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Models of Trauma Treatment

A 35-year-old financial executive sought therapy after starting a new job. Michael, a graduate of an Ivy League institution, described his new position as a dream job with one major challenge. It involved visiting the company's branches in other states. Michael stated that he needed therapy to help him with his flying phobia. He recounted that when he was 14 years old his father was killed in an air crash. As a result, any mention of planes and flying plunged him into a state of panic. However, with therapy he was able to keep his panic under control. His new employment was bringing up intense anxieties, and he was helpless in the face of them.

In further discussion with Michael, and by prioritizing his problems, the therapist and Michael decided to use systematic desensitization to help him with his flying phobia. Relaxation training is a first step in systematic desensitization, and Michael was already familiar with progressive muscle relaxation and deep breathing. The next step was to help Michael create an anxiety hierarchy (packing luggage, making reservations, driving to the airport, checking in, etc.). The third step was to have Michael engage in activities outlined in his anxiety hierarchy, beginning with the least anxiety provoking. As soon as his distress increased, he was encouraged to stop the activity and practice relaxation.

This phase of treatment took several months, but Michael was able to manage his fears and take short trips. At this point, the therapist suggested the next phase of treatment should focus on the issues underlying Michael's flying phobia. Using a stage-oriented trauma treatment approach, Michael was gradually able to discuss his underlying thoughts and memories when his phobia began. He

reported being close to his dad and missing him terribly after he died. As the oldest of three children, he felt that he had to be stoic to support his mother and to watch over his younger siblings. He felt that he could not express his loss at the time. Since his father's remains were never identified, he lacked closure in an important relationship. In therapy, Michael was able to mourn his loss fully for the first time.

This chapter will examine the different models used in trauma-focused therapy with adult survivors, from the cognitive-behavioral to stage-specific and self-trauma models. Most of these models are theoretically integrative and focus on the healing that is possible in a therapeutic relationship. Eye Movement Desensitization Reprocessing and psychopharmacology are also outlined as treatment options. Specific strategies are provided for the beginning psychotherapist interested in working with traumatized populations. Trauma treatment with particular populations, such as victims of rape, domestic violence, and political trauma, will be covered in later chapters.

Therapeutic Approaches

Many effective therapeutic approaches and techniques have been used with trauma survivors. Most practitioners use a combination of approaches depending on their training and background. The client's needs, however, should be the final determinant of the approach the therapist chooses to use to support recovery. When shaping interventions, the therapist must consider the client's cultural and social background. The therapist's awareness of these factors inevitably affects the progress of treatment. If practitioners are not familiar with the culture of the client, they should make every effort to gain this cultural understanding. Attending professional conferences and workshops and reading independently are ways to increase one's cultural repertoire. However, when the cultural differences between client and therapist become insurmountable even after a therapist has worked at cultural understanding, it is reasonable for the therapist to refer the client to more appropriate services. The therapeutic relationship is not the venue for negotiating cultural differences.

In addition to, and sometimes concomitant with, cultural differences is the role of empowerment and disempowerment within a therapeutic session. As a professional with expertise, the practitioner holds a position of power.

The client who seeks services does not share the same privilege and may feel disempowered as a result. If racial and cultural differences exist in the client-therapist dyad, issues of power and privilege are highlighted. Racial and cultural differences can significantly impact therapy, and a culturally competent practitioner does not hesitate to raise the issues appropriately.

Finally, it is important to remember that trauma work is often integrated into therapeutic work with clients. Often, trauma material does not surface until much later in the therapeutic process. Establishing rapport and trust should be critical goals of any therapy, especially those that are trauma-specific. For some practitioners, these goals remain the primary focus of therapy with their clients for several years.

Brief Psychodynamic Psychotherapy

Brief psychodynamic psychotherapy is an abbreviated form of psychodynamic therapy in which the emotional conflicts caused by the traumatic event are the focus of treatment, particularly as they relate to the client's early life experiences (Horowitz, 1997; Horowitz, Marmar, Krupnick, Wilner, Kaltreider, & Wallerstein, 1997; Krupnick, 2002). The rationale of brief psychodynamic psychotherapy is that a client's retelling the traumatic event to a calm, empathetic, compassionate, and nonjudgmental therapist will result in greater self-esteem, more effective thinking strategies, and an increased ability to manage intense emotions successfully (Marmar, Weiss, & Pynoos, 1995). Throughout the process, the therapist helps the client identify current life situations that trigger traumatic memories and exacerbate PTSD symptoms. In this model of treatment, the therapist emphasizes concepts such as denial, abreaction, and catharsis (Horowitz, 1997; Horowitz et al., 1997).

By using a psychoanalytic approach, Burton (2004) found that clients were able to reenact their trauma. He concluded that these reenactments serve several purposes. First, reenacting a trauma is validating since it confirms for the client that the trauma really happened. Second, a reenactment helps the client gain mastery over the situation that was once an experience of helplessness. Finally, reenactments present the possibility of reversing prior outcomes, controlling what was uncontrollable in the past, and dealing with the trauma in different and more hopeful ways.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) combines two very effective kinds of psychotherapy: cognitive therapy and behavior therapy. Behavior

therapy, based on learning theory, helps clients weaken the connections between troublesome thoughts and situations and their habitual reactions to them. Cognitive therapy teaches clients how certain thinking patterns may be the cause of their difficulties by giving them a distorted picture and making them feel anxious, depressed, or angry (Beck, 1995). When combined into CBT, behavior therapy and cognitive therapy provide powerful tools for symptom alleviation and help clients resume normal functioning.

A cognitive approach has been found to be a suitable framework for trauma therapy because traumatic experiences usually impede the emotional process by conflicting with pre-existing cognitive schemas (Jaycox, Zoellner, & Foa, 2002). Cognitive dissonance, which occurs when thoughts, memories, and images of trauma cannot be reconciled with current meaning structures, causes distress. The cognitive system is driven by a completion tendency: a psychological need "to match new information with inner models based on older information, and the revision of both until they agree" (Horowitz, 1986, p. 92).

The fluctuation between symptoms of hyperarousal and inhibition commonly seen among trauma survivors is well described by van der Kolk (1996). During the acute phase of the trauma, in an attempt to comprehend and integrate the traumatic experience, the trauma survivor normally replays the event that has been stored in active memory. Each replay, however, distresses the traumatized individual, who may inhibit thought processes to modulate the active processing of traumatic information. This observable inhibition gives the appearance that the traumatized individual has disengaged from processing the traumatic memory. Thus, some trauma survivors, as a result of excessive inhibition, display withdrawn and avoidant behaviors. However, when an individual is unable to inhibit traumatic thoughts, the intrusive symptoms are expressed in the hyperarousal symptoms of flashbacks during the waking states and nightmares during sleep states (van der Kolk, 1996). For this reason, researchers commonly observe trauma survivors as oscillating between denial and numbness, or intrusion and hyperarousal (Lindy, 1996; van der Kolk, McFarlane, & van der Hart, 1996). Once clients can reappraise the event and revise the cognitive schemas they previously held, the completion tendency is served. These common reactions and cognitive processes seen among trauma survivors can be explained using the framework of cognitive theory. However, the therapist's central focus on the client's internal cognitive mechanisms and how the client processes information may result in a neglect of contextual and sociocultural factors in cognitive theory.

CBT primarily involves working with a client is cognitions to change emotions, thoughts, and behaviors (Meichenbaum, 1977, 1997).

CBT techniques used by trauma therapists focus on the following:

- Learning skills for coping with anxiety (such as breath retraining or biofeedback)
- Using cognitive restructuring to change negative thoughts
- Managing anger
- Preparing for stress reactions (stress inoculation)
- Handling future trauma symptoms
- Addressing relapse prevention and other substance abuse issues
- Communicating and relating effectively with people (social skills)
- Addressing thought distortions that usually follow exposure to trauma
- Relaxation training and guided imagery

Additional information on CBT can be obtained from www.cognitive therapy.com. Several specific CBT approaches are outlined below:

1. *Exposure Therapy.* In exposure therapy, clients are encouraged to confront the fear-inducing thought or memory in varying levels of exposure that can be imaginal or in vivo (Cook, Schnurr, & Foa, 2004; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Jaycox et al., 2002). Gradually and repeatedly, clients are guided through a vivid and specific recall of traumatic events until emotional reactions decrease through a process of habituation. The safe, controlled context of the therapeutic relationship helps clients face and gain control of the fear and distress that they previously experienced as overwhelming. For example, issues of safety dominate the lives of sexual assault victims. As the clients recount their narratives in exposure therapy, practitioners are able to identify possible risk areas. Making these distinctions can later be used to help clients discriminate unsafe situations from safe ones (Foa & Meadows, 1997).

   In some cases, the therapist may encourage clients to confront all their memories or reminders of trauma at once. This technique is referred to as *flooding*. It is critical that a practitioner discuss this technique with a client carefully, and it is also imperative to offer the client the option to refuse treatment. Clients should be aware of the technique's negative consequences; they should also be aware that it may not work. In general, exposure therapy has been found to be an ineffective and unsuccessful treatment modality with veterans who have experienced chronic combat-related PTSD (Schnurr, Friedman, & Foy, 2003). In fact, it was so poorly tolerated by this population that most participants chose to drop out of treatment (Foa, Keane, & Friedman, 2004; Keane, Fairbank, Caddell, & Zimmering, 1989). However, strong empirical support exists for the efficacy of exposure therapy with other trauma-affected groups (Foa & Meadows, 1997). Studies conducted among rape survivors, for example, suggest that exposure therapy may actually be an effective treatment for PTSD (Foa et al., 2002; Hembree & Foa, 2000).

2. *Systematic Desensitization.* Systematic desensitization, developed by Wolpe in 1958, is an effective form of treatment for individuals who prefer gradual

recall rather than immediate total recall of traumatic memories. When using systematic desensitization, clients are supported through deep muscle relaxation techniques and diaphragmatic breathing (see Appendix VI and Appendix VII). These techniques are taught to clients before treatment is administered; they are used during therapy whenever a client's anxiety increases. Once clients have established a hierarchy of fear-inducing stimuli and gained competence in using relaxation techniques to overcome these situations, the least upsetting situation is recalled. The client proceeds to systematically recall the least distressing aspects of the traumatic experience. If negative reactions ensue, relaxation is induced. Otherwise the client ascends up the hierarchy to recall the next distressing stimuli. In this systematic method, clients work toward overcoming and integrating their worst fears.

3. *Anxiety Management*. From an anxiety management perspective, the practitioner attributes the client's anxiety to a lack of skills in managing anxiety when faced with situations that provoke it. The aim of client treatment is to develop skills in managing anxiety. Clients are taught specific anxiety-reduction skills: relaxation training, positive self-talk, and distraction techniques. Anxiety management has been successfully used to treat PTSD in rape survivors (Foa, Rothbaum, Riggs, & Murdock, 1991).

4. *Stress Inoculation Therapy*. One of the most commonly used anxiety management treatments for PTSD is stress inoculation therapy (SIT). Originally developed by Meichenbaum (1994) for anxious individuals, SIT incorporates psycho-education and skill-building techniques such as relaxation, thought stopping, breath retraining, problem solving, and guided self-dialogue. When used with female rape victims, SIT has yielded encouraging results (Foa et al., 1991).

Positive client outcomes have been achieved by combining treatments. In a sophisticated controlled study, a combination of prolonged imaginal exposure, SIT, and supportive counseling was found to significantly reduce symptoms (Foa et al., 1991).

Eye Movement Desensitization and Reprocessing

In Eye Movement Desensitization and Reprocessing (EMDR), the goal is to help the client desensitize to traumatic stimuli through saccadic eye movements (Shapiro, 1995). The treatment procedure follows a structured sequence. Clients are first asked to perform bilateral eye movements while recalling a disturbing image or memory. The therapist then waves a finger repeatedly across a client's visual field while he/she tracks it with his/her eyes (Shapiro, 1995).

The treatment involves a combination of exposure therapy elements and eye movements, hand taps, or sounds to distract clients' attention. After

each sequence, clients indicate their subjective units of distress (SUD). If the SUD is high, the client practices relaxation techniques. When the client is ready, EMDR is resumed. Shapiro (1989, 1995) maintains that EMDR, with its brief exposures to associated material, external/internal focus, and structured therapeutic protocol, represents a distinctly different and new paradigm in therapy.

However, EMDR is a controversial therapeutic approach for several reasons. Some argue that EMDR lacks a theoretical foundation, empirical data, and sound methodology (Resick, 2004). Claims that EMDR is a rapid and effective treatment have been subjected to many empirical studies and much scientific scrutiny. More specifically, 12 controlled randomized studies, which investigated the efficacy of EMDR with PTSD-diagnosed participants, were conducted (Maxfield & Hyer, 2002).

With Vietnam veterans, Devilly, Spence, and Rapee (1998) compared EMDR to control conditions using two different forms of EMDR and psychotherapy. Although the EMDR groups showed some improvement, they found that at six-month follow-up, these treatment gains had not been maintained. Another study done by Devilly and Spence (1999) compared EMDR with a combination of exposure, SIT, and cognitive therapy techniques in a mixed sample of trauma survivors with PTSD. While EMDR was effective, cognitive therapy was found to be superior because treatment gains were maintained at three-month follow-up.

Some researchers suggest the effectiveness of EMDR derives mostly from its cognitive behavioral aspects, which include exposure, cognitive restructuring, anxiety desensitization, and breathing (Lohr, Tolin, & Lilienfeld, 1998; McNally, 1999). In fact, Lohr, Lilienfeld, Tolin, and Herbert (1999) state that if EMDR had been presented as a form of exposure therapy, "much of the controversy . . . could have been avoided" (p. 201). EMDR forces the client to think about the trauma, to think about the negative cognitions associated with the trauma, and to replace them with positive cognitions. Without the lateral eye movements, EMDR is similar to cognitive and exposure therapy methods, which facilitate a client's processing of traumatic memory. Any efficacy demonstrated by EMDR likely derives from a client engaging with and processing the traumatic memory, rather than from eye movements. Resick (2004) points out that EMDR treatments with a more extensive behavioral and imaginal exposure, as well as cognitive therapy, are likely to be more effective.

Despite ongoing scientific scrutiny, the originator of EMDR, Francis Shapiro, claims that even a single session of EMDR produces positive results (Shapiro, 1989). While the theory and research continues to evolve, there is some evidence that attentional alternation, which is unique to EMDR, may actually facilitate the accessing and processing of traumatic

material in adults (Chemtob, Tolin, van der Kolk, & Pitman, 2000; Hyer & Brandsma, 1997; Sweet, 1995). The aggregate evidence of research results demonstrates that EMDR is an effective treatment for civilian PTSD (Maxfield & Hyer, 2002; Perkins & Rouanzoin, 2002). EMDR demonstrates greater efficacy and requires less time to achieve positive results. However, several sampling and methodological flaws and the lack of control groups make it premature to draw any solid conclusions about the generalizability of these findings until they are replicated to confirm their reliability. Additional information on training and certification in EMDR can be obtained from www.emdr.com.

A Stage-Specific Model

Herman (1997) describes trauma recovery as unfolding in three broad stages. The first stage focuses on establishing a client's safety and stabilization. Once these goals are reached, the client proceeds to the next stage of remembering, exploring, and mourning past traumas. The third and final stage of recovery is described as one of reconnection. This stage focuses on expanding and revitalizing the relational world of the client. The therapeutic alliance is described as a collaborative relationship with the client in charge of recovery; the therapist's role is described as that of witness, consultant, and ally (Herman, 1997). A more comprehensive discussion of Herman's specific stage model is described below.

1. Safety

According to Herman (1997), trauma causes disempowerment and disconnection. The focus of the first stage of recovery is empowerment and connection. Effective therapy shifts unpredictable danger to reliable safety, dissociated trauma to acknowledged memory, and stigmatized isolation to restored social connection (Herman, 1997). A healing therapeutic relationship restores a survivor's trust in others by validating the client's experience. Practitioners of this model are described as

- allowing clients to ultimately have control in the therapeutic setting;
- acting as assistants, allies, and advocates in the role of bearing witness;
- exercising care in not resorting to dysfunctional rescuing and patronizing, both of which can take control away from client;
- adopting a neutral stance and not taking sides in the client's interpersonal conflict.

The timing and focus of treatment is paced to suit the client's needs. Recovery is viewed like running a marathon, with the therapist acting as coach and the client determining the pace. Therapists who share their diagnosis and treatment plans with their client early in treatment can actually empower the client because knowledge is power. In some circumstances, to help clients re-establish control and reduce anxiety and hyperarousal, psychopharmacology may have to be used.

2. Remembrance and Mourning

The second stage of Herman's (1997) model is referred to as remembrance and mourning. It focuses on past issues, in particular the traumatic event that causes a client's difficulties. Clients are encouraged to recall traumatic memories so that they are transformed from a snapshot to a full picture. The goal of this stage is to tell the full story of the trauma with the therapist in the role of witness and ally. The survivor determines how much is shared in each therapy session. The subtle balance between facing the past and preserving safety is constantly negotiated between clients and therapists. Clients who avoid their traumatic memories may stagnate and not improve in therapy. On the other hand, those clients who recall their traumatic memories too quickly can become overwhelmed and may compromise their safety.

A full recall of the traumatic memory includes the participation of all five senses so that all aspects of the memory are available to consciousness. Two techniques help the recall of traumatic memories: flooding and testimony. Flooding is a behavioral technique. The client is taught relaxation techniques before directly recalling traumatic material. However, flooding has been found to be effective only with those individuals who have experienced a single incident of trauma (Herman, 1997). The testimony method involves a detailed record of the traumatic experience. This record is created from the clinical material that emerges in the therapy sessions. The testimony method has been found to be successful with those who have experienced political trauma (Herman, 1997). Both these techniques involve an active collaboration between client and counselor. The outcome is the construction of a detailed trauma narrative in which the client relives the intense experience of the trauma in a safe and trusting therapeutic relationship.

Hypnotherapy is another technique that Herman (1997) recommends for those client's whose gaps in memory disallow them from fully recalling traumatic events. She cautions practitioners on several aspects of this therapeutic method. First, she notes, hypnotherapy requires a high degree of therapeutic

skill. Second, it requires adequate preparation of the client. Third, once a memory is uncovered, the practitioner must ensure that it is carefully reintegrated into the client's life.

Mourning is an inevitable outcome of traumatic loss. Sometimes clients resist mourning in order to "deny victory to the perpetrator" (Herman, 1997, p. 188). Ultimately, mourning is a necessary aspect of healing. The therapist helps the client accept grief as an act of courage rather than defeat. Mourning can have a restorative power by helping clients come to terms with fantasies of revenge. However, clients never discard the quest for justice and tenaciously hold perpetrators responsible for their immoral acts.

3. Reconnection

In the third stage, Herman (1997) describes clients reconnecting as they create new selves, reconcile with the past, and repudiate those aspects of the self that may have been imposed by the trauma. She notes that for those victims recovering from childhood sexual abuse, the new identity may feel like a second adolescence. Clients transition from victims to survivors by taking concrete steps to increase their sense of power and control, by protecting themselves from future danger, and by deepening their alliances with those whom they have learned to trust (Herman, 1997, p. 197).

The goal of reconnection is to remain autonomous while simultaneously developing connections. In this way, the ability to trust both self and others becomes more possible. Individuals who come from abusive families may consider confronting their families, the perpetrator, or those who were silent about their trauma. These confrontations can be emotionally useful if they are carefully planned and executed.

Some clients, in the reconnection stage of recovery, choose to become social activists and commit to a survivor mission pursuing the eradication of violence. In joining such groups, the survivor satisfies a yearning for connection while creating opportunities to ally with others who share a common purpose. Herman (1997) describes joining survivor groups as a constructive way of transforming the meaning of personal tragedy. Sarah Buel, a victim of domestic violence, is a survivor who overcame personal challenges by creating new meaning out of a traumatic experience. Buel attended school at night while raising a son as a single parent. After earning a law degree from Harvard University in 1990, she drafted the first abuse-prevention law in New Hampshire. The law allows abuse victims without a lawyer to petition the court for a restraining order; it also specifies other ways that abuse victims can maintain safety. Buel has become an accomplished and sought-after public speaker on domestic violence. In her legal practice, she concentrates on legally protecting abuse victims.

A Self-Trauma Model

The trauma model developed by Briere (1996) is a blend of humanistic, psychodynamic, and cognitive-behavioral theories. Important principles of Briere's treatment model include respect, positive regard, and the assumption of growth. Key concepts for practitioners to follow are safety, support, therapeutic feedback, and working through the trauma.

Safety and Support

Through extended and intensive psychotherapy, clients build a positive source of identity. They become better able to regulate affect and monitor internal states, they begin to rely on inner resources in times of stress, and they maintain internal coherence in their interactions with others. The support and care shown by the therapist is an important aspect of treatment. A stable and optimistic therapeutic environment supports a client's positive sense of self. Such an environment also allows clients to transition from a state of hypervigilance regarding their external environment to one that focuses on their internal psychological environment. A consistent, caring, and nonjudgmental therapist demeanor helps clients develop an ability to explore their inner landscape safely.

Therapeutic Feedback

According to Briere (1996), therapeutic feedback is an important aspect of client-therapist interaction because it increases clients' self-understanding. With the therapist's encouragement, clients examine illogical thoughts and compare these thoughts to their actual experiences. Therapists act as a positive mirror, by illuminating avoidant and dissociative client responses (Kohut, 1977). As clients learn more about themselves, self-defeating and self-destructive behavior decreases. A state of helplessness is replaced with a greater sense of control. Most importantly, clients develop increased self-nurturance, self-confidence, and an improved ability to self-support.

Working Through

Since the therapeutic relationship carries the potential to elicit needs, projections, and responses that are abuse-related, it is possible that clients may experience boundary confusion. When this occurs, the effective therapist uses the opportunity to help the client rework old relationships in which boundaries may have been violated. Clients are able to recover

"missed" stages of development while in an environment of unconditional positive regard.

With therapeutic support, clients can test their autonomy by attempting behaviors they previously considered risky. They may assertively confront a boss or an abusive parent. An important and useful idea described in the self-trauma model is the concept of the "therapeutic window." Briere (2002) describes this as the psychological area that has the upper limit of clients feeling overwhelmed by exposure to abuse-related material and the lower limit of excessive avoidance of traumatic material. The therapist strives to work within the area demarcated by the therapeutic window so that sessions are tolerable in intensity. At the upper limit of the therapeutic window, the experience is likely to become an "insurmountable affective task" (p. 185). On the other hand, interventions that are not psychologically demanding can result in minimal psychological growth or "a surmountable affective task" (p. 185). Therapists constantly monitor the amount of abuse-related distress that clients can tolerate, with the aim of balancing exploration and consolidation of traumatic material.

The self-trauma model of treatment requires the active involvement of client's in order for healing to occur. It is based on the premise that to overcome pain and fear, both of these elements must be directly confronted in the safety of the therapeutic setting (Briere, 2002). The therapist is cautioned to maintain sight of the clients' courage and strength in attempting to achieve this goal.

A Stage-Oriented Treatment Model

Chu (1998) describes a stage-oriented trauma treatment model that includes self-care, acknowledgment of the trauma, improving functioning, expression of affect, and relationship building. It is summarized and represented by the acronym SAFER:

S = Self-Care

A = Acknowledgment

F = Functioning

E = Expression

R = Relationships

These five stages of treatment can be further differentiated into early, middle, and late stage categories.

Early Stage Treatment

1. Self-Care

Behaviors that are self-destructive and high risk commonly occur among trauma survivors and increase their vulnerability to revictimization. A focus on self-care eradicates a trauma survivor's feelings of unworthiness and instills a positive sense of identity. The control of traumatic symptoms, especially those that interfere with current functioning, reduces a client's sense of helplessness (Chu, 1998). Grounding and self-soothing techniques such as deep breathing, squeezing a ball, or rubbing a stone can help clients overcome intrusive thoughts and re-orient to the moment.

2. Acknowledgment

Acknowledgment of abuse is a central concept in trauma recovery. Clients are constantly reassured they were not responsible for the abuse. By acknowledging abusive experiences, counselors tacitly avoid colluding with a client's denial of abuse and flawed beliefs of personal defectiveness.

3. Functioning

In this stage of treatment, clients are guided toward normal functioning in the current reality of their lives. To avoid dwelling on past trauma issues and to ameliorate distress, clients are encouraged to establish and maintain a routine while developing supportive relationships.

4. Expression

To relinquish the unspeakable aspects of the trauma, clients must find other outlets for expression. Several expressive therapy techniques, including poetry writing, drawing, and movement, can potentially capture the unspeakable aspects of trauma in constructive ways.

5. Relationships

Establishing mutually beneficial and collaborative relationships is an important task of early recovery. Since the client is likely to reenact early abusive relationships within the therapeutic setting, the therapist may find that the therapeutic alliance has to be constantly renegotiated. The process of disconnection and reconnection is likely to repeat itself, but by continuing to provide support and care, the therapist models a corrective emotional relationship for a client.

Middle Stage Treatment

Once clients master the tasks of early treatment, they can begin to tackle the tasks of the middle treatment stage. Exploration and abreaction are the major tasks of this stage. Chu (1998) cautions that abreaction and exploration can only take place when clients have achieved a position of strength; exploration of traumatic material should not be done with clients who display vulnerability or with clients who find themselves in a new crisis. Although the direction of abreaction differs among clients, several common features are evident:

- An increase in symptoms
- Intense internal conflict
- Acceptance and mourning
- Mobilization and empowerment

Abreaction frees the client from the fears instilled by past trauma (Chu, 1998). Clients can then develop a personal narrative of understanding that allows them to continue with their lives.

Late Stage Treatment

Chu (1998) describes the last stage as the consolidation stage of trauma treatment. In this stage, the client continues to develop new skills while stabilizing gains. With a newly empowered sense of self, the client can participate in interactions that were earlier viewed with anxiety. Although clients may achieve good ego strength, continuing treatment may be a necessary option as the client inevitably encounters new challenges.

The stage-oriented model was primarily developed for treating clients who experienced childhood trauma. It may therefore be limited to use with this specific group.

Pharmacotherapy

Medication can reduce the anxiety, depression, and insomnia that often accompany PTSD. In some cases, medication may also relieve the distress and emotional numbness caused by traumatic memories. Several antidepressant drugs have yielded mostly positive results in clinical trials. Antidepressant drugs used to control PTSD symptoms include tricyclic antidepressants (TCAs), monamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs).

Other classes of drugs have shown some promise. For example, Clonidine reduces hyperarousal symptoms, while Clonazepam regulates anxiety and panic symptoms. The SSRIs have good outcomes in globally and effectively treating all categories of PTSD. This class of drugs is currently the most widely used and best studied (Sutherland & Davidson, 1998).

Currently, no particular drug has emerged as a definitive treatment for PTSD, although medication has been clearly successful in providing immediate relief of traumatic symptoms. Once clients are able to control their symptoms through pharmacotherapy, it becomes possible for them to participate more effectively in psychotherapy. As a sole treatment, pharmacotherapy will not help clients recover from trauma (Vargas & Davidson, 1993). It can, however, stabilize clients so that psychotherapy and other interventions are possible.

Cultural factors should be an important consideration when psychopharmacology is used as a treatment option. Clinical trials are seldom done on every population group. Caution is necessary when medicating individuals from groups who may not have been tested for a particular drug. For example, it has been suggested that the dosage of medication should be reduced with traumatized Southeast Asian refugees. Indochinese people regularly eat food rich in tyramine and/or use herbal remedies, which can exacerbate the side effects of TCA and MAOI (Demartino, Mollica, & Wilk, 1995). In some cultures, the sharing of medication is common practice. Before dispensing medication to such clients, the practitioner should fully discuss side effects of the medication and the dangers of sharing it with those for whom it was not prescribed (Demartino et al., 1995).

In some cultures, there may be a cultural stigma associated with taking medication. For example, an ethnographic study of psychiatric patients in hospital care in East Malaysia, where traditional healing continues to be a popular alternative to biomedicine, found that few patient rights are recognized (Crabtree, 2005). The researcher found that the medical culture remains embedded in a paternalistic and custodial attitude that does not acknowledge issues of spirituality or alternative healing practices that are important to hospitalized patients. Modernization of services has not included patient participation or an appropriate inclusion of cultural responses. The researcher concludes that until this takes place, treatment resistance will continue to be exhibited.

Marotta (2000) describes the key role that counselors play with clients who use psychopharmacology as an adjunctive treatment. Counselors see clients more often than the professionals who prescribe medications and can monitor potential side effects of medication. By communicating with the prescribing physician on a client's behalf, practitioners become strong

advocates for their clients. For these reasons, counselors are encouraged to familiarize themselves with the different medications used to treat PTSD, especially the SSRIs, which are prominent in the treatment of PTSD. Counselors can help wary clients who may not be convinced about the benefits of pharmacotherapy to better understand the consequences of using medication. Finally, counselors play an important role in improving clients' compliance with medication. This can be achieved by planning adjunctive sessions with family members or significant others.

Determining Which Approach to Use

Several approaches to trauma treatment have been outlined. The approach that a therapist adopts depends on several factors. First, the specific training of the therapist determines the approach used. Second, the client's phase of recovery guides treatment. The most effective mental health intervention in the immediate aftermath of a traumatic event is psychological first aid, which includes the provision of basic needs (food and shelter) and safety and security. Psycho-educational approaches help in stabilization and increasing one's knowledge about a traumatic event. Cognitive-behavioral approaches, which include relaxation techniques, assist in the reduction of physiological arousal. Co-morbid disorders are treated before beginning trauma-focused therapy, which involves in-depth exploration of traumatic material.

Clinicians often combine treatment methods. Psychopharmacology is often combined with individual therapy to reduce clients' physical symptoms associated with PTSD; this also makes clients more psychologically available for individual treatment. Other adjunctive treatments are family therapy and group therapy. However, when combining treatments, it is important to introduce one treatment at a time and evaluate its effectiveness before introducing another modality.

For therapists who have expertise in multiple approaches, the clients' needs take precedence over the therapeutic approach utilized. Discussing one's training with clients, especially if a client is seeking a particular model of therapy, is important early in the therapeutic relationship. For example, a client may have unsuccessfully tried cognitive therapy approaches and may be seeking an insight-oriented approach to therapy; being clear about therapeutic expertise helps clients establish clarity about their own needs. Finally, a consideration of cultural factors is a crucial determinant of the approach used and will influence clients' compliance.

Conclusion

Several models of treatment are currently used in trauma therapy. These include cognitive-behavioral therapy, EMDR, stage-oriented, and self-trauma models. Thus far, cognitive-behavioral therapy has been shown to be most successful (Cook et al., 2004; Foa et al., 2000). Other treatments, such as exposure therapy and EMDR, have received widely divergent evaluations from the scientific and professional community. Pharmacotherapy may be a necessary adjunctive treatment for clients who experience intense traumatic symptoms. The counselor can play a salient role in helping clients understand the effects of medications and in ensuring medication compliance.

Since trauma affects all aspects of an individual's functioning, treatment approaches that are holistic, comprehensive, and biopsychosocial are the most rational approaches; this is exemplified by the stage-oriented models proposed by Herman (1997), Briere (1996), and Chu (1998). These models are clinically sequenced according to three primary phases, each with a variety of healing tasks. Symptom reduction and stabilization appears to be the first goals of all three models. After these goals are reached, the client focuses on processing trauma memories and emotions. The final stage focuses on life integration, rehabilitation, and reconnection (Ford et al., 2004). Since these stage models of treatment illustrate a major overlap in terms of goals, areas of focus, and steps in treatment, it is quite likely that counselors can use any them to achieve similar results.

References

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford.

Briere, J. (1996). *Therapy with adults molested as children* (2nd ed.). New York: Springer.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 175–203). Thousand Oaks, CA: Sage.

Burton, K. B. (2004). Resilience in the face of psychological trauma. *Psychiatry, 67*(3), 231–234.

Chemtob, C. M., Tolin, D. F., van der Kolk, B. A., & Pitman, R. K. (2000). Eye movement desensitization and reprocessing. In E. B. Foa, T. M. Keane, & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for the Traumatic Stress Studies* (pp. 139–154). New York: Guilford.

Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders.* New York: Wiley.

Cook, J. M., Schnurr, P. P., & Foa, E. B. (2004). Bridging the gap between post-traumatic stress disorder research and clinical practice: The example of exposure therapy. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 374–387.

Crabtree, S. A.(2005). Medication, healing and resistance in East Malaysia. *Mental Health, Religion and Culture, 8*(1), 17–25.

Demartino, R., Mollica, R. F., & Wilk, V. (1995). Monamine oxidase inhibitors in posttraumatic stress disorder. *Journal of Nervous and Mental Disease, 183,* 510–515.

Devilly, G. J., & Spence, S. H. (1999). The relative efficacy and treatment distress of EMDR and cognitive behavioral trauma treatment protocol in the amelioration of post-traumatic stress disorder. *Journal of Anxiety Disorders, 13*(1–2), 131–157.

Devilly, G. J., Spence, S. H., & Rapee, R. M. (1998). Statistical and reliable change with eye movement desensitization and reprocessing: Treating trauma with a veteran population. *Behavior Therapy, 29,* 435–455.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford.

Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for post-traumatic stress disorder. *Annual Review of Psychology, 48,* 449–480.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Clinical and Consulting Psychology, 59*(5), 715–723.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70*(4), 1022–1028.

Ford, C. V., & Ebert, M. H. (2004). Remembering trauma. *Journal of Clinical Psychiatry, 65*(11), 1580.

Hembree, E., & Foa, E. B. (2000). PTSD: Psychological factors and psychosocial interventions. *Journal of Clinical Psychiatry, 61*(Supp. 7), 33–39.

Herman, J. L. (1997). *Trauma and recovery.* New York: Basic Books.

Horowitz, M. J. (1986). *Stress-response syndromes* (2nd ed.). New York: Jason Aronson.

Horowitz, M. J. (1997). *Stress response syndromes* (3rd ed.). Northvale, NJ: Jason Aronson.

Horowitz, M. J., Marmar, C., Krupnick, J., Wilner, N., Kaltreider, N., & Wallerstein, R. (1997). *Personality styles and brief psychotherapy* (2nd ed.). New York: Basic Books.

Hyer, L., & Brandsma, J. M. (1997). EMDR minus eye movements equals good psychotherapy. *Journal of Traumatic Stress, 10,* 515–522.

Jaycox, L. H., Zoellner, L., & Foa, E. B. (2002). Cognitive behavior therapy for PTSD and rape survivors. *Psychotherapy and Practice, 58*(8), 891–906.

Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimmering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy, 20,* 149–153.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Krupnick, J. L. (2002). Brief psychodynamic theory and PTSD. *Journal of Clinical Psychology, 58*(8), 919–932.

Lindy, J. D. (1996). Psychoanalytic psychotherapy of posttraumatic stress disorder: The nature of the relationship. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 525–536). New York: Guilford Press.

Lohr, J. M., Lilienfeld, S. O., Tolin, D. F., & Herbert, J. D. (1999). Eye movement desensitization and reprocessing: An analysis of specific versus nonspecific treatment factors. *Journal of Anxiety Disorders, 13,* 185–207.

Lohr, J. M., Tolin, D. F., & Lilienfeld, S. O. (1998). Efficacy of eye movement desensitization and reprocessing: Implications for behavior therapy. *Behavior Therapy, 29,* 123–156.

Marmar, C. R., Weiss, D. S., & Pynoos, R. S. (1995). Dynamic psychotherapy of posttraumatic stress disorder. In M. J. Friedman, D. S. Charney, & A. Y. Deutch (Eds.), *Neurobiological and clinical consequences of stress: From normal adaptation to post traumatic stress disorder* (pp. 495–506). Philadelphia: Lippincott-Raven.

Marotta, S. A. (2000). Best practices for counselors who treat posttraumatic stress disorder. *Journal of Counseling & Development, 78*(4), 492–495.

Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology, 58*(1), 23–41.

McNally, R. (1999). EMDR and mesmerism: A comparative historical analysis. *Journal of Anxiety Disorders, 13,* 225–236.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder (PTSD).* Waterloo, ON: Institute Press.

Meichenbaum, D. (1997). *Treating post-traumatic disorder.* Chichester, England: Wiley.

Meichenbaum, D. (1977). Dr. Ellis, please stand up. *Counseling Psychologist, 7*(1), 43–44.

Perkins, B. R., & Rouanzoin, C. C. (2002). A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. *Journal of Clinical Psychology, 58*(1), 77–97.

Resick, P. A. (2004). *Stress and trauma.* Philadelphia: Taylor Francis.

Schnurr, P. P., Friedman, M. J., & Foy, D. W. (2003). Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: Results from a

Department of Veterans Affairs cooperative study. *Archives of General Psychiatry, 60*(5), 481–489.

Shapiro, F. (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavioral Experimental Psychiatry, 20,* 211–217.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures.* New York: Guilford Press.

Sutherland, S. M., & Davidson, J. R. T. (1998). Pharmacological treatment of post-traumatic stress disorder. In P. A. Saigh (Ed.), *Posttraumatic stress disorder: A comprehensive text* (pp. 95–115). Boston: Allyn & Bacon.

Sweet, A. (1995). A theoretical perspective on the clinical use of EMDR. *The Behavior Therapist, 18,* 5–6.

van der Kolk, B. A. (1996). Trauma and memory. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 279–302). New York: Guilford Press.

van der Kolk, B., McFarlane, A., & van der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 417–440). New York: Guilford Press.

Vargas, M. A., & Davidson, J. (1993). Post-traumatic stress disorder. *Psychopharmacology, 16,* 737–748.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition.* Stanford, CA: Stanford University Press.