Best Practices for Counselors Who Treat Posttraumatic Stress Disorder

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Counselors in settings as diverse as schools, corporations, and community agencies are well aware of the numbers of people in the United States who daily come in contact with stressors that are extreme and potentially traumatic. Automobile accidents, disasters, or encounters with interpersonal violence are ubiquitous. Professional counselors, regardless of their professional identification or the settings in which they work, are very likely providing services to many people who are in distress after traumatic exposures. These counselors would benefit from knowing what other mental health professionals consider to be best practices for preventing and treating posttraumatic stress disorders (PTSDs). The purpose of this article is to summarize for counselors those best practices that have been recently developed and published by a multidisciplinary expert group (E. B. Foa, J. R. T. Davidson, & A. Frances, 1999) in their article "Treatment of Posttraumatic Stress Disorder."

In reading the guidelines, counselors should note that expert consensus guidelines represent only one form of guideline development. Another type of treatment guideline is based on empirically validated studies or controlled outcome research (efficacy studies). Expert consensus guidelines bridge the gap between highly controlled efficacy studies and clinical practice as it is experienced in real-world settings. The type of guideline summarized here uses a survey research method to describe the more complicated conditions that practitioners actually encounter but that are often excluded from efficacy studies in the interest of maintaining internal validity. Expert consensus guidelines supplement the mental health practitioner's clinical judgment with an expert opinion about both research and practice.

Two categories of experts were consulted in developing these treatment guidelines: psychotherapy experts and medication experts. Experts were identified from the published literature, from those receiving posttraumatic stress disorder (PTSD)-related grants, and from professional associations. There was a 95% response rate from the psychotherapy experts contacted and a 93% response rate from the medication experts contacted. A total of 109 experts participated in the survey (52 psychotherapy experts and 57 medical experts). The final pool was multidisciplinary in training and work setting. Counselors can obtain detailed information on the actual survey results, survey construction, analysis, limitations of the methods, and information for consumers at www.psychguides.com (Foa, Davidson, & Frances, 1999).

EXPERT CONSENSUS GUIDELINES

The 11 guidelines recommended by Foa et al. (1999) are organized in four domains: (a) diagnosis, (b) selecting initial treatment strategies, (c) what to do after the initial trial, and (d) other treatment issues. Because of space limitations in this article, and because the use of medications is beyond the scope of practice of counselors, the psychopharmacological guidelines will be only briefly described, whereas the psychotherapeutic recommendations will be more fully detailed.

Diagnosis

Guideline 1: How to recognize PTSD. This guideline defines for the practitioner the types of stressors that meet Criterion A (exposure to a traumatic event involving actual or threatened injury; American Psychiatric Association [APA], 1994) for PTSD, describes sample stressors, and outlines the required intensity of the stressor. For example, if the

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stressor is child physical abuse or neglect, the specific behaviors could include beatings, burning, restraints, or starvation. Actual or threatened serious injury with intense fear, helplessness, or horror must be experienced along with the stressor. In addition to interpersonal stressors, examples of accidents and natural disasters are listed. Key symptoms such as reexperiencing the traumatic event (e.g., nightmares or flashbacks), avoidance of trauma-related activities, emotional numbing, and increased arousal, and the duration for diagnosing acute non-PTSD stress, acute PTSD, and chronic PTSD are given in table form. Recognizing that PTSD is often accompanied by other disorders, the experts recommend that practitioners screen for substance abuse or dependence, major depressive disorder, panic disorder or agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, social phobia, and bipolar disorder.

Selecting Initial Treatment Strategies

Guideline 2: Selecting the overall treatment strategy. Regardless of the age, the severity level, and whether PTSD is acute or chronic, the experts agree that psychotherapy is the treatment of choice. The medication experts, however, often combine psychotherapy with medication initially, especially if the level of symptoms is severe. During the first 3 months of treatment, the experts prefer weekly sessions of individual therapy of about 60 minutes as the primary modality. The exception to this is for those using exposure therapy, in which case sessions longer than 60 minutes are recommended. For medication visits, experts recommend weekly appointments for the first month, followed by appointments every other week. It is important to note that when PTSD is accompanied by other psychiatric conditions, both types of experts recommend using psychotherapy in combination with medication. When severe substance abuse or dependence is comorbid with PTSD, the experts recommend treating the substance abuse problems first or at least simultaneously.

Guideline 3: Selecting the initial psychotherapy. Overall, the most highly recommended psychotherapy techniques are anxiety management, cognitive therapy, exposure therapy, and psychoeducation. Play therapy is recommended for children. The experts reported three preferences for treating specific PTSD symptoms: exposure therapy for intrusive thoughts, flashbacks, trauma-related fears, and avoidance; cognitive therapy for guilt and shame symptoms; and anxiety management for hyperarousal and sleep disturbances. Play therapy is recommended as a secondary intervention for children with intrusive thoughts, trauma-related fears, avoidance, guilt or shame, and hyperarousal or hypervigilance. Psychoeducation, although not considered a first-line treatment, was suggested for all categories of symptoms as a secondary intervention and for use with comorbid conditions. Choice of psychotherapy is also influenced by comorbidity. For example, treatment for a person with PTSD and substance dependence would begin with anxiety management.

Age of the client also influences choice of psychotherapy. Play therapy is preferred for children and younger adolescents, and exposure therapy is not recommended for older persons. The experts rated their preferences on several other criteria, such as most effective (exposure and cognitive therapies), fastest (exposure), safest (anxiety management, psychoeducation, and cognitive therapy), and most acceptable to the person (psychoeducation, cognitive therapy, and anxiety management).

Guideline 4: Selecting the initial medication. There are seven categories of preferences regarding medications for the treatment of PTSD. Like the psychotherapies, these delineate target symptoms, type of stressor, comorbidity considerations, age, adequacy of initial trial, and safety. With very few exceptions (e.g., sleep disturbances, bipolar disorder), the experts prefer the selective serotonin reuptake inhibitors (SSRIs) as the first line of treatment.

What to Do After the Initial Trial

Guideline 5: When the client has had no response. *No response* is defined as less than a 25% reduction in symptoms. A *good response* is defined as greater than a 75% reduction in symptoms that is maintained for at least 3 months. In a no-response situation, experts recommend adding one of the three preferred therapies not previously tried, switching to a different psychotherapy or medication, or both. Psychoeducation should be offered concurrently. If there has been no response to medication, another medication trial should be given.

Guideline 6: When the client has only a partial response. Partial response is defined as 25% to 75% of symptoms remaining. In this case, experts recommend continuing the treatment and adding either an additional therapy or another medication. To improve a partial response, the experts recommend adding one of the remaining treatments and psychoeducation. When the partial response is to medication alone, the most frequent addition is a mood stabilizer.

Guideline 7: When the client has not responded to multiple previous treatments. For those clients with persistent and nonresponsive PTSD, experts recommend careful evaluation of possible reasons for the lack of response, specifically by assessing for other comorbid conditions. Combinations of treatments proffered systematically and tailored to the individual are necessary in these cases.

Guideline 8: When the client has a remission or good response—strategies for the maintenance phase. Booster sessions of psychotherapy are recommended to maintain a good response to treatment. This is particularly useful for ongoing current stressors, poor functioning, risk of suicide or violence, and the presence of comorbid disorders. Medication management after a good response is necessary as well, and the experts recommend tapering rather than discontinuing medication.

Other Treatment Issues

Guideline 9: Medication dosing. This guideline provides a chart for each type of medication; the starting dose for adults; average dose for adults, children, and older adults; and the highest target dose. Caution is advised especially for medication usage among children and older adults.

Guideline 10: Enhancing compliance. In general, the experts recommend psychoeducation, frequent consultation with the client, and early involvement of the client's social support network. Information about medication side effects is also recommended.

Guideline 11: Prevention of PTSD and avoiding chronicity. This guideline recommends early intervention to prevent full-blown PTSD in the immediate aftermath of exposure, and in the acute phase of PTSD. Psychoeducation is recommended for both primary and secondary intervention when there are symptoms after exposure to an extreme stressor. It is especially important to help people understand what is normal about their reaction to a stressor. Relieving irrational guilt and facilitating client recall are recommended prevention strategies.

IMPLICATIONS FOR COUNSELORS

Within our profession, it is argued that counseling has been slow to identify best practices for delivering mental health services (Granello & Witmer, 1998; Steenbarger & Smith, 1996). Psychology and psychiatry, too, have labored to develop practice guidelines (Nathan, 1998) by conducting therapy outcome research and, more recently, with task forces studying the cumulative products of efficacy studies (cf. American Psychiatric Association, 1995; Chambless et al., 1996; Foa, Keane, & Friedman, 2000). Both critics and advocates of guideline development understand that the time is long past when practicing without guidelines is acceptable to both the public who use services and the professionals who provide such services. In addition, accountability in service provision is one way for a profession to grow in recognition. It is especially appropriate for professional counseling to be able to show the public and public policymakers that its practices are effective, efficient, and ethical. We do that in part by being knowledgeable about standards of care used by other mental health professionals and by staying abreast of evolving trends.

The *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (APA, 1994) reports that lifetime prevalence rates for PTSD range from 1% to 14%. By some estimates, up to three fourths of the population has been exposed to stressors severe enough to meet Criterion A for the diagnosis (Green, 1994). This means that counselors will work with people who have been exposed. It is important to remind ourselves that only a small proportion of those who encounter a severe stressor will go on to develop PTSD. The stressor is a necessary but not sufficient condition for a diagnosis of PTSD. Counselors will serve their clients better by knowing the differences between acute stress, acute PTSD, and chronic PTSD. Counselors who are attentive to prevention can help people to normalize their reactions after exposure so that further sequelae and a full diagnosis can be forestalled. On the other hand, because of the high rates of comorbidity in people with a PTSD diagnosis (Newman, Kaloupek, & Keane, 1996), counselors may encounter people whose initial presenting concern is depression or substance abuse but whose condition may mask a stress-related diagnosis. It is as unacceptable to overdiagnose PTSD based solely on the presence of a stressor as it would be to miss the diagnosis because the client's initial presentation is depression or anxiety. A thorough and ongoing assessment is required to arrive at the best-fit diagnosis or diagnoses and subsequent treatment plan.

The issue of comorbidity raised by these guidelines has another focus for counselors to consider. Given the likelihood that people with a PTSD diagnosis may have concurrent diagnoses, counselors would benefit from establishing a network of psychiatrists with whom they can collaborate in constructing treatment plans. New counselors should consider this an early and ongoing activity regardless of the type of employment setting they select. Some psychiatrists prefer to do their own psychotherapy, whereas others limit their practices to psychopharmacology. Knowing this can save a client considerable time, effort, and money when a counselor refers someone for psychiatric evaluation. This type of resource and referral list is as important to the school counselor as it is to an Employee Assistance Program (EAP) counselor.

One of the strengths of counselors is our focus on developmental approaches to treatment (Ginter, 1999). Our theoretical approach is especially useful when PTSD is the diagnosis because disruptions in trust or identity, for example, are known to be common consequences of PTSD. Because PTSD affects the ability of a person to trust others, building a working alliance between counselor and client is itself a primary helping strategy. Instilling hope, a healing factor that is particularly useful with complex PTSD presentations, is a developmental outcome of trusting relationships. Another strength of our theoretical foundation is that the level of cognitive or emotional development of our clients is automatically factored in to the models that we use. Counselors are attuned to the potential impact of life stage transitions on traumatic symptoms. A trauma experienced in childhood and treated then may resurface at a developmental transition such as marriage or the death of a significant family member. Counselors who use life story reviews with their older clients may need to keep in mind that such a review can elicit PTSD symptoms in older persons, especially if they are in the midst of life transitions.

Counselors have an educational approach to interventions, and these experts recommend psychoeducation as a secondary and sometimes as a primary intervention strategy. Psychoeducation that is age appropriate helps clients to normalize their situations and their symptoms. Clients can benefit from being informed about the etiology and potential consequences of PTSD. The guidelines caution us, however, that education in and of itself is not enough to address the spectrum of symptomatology experienced by people with trauma histories.

Counselors who follow these therapy guidelines will be seeing their clients more frequently than the professionals who administer medications. This means that they are in a good position to help clients monitor potential side effects.

To do that effectively, counselors must be able to communicate with the prescribing physician and to advocate on the client's behalf if necessary. Counselors' training in case management can be helpful in this regard. Given the prominence of SSRIs in the treatment of PTSD, it would be helpful for counselors to familiarize themselves with the effects of this one class of drugs. This will provide counselors with common language to use when collaborating with a treating physician. Counselors could also play a key role in helping clients who are wary of psychoactive agents to understand the benefits and costs of using medication.

The treatment guidelines highlight the need for counselors to be accountable for their treatment strategies. Accountability implies ongoing evaluation by counselor and client in a collaborative fashion. Regular evaluation procedures should be recorded in progress notes, along with specific behavioral indicators of client responses to specific interventions. Counselors might consider using standardized ways of evaluating response to treatment, such as symptom checklists, in addition to measuring subjective well-being in discussions with clients or family members.

Counselors can help improve compliance with psychotherapeutic interventions and medication regimens by incorporating adjunctive sessions with family or significant others. Although these experts did not regard family therapy as a primary treatment, it is considered a useful secondary intervention with the more complicated cases of PTSD. These adjunctive sessions could be structured around evaluating client progress and response to individual therapy.

Counselors in their role as consultant can also design in-service training for teachers, safety workers, and anyone who encounters victims of accidents, natural disasters, or interpersonal violence. The goal of these training sessions is to inform helpers about risk factors but also to provide concrete strategies for ameliorating the natural distress noted in the aftermath of a severe exposure. Because helpers are themselves at risk for vicarious traumatization, training might facilitate relief of symptoms among helping personnel. Some counselors might want to learn specific debriefing skills to prevent the development of PTSD.

CONCLUSION

Treatment guidelines are most useful when they are supplemented by the judgment of a counselor faced with a particular client, in a particular setting, with a particular set of problems. This is as true for the treatment of PTSD as it is for other problems with living. Counselors who take these guidelines seriously and who document their procedures well may find that they are better able to address the complexities of clients with stress-related disorders. Systematic documentation may help the counseling profession to develop its own best practices for mental health counseling in the future.

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