

Article 4

Moving Forward: Issues in Trauma Response and Treatment

Jane M. Webber, J. Barry Mascari, Michael Dubi, and J. Eric Gentry

The field of trauma treatment is at a crossroads. Evolving research and experience demonstrate that there is a strong need to include trauma response and treatment skills across counselor training. Advances in traumatology further indicate the need to separate trauma treatment into individual trauma treatment (sexual abuse, physical and emotional abuse, domestic violence) and mass disaster mental health response (hurricanes, floods, terrorist attacks). While both require trauma response, they are in fact different kinds of trauma events and necessitate specialized skills.

With recent research and study, the field is closer to matching specific types of interventions with the type of trauma experienced. Over the past 20 years, and especially since September 11th, public and professional interest in the impact and effects of trauma has increased. With each disaster, we are more knowledgeable about the complex relationships that exist among experience, neurophysiology, endocrinology, and behavior related to traumatic stress (Solomon & Heide, 2005). This article briefly reviews the history of trauma treatment and advances in treatment approaches, and makes recommendations for further research and policy to help counselors gain the skills necessary for contemporary practice.

Advances in Trauma Treatment: A Brief History

Trauma and its effects have been studied and referred to throughout history as early as 700 BCE in the Iliad and the Bible. In the 19th century terms like *nervous shock* began to appear describing posttraumatic disorders. At that time clinical conditions such as war neuroses and hysteria and their similarities were being discussed by physicians and psychologists. As early as 1859 there was recognition of the similarity between symptoms of hysteria and childhood trauma. Freud and Breuer in Austria and Janet in France concluded the cause of hysteria was psychological trauma that somehow produced altered states of consciousness. Janet referred to these states as *dissociation*, and Freud used the term *double consciousness* (Gentry &

Baranowsky, 2002a). Ironically, their approaches to treating these conditions are conceptually related to contemporary interventions employing exposure and reexperiencing the traumatic events.

During World War I, posttrauma symptoms were mainly attributed to weakness and cowardice, but by World War II, popular belief held that symptoms of combat neurosis could befall anyone. It was not until the period after the Vietnam War that posttraumatic stress received serious attention when returning soldiers complained of being ill-tempered, of having violent outbursts, nightmares, problems with alcohol and drugs, and work and relationship problems. The Veterans Administration eventually recognized the condition and began providing treatment throughout the U.S.

In 1980 when posttraumatic stress disorder (PTSD) was validated and included in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*; American Psychiatric Association [APA], 1980), symptoms common to victims of rape, domestic violence, and child abuse were recognized by the medical and psychological communities as being similar to those experienced by returning veterans. These symptoms are also common to residents of community war zones, mainly children living in violent cities (Gentry & Baranowsky, 2002a, 2002b; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997).

In addition to the trauma experience, the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; APA, 2000) includes discussion of the individual's response to the traumatic event. This makes the individual's response to the event as important as the event itself, helping make sense of why some individuals become debilitated after experiencing an event while others appear to experience no negative effects.

Although individual reactions may vary, common patterns of behavioral, biological, social, and psychological responses have been identified among individuals who have been directly or vicariously exposed to life-threatening events. In some cases complex PTSD, a syndrome in survivors of prolonged

and repeated trauma, is experienced as well as disorders of extreme stress (DESNOS). Researchers suggested that PTSD seems to mimic various personality disorders. Prolonged childhood sexual abuse has been described as severe PTSD which includes dissociative states, ego fragmentation, affective and anxiety disorders, somatization, and suicidality as well as reenactment and revictimization (Gentry & Baranowsky, 2002b).

Advanced Trauma Treatment Approaches

There are a variety of treatment approaches for survivors of trauma. One of the more effective is the Triphasic Model (Baranowsky, & Gentry, 2002; Baranowsky, Gentry, & Schultz, 2004; Herman, 1992). The three phases of this model are safety and stabilization, remembrance and mourning, and reconnection. Safety is the actual task of recovery with the clinician primarily helping the client to regain both internal and external control. The goal is to enable the client to make a gradual shift from unpredictable danger to reliable safety.

The mourning and remembrance phase allows the client to reconstruct the story of his or her trauma in minute detail. The clinician bears witness to the client's experiences to help him or her find the strength to heal. Within this phase there are many techniques that are effective such as EMDR (Eye Movement Desensitization and Reprocessing) and TIR (Traumatic Incident Reduction). Reconnection is the final phase and involves redefining oneself in the context of meaningful relationships. Survivors bring closure to their experiences and learn that these events do not determine who they are. They are liberated by the conviction that regardless of what else happens to them they always have themselves.

In selecting appropriate therapeutic interventions, expert guidelines are often considered instead of research. This is important because research does not often generalize well or answer the questions that arise in clinical practice in a comprehensive and effective manner. Many systematic studies have failed to address the complexities of the clinical cases addressed in practice. Research can often be tedious and time-consuming, but it is as critically important to advancing the field of traumatology. However, an expert consensus must also be considered.

Table 1 and Table 2 reflect the preferences of expert clinicians in the field of traumatology and are adapted from Foa, Davidson, and Frances (1999). These preferences reflect a work in progress in treating trauma survivors.

Table 1. Preferred Psychotherapy Techniques for Different (PTSD) Target Symptoms

Most Prominent Symptom	Recommended Techniques	Also Consider
Intrusive thoughts	Exposure therapy	Cognitive therapy Anxiety management Psychoeducation Play therapy for children
Flashbacks	Exposure therapy	Anxiety management Cognitive therapy Psychoeducation
Trauma-related fears, panic, and avoidance	Exposure therapy Cognitive therapy Anxiety management	Psychoeducation Play therapy for children
Numbing/detachment from others/loss of interest	Cognitive therapy	Psychoeducation Exposure therapy
Irritability/angry outbursts	Cognitive therapy Anxiety management	Psychoeducation Exposure therapy
Guilt/shame	Cognitive therapy	Psychoeducation Play therapy for children
General anxiety (hyperarousal, hypervigilance, startle)	Anxiety management Exposure therapy	Cognitive therapy Psychoeducation Play therapy for children
Sleep disturbances	Anxiety management	Exposure therapy Cognitive therapy Psychoeducation
Difficulty concentrating	Anxiety management	Cognitive therapy Psychoeducation

Table 2. Selecting Psychotherapy Techniques Based on Effectiveness, Safety, and Acceptability

	Recommended Techniques	Also Consider
Most effective techniques	Exposure therapy Cognitive therapy	Anxiety management
Quickest acting techniques	Exposure therapy	Anxiety management Cognitive therapy Psychoeducation
Techniques preferred across all types of trauma	Cognitive therapy Exposure therapy Anxiety management	Psychoeducation
Safest techniques	Anxiety management Psychoeducation Cognitive therapy	Play therapy for children Exposure therapy
Most acceptable techniques	Psychoeducation Cognitive therapy Anxiety management	Play therapy for children

These techniques help provide the clinician with an array of interventions to address the chaos and unpredictability that often surround traumatic events. Individuals who experience trauma have the sights, sounds, and smells of the event imprinted in their minds. These techniques can be effective in helping the client resolve these psychological issues and resume optimal functioning.

Moving Trauma Counseling Forward

Although practicing clinicians regularly treat trauma survivors, they tend to be inadequately trained in the theory and practice of trauma counseling. As the real world continues to be perceived as a more dangerous place, the need for specialists trained and certified in trauma counseling becomes more important in treating a wide range of individual and mass trauma victims. Mascari and Webber (2005) noted that trauma training is a complex challenge. There are different types of disaster events, and a single event may involve multiple levels of intervention for victims and mental health responders' needs. It is likely that counselors across a wide range of employment settings will see clients who have experienced Type I trauma in the form of sexual abuse, physical abuse, rape, witnessing gang violence, and other unexpected powerful events. Since

counselors often work with children, Baggerly (2005) proposed the employment of trauma techniques that are developmentally appropriate such as play therapy as well as special disaster response procedures in schools (Baggerly & Rank, 2005). Counselors need the most effective techniques at hand to provide a timely response; this can only come through additional graduate or postgraduate training.

After September 11th, it became clear that counselors need to be trained, certified, and competent to treat posttrauma disorders. Specialized models of training built on the ground-breaking work of pioneers like Gentry and Baranowsky are needed. All counselors should be competent in basic trauma knowledge and response. According to Smith (2005), an American Red Cross Disaster Mental Health Services trainer,

Providing mental health services in a disaster environment requires an additional set of skills that are noticeably lacking in counselor education programs. That skill set, in brief, includes the ability to apply clinical skills in an environment where chaos and lack of organization prevails, to concentrate on getting individuals to an acceptable level of functioning quickly following traumatization, and applying these skills in a systematic manner for the benefit of all. (p. 37)

At this time the American Counseling Association does not have a division or affiliate dedicated to trauma counseling. The Trauma Interest Network made significant progress under the leadership of Dr. Karen Jordan. *Counseling Today* published several features on individual trauma treatment and disaster response.

The American Counselor Association Foundation (ACAF) advanced trauma knowledge and practice through two initiatives. The Winter Counseling Symposium: Responding to Tragedy, Trauma, and Crisis, at Argosy University Sarasota, encouraged the exchange of current research and techniques by both practitioners and counselor educators. The ACAF volume, *Terrorism, Trauma, and Tragedies: A Counselor's Guide to Preparing and Responding* (Webber, Bass, & Yep, 2005) focused on practical strategies for counselors across several settings including schools, the military, the community, private practice, the workplace, agencies, and government.

With the impact of terrorism on American soil, Webber and Mascari (2005) emphasized the "critical need to research effective ways to assess clients' immediate needs and match trauma symptoms to treatment strategies for those who experienced trauma

directly” (p. 23). Data collection and research response are essential during disaster response to study the effects of both victims and responders.

The Trauma Network will continue efforts to develop an organizational affiliate and ultimately a division for trauma counselors and to build bridges between trauma counselors here and internationally. We also plan to

- actively encourage and mentor trauma counselors to document their practice and research;
- advocate for the inclusion of crisis and trauma training in counselor education programs;
- promote timely publications and Web resources helpful to the profession (see David Baldwin’s <http://www.traumapages.com>);
- develop continuing education and professional development programs for counselors at all levels of skills and across divisions and regions;
- dialog with public and private sector groups dedicated to trauma and disaster response;
- collaborate with trauma experts, universities, ACA, and ACES to develop training models and curricula for graduate programs;
- develop research designs and training for volunteers to be ready to conduct research should a disaster occur in the future;
- encourage research to determine efficacy of approaches and treatment matching; and
- promote public awareness of community models of disaster response to dispel myths and to prepare the public.

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