of treatment to be more pronounced (Foa & Rothbaum, 1998). Lastly, a common finding regarding exposure therapy and PTSD is that often, clients who endure elevated stress levels in the beginning of treatment may present the largest decrease in signs of trauma; therefore, an important aspect to bear in mind is that the therapist may need to consider this finding before ending treatment and potentially preventing an improvement in client functioning (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002).

Trauma-inducing event. Researchers have conducted further studies on the utility of exposure therapy for victims of specific traumas such as sexual assault. In a sample of 45 sexual-abuse victims, researchers found that exposure was superior to other treatment conditions in decreasing PTSD symptoms; however, this form of therapy was not successful in decreasing depression and anxiety (Foa et al., 1991).

Lastly, a recent study examined 284 female war veterans who had been diagnosed with PTSD and compared two treatment conditions, with the first being prolonged exposure and the other group being present-centered therapy (Schnurr et al., 2007). This

latter form of therapy seeks to focus on current problems that the person is experiencing in their daily life as a result of the trauma, as opposed to discussing the trauma itself. Results indicated that the prolonged exposure group improved more than the present-centered therapy group. Furthermore, there was a higher desire for pharmacological methods in the present-centered therapy condition after treatment was terminated (Schnurr et al., 2007).

Cognitive Restructuring

Cognitive restructuring has been shown to benefit refugees (Paunovic & O' st, 2001) and victims of sexual assault (Ullman, Townsend, Filipas, & Starzynski, 2007). Cognitive therapy can be viewed as a form of treatment that modifies a client's thoughts to new forms of thinking that are more realistic and positive for the client (Yule, 1999). This method examines how client thoughts are affecting their thinking and behaviours. When thoughts have been modified to result in more management by the client, the goal is that behaviours will also become modified as a result of a client acting differently because they are now thinking differently. Therefore, the process of cognitive therapy is to aid PTSD victims in modifying their thoughts in order to produce cognitions that are more adaptive for them and result in less distress and therefore, a decrease in trauma symptoms (Yule).

Researchers have uncovered three distorted thoughts that trauma victims may be experiencing that may be leading to the continual persistence of PTSD symptoms. The first thought is a belief that the world is now unsafe, a further belief is that others cannot be trusted, and the last unrealistic thought is that the client is not capable of managing their life (Foa, Riggs, Dancu, Rothbaum, & Olasov, 1993; Herman, 1997).

A psychoeducational component can often be encompassed within cognitive therapy. This educational element can help victims understand the prevalence of PTSD, as well as symptoms that they may be experiencing as a result of their traumatic event (McFarlane, 2001). Clients may be blaming themselves for their misfortune and may not be dealing with their incident in an adaptive way. Coping methods can be discussed and reviewed to educate and aid clients in developing more effective ways of dealing with their hardship. This psycho-educational aspect can help a client in acknowledging their event as well as dealing with their reactions and understanding that their response is common among trauma victims (Amstadter et al., 2007). Self-management therapy (SMT) can be utilized as a form of cognitive behavioural therapy in a group format. This form of therapy can be used in the treatment of depression. This therapy targets two main areas with those being self-control, and instilling positive self-esteem (O' Donohue, Hayes, & Fisher, 2003).

Sexual assault victims. A recent study examined women who have experienced a sexual assault and have been diagnosed with PTSD; this study found high self-blame of the victim. This could have been the result of responses of others around them; therefore, other persons around the victim may have negatively influenced them to believe that they were responsible for their trauma (Ullman et al., 2007). These reactions may not be favorable and supportive of the victim and may have resulted in further distress. Therefore, understanding the victim's social support network and environment may also be a key component in treatment. Furthermore, employing an intervention that seeks to increase social support may result in a decrease in symptoms for trauma victims in general (Ullman et al.).

Refugees. Research has shown that cognitive therapy has been tested on PTSD victims and has been shown to decrease symptoms for adult refugees (Paunovic & Ost, 2001) and young refugees (Ehnholt, Smith, & Yule, 2005). Children who engaged in this therapy received a specified format designed for treatment in school (Smith, Dyregrov, Yule, Perrin, Gjestad, & Gupta, 2000), which consisted of a psychoeducational component, cognitive restructuring and relaxation techniques. However, at a 2-month assessment of treatment maintenance, it was found that the positive results obtained no longer existed. Possible reasons for this finding is that the therapy was performed in a school setting and therefore, not conducted on an individual basis possibly resulting in a general treatment model as opposed to a more individualized form of therapy for each child (Ehnholt & Yule, 2006).

Cognitive Processing Therapy

A further treatment utilizes a combination of exposure therapy and cognitive restructuring; this method is referred to as cognitive processing therapy (CPT). The results for this therapy are mixed with some research revealing that CPT is more beneficial than cognitive or exposure therapy (Bryant, Moulds, & Guthrie, 2003) and other studies state that CPT may not be more successful for clients (Yule, 1999). Researchers have found that rape victims that were treated with this combined therapy found more positive results than if no treatment had occurred (Resick & Schinicke, 1992). This therapy is short term and involves a psychoeducational component that discusses PTSD and its symptoms. Clients are asked to discuss their thoughts and feelings about the trauma as well as how they feel they have altered their thoughts and behaviours since the incident. Furthermore, clients can develop a deeper understanding of

their feelings and how these feelings may be contributing to current unrealistic behaviours.

Clients can also eventually talk about their trauma and imagine that they were experiencing it again; this experience can include thoughts and feelings that they were enduring at the time. By continually exposing themselves to the trauma, clients can understand the parts of the event that resulted in the most distress and therefore, modify these thoughts by examining their validity. Clients will challenge distressing thoughts and learn to understand how they are negatively affecting their lives.

Researchers utilized a sample of sexual assault victims to evaluate CPT with prolonged exposure techniques (Resick et al., 2002). Results found that both treatments produced similar effectiveness for victims; however, a small portion of these clients were still diagnosed with PTSD after treatment (Resick et al.).

Challenging populations. In regards to CPT, specific client samples may need to be further examined in terms of the efficacy of treatment. Researchers have found that sexual abuse victims who are currently involved in relationships have a high probability of having a past with prior sexual incidents (Ehnholt & Yule, 2006). Therefore, the necessity of long term therapy may be required because of their continual exposure to violence and abuse (Resick & Schnicke, 1996). A further at risk population are those suffering from mental illness and more specifically, borderline personality disorder. These individuals may require one on one therapy because research has found that they may not progress well in group settings. Lastly, this population may also require longer-term therapy because of the complexity of their diagnoses, with the diagnoses being mental illness, PTSD, as well as a past history of possible abuse (Ehnholt & Yule). They

may also require a different type of therapy that doesn't re-expose them to stimuli which lessens their ability to be sensitive to abuse.

Research has further found that CPT may not be more successful for clients as a treatment choice in comparison to cognitive therapy or exposure therapy applied alone (Yule, 1999). Outcomes studies have found that either of these treatments used separately have produced as successful results as when utilized together. However, it is important to bear in mind is that the above study used a sample that had been diagnosed with PTSD as a result of different forms of trauma among participants. Clients who were currently enduring PTSD as well as another disorder, or clients who currently had addictions issues along with PTSD were not highlighted (Yule). These clients may have responded more favourably to a multimodal approach such as CPT as opposed to a single treatment method. Lastly, another area that was not focused on in the study was the client's past history of trauma. Past abuse or violence may need to be examined in order to determine if a continual pattern of trauma has existed and therefore, if a combined treatment method is needed (Yule).

Comparison of exposure therapy and CPT. A study sought to compare an exposure condition with an exposure and cognitive restructuring condition (CPT) with PTSD victims (Bryant et al., 2003). A condition of supportive counseling (SC) was also employed which consisted of participants receiving support from their counselor as well as being educated about trauma. Researchers found that exposure therapy and CPT conditions resulted in marked improvements for victims with PTSD symptoms in comparison to the SC condition. Both groups also showed improvements at a 6-month follow-up in comparison to the SC group who did not (Bryant et al.).

Furthermore, researchers in the above study found that the condition that contained 2 therapies (CPT) resulted in participants stating that they engaged in avoidance less, and experienced less depression than participants in the SC group. A previous finding that this study contradicted is that a combination of therapies produces more favorable outcomes (Foa, et al., 1999); previous studies have stated that a multimodal method may produce more success in treatment. However, this finding may be due to the fact that imaginal exposure was used in the present study whereas in vivo exposure was employed in previous studies. Therefore, the exposure treatment condition may not have achieved the effects that real-life exposure may have previously obtained (Bryant et al., 2003).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) can be viewed as a common treatment method for PTSD (Konuk, Knipe, & Eke, 2006; Shapiro, 1995). This method argues that the traumatic material experienced involves the client's neurophysiology while thinking about the trauma (Shapiro, 1995). Therefore, this process combines exposure with the exercise of the eye movements from side to side to alleviate PTSD symptoms. This procedure begins with the practitioner learning about the most distressing memories of the client in order to use these during treatment. Eye movements are rehearsed by the client initially. Furthermore, relaxation techniques as well as guided imagery can be employed at the end of the session in order to bring the client back to a state of calmness (Yule, 1999). EMDR has been shown to decrease emotional arousal symptoms for earthquake survivors (Konuk et al.) and it has been a beneficial treatment for victims of multiple traumas (Marcus, Marquis, & Sakai, 2004). Furthermore, EMDR has been a beneficial treatment for war veterans (Zimmermann, Biesold, & Barre, 2007).

The EMDR process differs from exposure therapy because the client does not need to describe their traumatic memory in detail (Shapiro, 1995). They only need to talk about how they view the incident negatively and what it represents for them cognitively. Then, a positive cognition is chosen by the client in order to express how they would like to think about the incident. Next, the client can think about how much that they actually believe in this constructive idea. Also, the clinician will need to inquire about the client's physiology when thinking about their memory. During treatment, the client is asked where in their body they feel physically stimulated when recalling the memory. Treatment involves the client following the practitioner's finger with their eyes back and forth while the speed of the moving finger is slowly increased to a level that the client is able to still focus on (Shapiro, 1999; Yule, 1995).

A theory for EMDR is that the swift eye movements cause a form of brain activity that is much like rapid eye movement (REM); this process occurs when sleeping (Yule, 1999). REM may allow individuals to sort out conflicts that they may be experiencing. Therefore, the memory of the trauma can transform into one that is remembered without the negative psychological and physical effects (Yule). Questions still remain about how utilizing eye movements can reduce symptoms of PTSD. Researchers postulate that this task can be viewed as a diversion while thinking about the traumatic memory; furthermore, this process may allow the client to view the traumatic images and become accustomed to them; therefore making them manageable to endure (Lipke, 2003).

The client is asked to imagine their traumatic image while following the clinician's finger. The clinician can then inquire about what the client is thinking and feeling as well as changes that they may be experiencing. This practice is repeated numerous times

during a session and may be stopped based on reactions from the client. The end goal is to continue therapy until the client is not experiencing any more physical or psychological changes in processing of their memory images (Yule, 1999).

Earthquake victims. In a recent study of earthquake survivors who were diagnosed with PTSD, EMDR was utilized as a form of treatment (Konuk et al., 2006). The earthquake had resulted in over 25,000 deaths and therefore, was considered very severe. Forty-one clients were included in the sample and results revealed that for most of these participants, there were significant decreases in emotional arousal. Therapy also resulted in clients having a more positive sense of themselves (Konuk et al.).

In the above study, participants who were on medication for psychological effects were included in the sample. A finding was that the use of medication did not produce different results in comparison to non-medicated participants being treated with EMDR; therefore, clients did not feel that they benefited more or less from being on medication (Konuk et al., 2006). This finding relates to a study conducted in 2003 that compared EMDR with medication (specifically antidepressants) and found that post-treatment, clients who stopped medication began to experience PTSD symptoms again; whereas, the participants in the EMDR condition displayed improvement even after the EMDR treatment had ended (van der Kolk et al., 2005).

Victims of multiple trauma. A study of 67 trauma victims who had experienced single and multiple traumas was conducted and EMDR was utilized as the treatment modality for one group (Marcus et al., 2004). The goal of this study was to determine treatment effects 3 to 6 months post-therapy. A further component was that there were two

treatment groups; one that involved EMDR and the other utilized cognitive, behavioural or psychodynamic therapy and medication for some participants.

Results found that EMDR was an effective treatment for clients and maintained its effects at the 3 and 6-month follow-up (Marcus et al., 2004). A further point is that other treatment modalities may have included homework (such as the cognitive therapy condition) but EMDR did not; therefore, clients were able to spend less time engaging in treatment but resulted in comparable positive outcomes. A further finding was that the condition that utilized other therapies reported more improvements at the 3-month mark as opposed to the 6-month mark (Marcus et al.). Therefore, this aspect can exemplify that although these treatments were initially successful in decreasing negative symptoms, a later follow up found that symptoms had elevated again. However, the EMDR condition showed an even larger decrease in symptoms at the 6-month follow up in comparison to the 3-month follow up; this finding can highlight that EMDR therapy allows clients to continually improve after treatment (Marcus et al.).

EMDR has recently been applied to the treatment of refugee children and researchers found that trauma symptoms decreased after treatment (Oras, Cancela de Ezpeleta, & Ahmad, 2004). Some limitations to this study were that there was no control group and other therapies were utilized along with EMDR. Therefore, it is not clear if EMDR was responsible, partly responsible or did not have an effect at all in decreasing trauma symptoms on the young refugees.

War veterans and military soldiers. One study utilized EMDR on war veterans; this study found that PTSD symptoms decreased as well as depression after only two sessions (Zimmermann et al., 2007). Although current research highlights specific therapies such

as exposure and EMDR for treatment of PTSD populations, extremely few studies exist that discuss the examination of older populations and treatment for PTSD. This factor can highlight the need for future research into studying ways to decrease trauma symptoms specifically for older adults (Owens, Baker, & Kasckow 2005).

Lastly, in a recent study, 89 German soldiers were examined; these military personnel had been diagnosed with PTSD but this disorder was not the result of combat-related trauma; all of the participants had experienced their trauma within the past year (Zimmermann et al., 2007). The large majority of participants were men and approximately one-third of them had also been diagnosed with a secondary disorder. Examples of the types of traumatic event experienced involved violence and sexual assault. The soldiers were divided into 2 groups with half of them receiving EMDR treatment. One important consideration was that persons who participated in EMDR therapy twice per week chose this therapy and felt that they were ready for this form of treatment (Zimmermann et al.).

Researchers found substantial improvements in persons who had participated in EMDR therapy and these improvements were maintained at a 29-month follow-up in comparison to the other group that did not receive EMDR; this group fared worse than this treatment group. A last point to highlight is that although none of the soldiers had participated in major combat, the ones that had suffered a traumatic experience which involved a death, did not display the improvements of persons who had suffered a different traumatic experience. (Zimmermann et al., 2007).

EMDR and predictors for treatment outcome. A recent study's goal was to establish predictors for treatment outcome for PTSD clients (Karatzias, Power, & McGoldrick,

2007). A post-treatment assessment was utilized as well as a 15-month follow-up. Treatment was given to 48 participants and occurred for 12 weeks. There were 2 treatment conditions with one utilizing the EMDR approach and the other combining cognitive and exposure therapy (CPT). Researchers found that there were 4 variables that predicted treatment outcomes for PTSD. These factors included the symptoms of PTSD at baseline, number of sessions, gender, and type of therapy (Karatzias et al.). Lower baseline scores of PTSD were associated with client improvements as a result of treatment. A further finding was the clients who had received fewer treatment sessions showed more significant improvements in comparison to other participants. However, potential causes for this outcome could have been that because clients were able to end treatment whenever they felt a reduction in symptoms, the clients that may have initially presented with less difficulties may have required fewer treatments and therefore, ended treatment sooner (Karatzias et al.).

A further finding of this study was that female participants seemed to respond better to treatment. Other researchers have postulated that this aspect may be the result of the female's abilities and nature to openly express emotions and feelings (Tarrier, Sommerfield, Pilgrim, & Faragher, 2000). Lastly, at post-treatment as well as at follow-up, it was found that EMDR was superior to the exposure and cognitive therapy (CPT) condition resulting in less depression for participants from this group.

Anxiety Management Training

A common form of treatment for PTSD is known as anxiety management training (Foa et al., 1999). This form of therapy can be utilized in different ways and can involve the learning and practicing of breathing exercises. Persons who are experiencing anxiety

may have difficulty in breathing appropriately. Therefore, teaching methods that reduce distress may lead to a decrease in trauma symptoms. One form of anxiety management is known as progressive muscle relaxation. This treatment involves tensing and releasing various muscle groups throughout the body. The client may tense a muscle for 10 to 15 seconds and then release it while also acknowledging the tension that they are currently experiencing (Foa et al.).

Clients may also be asked to supplement this process with imagery by imagining a calming scene. A finding from research on this form of therapy is that because it places much emphasis on reducing physiological symptoms of stress, it may be most useful for victims who have experienced a crime. Research has shown that crime victims may experience more anxiety in comparison to other trauma victims (Amstadter et al., 2007).

Research on relaxation training has uncovered that although it may decrease symptoms of PTSD and trauma to a certain degree, it does not hold the empirical support that other therapies such as exposure therapy do (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). The goal of relaxation training is to reduce physiological symptoms to result in clients learning to manage trauma symptoms when exposed to trauma cues.

Emotional Intelligence Training

Current research has focused on the idea that emotions play a large part in the processing of information. Researchers postulate that the regulation of emotions is needed for an individual to experience positive outcomes in life (Mayer and Salovey, 1997). These researchers state that the learning process of emotional expression begins in childhood and unfolds as a healthy way of understanding others; it is also a way of conveying meaning to others about one's own behaviour. Lastly, researchers state that

positive emotional expression as well as an understanding of emotions can be learned after childhood through teaching processes. Researchers have incorporated the concept of emotional intelligence (EI) training into treatment for trauma (Simha-Alpern, 2007).

The (EI) model is attuned with psychoanalytic theory because of common beliefs that early experiences of learning about, understanding and communicating emotions shape a person's life later on (Simha-Apern, 2007). A further similarity of these two models is that EI training views the idea of motivation as the most significant factor for positive results in treatment. Comparably, the idea of resistance is prominent in psychoanalytic thinking, which can influence a client's participation in treatment; this concept can combine the theories of psychodynamic treatment with EI concepts to create the idea of EI training (Simha-Apern).

This form of intervention was formulated by researchers in order to teach emotional expression to persons of any age; whether they are young or old. This form of training postulates that there are two main factors that will determine whether treatment is successful (Cherniss & Goleman, 2001). Success depends upon an individual's motivation to change, and therefore, the extent that they involve themselves in the learning of emotions and how they affect themselves as well as others. Therefore, a client's level of motivation can be initially determined in order to predict client outcomes (Cherniss & Goleman).

Trauma can result in a person feeling helpless as well as displaying behaviours that are uncharacteristic of normal actions. Some studies have documented that the incidence of trauma may cause an individual to shut down, and they may not have the potential to vocalize their experience (Simha-Alpern, 2007). Furthermore, the traumatized person

may not have a memory of the event but still respond to cues or triggers to the event. Therefore, individuals enduring PTSD may be reactive to triggers of the incident, but may not express any emotional expression about the trauma (Simha-Alpern).

Therefore, engaging in training that may result in learning, or relearning how to express and understand emotions may result in PTSD victims being able to express their emotions, as opposed to just displaying behaviours as a result of trauma cues. Expressing emotions about the traumatic event can help researchers determine cognitive components of the trauma (Simha-Alpern, 2007). Lastly, having a deeper understanding of the cognitions of a person who has suffered a trauma can aid researchers in comprehending the process that is occurring in the victim's mind, as well as what they are feeling and experiencing post-trauma. Verbalizing thoughts and emotions may be achieved through the process of EI training.

Emotionally Focused Couple Therapy

Historically, trauma treatment has been concentrated on individual therapy. However, a new movement in therapy has highlighted how the effects of trauma can negatively affect personal and romantic relationships (Johnson & Makinen, 2002). Emotionally-focused couples therapy was developed by Greenberg & Johnson (1988). It focuses on development of the self as well as the relationship in a couple dynamic. The negative repercussions may involve the affected individual detaching themselves from their relationships as a result of the lack of trust they developed because of the trauma. Conversely, couple therapy can be used to alleviate the symptoms of trauma (Johnson & Makinen).

Emotionally focused couple therapy is a person-centred method combined with a cognitive-behavioural approach (Johnson & Makinen, 2002). The counsellor seeks to help the couple understand how their emotions and security of attachment shape interactions between them. The counsellor can help the couple express needs from their partners as a result of the trauma. The EFT model encompasses three stages (Johnson & Makinen).

The first part of therapy involves having the couple understand the negative patterns in their relationship; once this process is understood the couple can make an effort to promote a reduction in this cycle. The second stage involves stabilization; this process involves practicing interactions that promote greater intimacy in a relationship (Johnson & Makinen, 2002). Lastly, the counsellor can encourage new ways of being with oneself and their spouse so the couple can engage in positive and supportive behaviours to promote more closeness and a stronger relationship (Johnson & Makinen). The EFT model can allow a trauma victim to reconnect with their partner in hopes of rebuilding their relationship. In doing so, traumatized individuals transcend the avoidance, numbness and fear which are part of the PTSD set of symptoms in re-making trusting, intimate connections with another human being.

Summary

The above research highlights that presently, there are effective forms of treatment for PTSD in specific circumstances. Interventions that have provided a decrease in PTSD symptoms include exposure, cognitive restructuring and cognitive processing therapy. Individuals who have suffered physical and/or sexual assaults (Foa et al., 1999) and war veterans (Schnurr et al., 2007) have shown a decrease in PTSD symptoms after

undergoing exposure therapy. Cognitive restructuring has been shown to benefit refugees (Paunovic & O'st, 2001) and victims of sexual assault (Ullman et al., 2007) by modifying the victim's thoughts to produce cognitions that are more positive for them and result in less distress. Lastly, research finds that CPT can be more beneficial than cognitive or exposure therapy for rape victims (Bryant et al., 2003). Researchers found that rape victims that were treated with CPT experienced a decrease in symptoms after treatment (Resick & Schinicke, 1992). However, other studies state that CPT may not be a more successful therapy for trauma victims (Yule, 1999). Nevertheless, treatment for PTSD had progressed and has provided a decrease in symptoms for numerous trauma survivors.

Chapter V: Synthesis and Implications

The present literature review discusses PTSD and treatment. Various trauma populations such as war veterans, victims of abuse, and refugees are discussed. Furthermore, common forms of therapy for the treatment of trauma and PTSD are described including exposure, cognitive restructuring and cognitive processing therapy as well as anxiety and emotional intelligence training, and couple therapy. Each of these therapies offers a decrease in trauma symptoms dependent upon individual trauma factors and characteristics, past history of trauma exposure, and the factor of PTSD being comorbid with other disorders. One aspect to bear in mind is that the above discussed therapies may not work for all traumatized populations. For example, those with interpersonal abuse or repeated traumas may not be diagnosed with PTSD but may still be traumatized. The below section discusses further factors that contribute to treatment of trauma.

The Counsellor-Client Relationship

The therapeutic relationship is found to be a key factor during treatment of PTSD. Researchers have established a strong effect size between the variables of the therapeutic alliance and symptoms of PTSD after treatment is terminated (Cloitre, Stovall-McClough, Miranda, and Chemtob, 2004). A current study used a sample of females who had been sexually abused as children; in this sample the client/counsellor relationship was viewed as a strong predictor of treatment outcomes (Cloitre et al.). The counsellor displaying empathy and positive regard toward the client allows the client to understand and acknowledge that they now have an ally during the treatment process. This re-establishment of trust with another individual results in an increase in client openness as

well as cooperation during therapy (Cloitre et al). Furthermore, empathy from the counsellor aids the client in calmly expressing feelings as well as promoting a sense of safety that has been in jeopardy for individuals who have PTSD symptoms.

Emotional Regulation

A further task in therapy is for the counsellor to help the traumatized client develop emotional regulation skills before actual trauma treatment occurs. Research has shown that persons who endured abuse as children may not have adequate coping mechanisms to deal with strong emotions as a result of their trauma. The DSM-IV-TR study found that three quarters of participants who has endured abuse as children did not possess appropriate emotional regulation skills. A comparison group of disaster survivors found that 37% of these victims had emotional regulation problems (Pelcovitz et al., 1997).

Therefore, applying exposure therapy to persons who have yet to develop adequate self-regulation may not result in success; the heightened arousal may not allow the client to learn new information and therefore, symptoms may persist without improvement (Wolsdorf & Zlotnick, 2001).

Trauma and Culture

Some research has postulated that trauma occurs as a social phenomenon and therefore needs to be alleviated in that same context. (Boehnlein, 1987). A strength of Western society professionals is the ability to intervene in PTSD and efficiently work with populations from various ethnic backgrounds that may encompass different values, beliefs and practices (Boehnlein). Certain cultures may not endorse emotional expression as a means of communication. Therefore, victims of trauma may be less inclined than their Western-society counterparts to express their emotions about their trauma. This

result could lead to prolonged PTSD and the worsening of symptoms. A further point in relation to cultures that may not encourage emotional expression is that the negative trauma symptoms that they may be experiencing may take shape in somatic ways because this may be a more appropriate form of expression (Boehnlein). Therefore, a counselor must be aware of this and provide treatment to the client within their cultural values and beliefs to produce more successful results in treatment.

Discussion/Future Directions

Given the prevalence of traumatic experiences and its comorbidity with mental health and addiction (Dansky et al., 1995; Kessler et al., 1995), counselor education and training in the field of trauma and treatment is paramount. This knowledge and preparation of counselors in trauma research and treatment will better serve many client populations, especially those who are war veterans, victims of abuse and refugees (Goldsmith, Barlow, & Freyd, 2004). Furthermore, acknowledging and understanding the symptoms of trauma as well as the influence that these events have on the victim will help build a strong, effective therapeutic relationship so important to the progress of PTSD treatment. Lastly, engaging in a thorough assessment process that includes detailing the victim's trauma-inducing event, examining possible multiple traumas, and the age of trauma will allow us to more clearly understand the contributing factors, potential facilitators and barriers to PTSD treatment for each client.

War Veterans

In evaluating research findings, it is important to note the time lapse after the traumatic experience (s) occurred. Researchers indicate that samples of war veterans display less success with treatment than persons who have experienced other forms of trauma (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). A possible reason for this could be the time lapse that has occurred since the trauma; other research samples may use participants that experienced their trauma as little as a few months ago in comparison to war veterans who may have been suffering from PTSD for over 20 years (Ehlers et al.). Furthermore, war veterans may be less likely to reveal information to family and friends upon returning home; therefore, resulting in the avoidance of signs of

the trauma further leading to isolation. A future direction in research could be to examine the war veteran population to understand the differences between them and other trauma victims in terms of social support, and onset of trauma symptoms.

Client Characteristics

A further future direction for counselors can be to examine cognitive aspects in trauma clients. Research has found that a client's readiness and aptitude to take in information may be correlated with specific methods of treatment (Doubleday, King, Papageorgiou, 2002). A future direction for trauma research may be to initially assess a client's cognitive abilities and compare these findings with treatment outcomes of clients with a similar level of cognitive abilities in order to determine a correlation for treatment modality. Furthermore, treatment could also be focused on improving cognitive ability in order to promote more recovery and a decrease in symptoms (Schottenbauer, Glass, & Arnkoff, 2008).

A further route for research could involve not only examining cognitive aptitude, but also having a better understanding of personality variables of clients. Certain studies have found that the traits of being extraverted and open have been correlated with better treatment results (Ogrodniczuk, Piper, Joyce, McCallum, & Rosie, 2003). Therefore, initially conducting a personality assessment and then comparing personality traits with client outcomes may result in a further awareness of which client characteristics are associated with which treatment modalities and outcomes. Researchers have postulated that the trait of conscientiousness may be paired up with a homework condition in cognitive therapy to produce more positive treatment results (Kazantzis & L'Abate, 2006).

On a final note, studying a trauma client's perceived distress may result in a counselor understanding how much they are affected by the trauma; also, assessing a client's attitude and perceptions may be factors that can aid in treatment. One study found that clients who selected their treatment method were more likely to continue and finish therapy (Elkin, Yamaguchi, Arnkoff, Glass, Sotsky, & Krupnick, 1999). Allowing clients to choose certain treatments over ones that they may not be comfortable with may also result in more comfort, and hence, more positive outcomes.

Therapeutic Alliance

Lastly, the therapeutic alliance can be viewed as a significant component in the treatment process. Various studies have found that the therapeutic alliance has been a key determinant in client change (Luborsky & Luborsky, 2006). The counselor can work to provide empathy, genuineness and positive regard to the client. All of these factors can contribute to decreasing PTSD symptoms as well as drop-out rates in therapy, and further result in positive outcomes in treatment. The trauma victim may learn to develop trust for their counselor; therefore beginning the healing process.

Conclusion

Trauma treatment requires continued development. While cognitive behavioural approaches predominate, an attempt to help clients process and regulate emotions is found among some approaches such as Cognitive Reprocessing Therapy, Emotional Intelligence Training, and Emotionally Focused Therapy for couples. Although we do not have all the answers to what constitutes an effective and comprehensive treatment for trauma, it is clear that the field has made significant progress since the establishment of PTSD as a diagnostic category in the 1980s. With increasing attention drawn to trauma

and PTSD in the mental health and addiction fields, we expect that research into treatment will continue to advance and claim the attention of clinicians and researchers in this decade. The first step in the treatment of trauma has been professionals educating themselves on trauma symptoms, trauma populations and treatment modalities. The next step can be to merge this information and examine how trauma-inducing events are positively connected to specific treatment modalities. The desired result is to establish effective treatments for trauma victims in the hopes of decreasing, or even alleviating PTSD symptoms.

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